MENTAL HEALTH ACT
POLICY

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Purpose of Policy	The effective and efficient administration of the Mental Health Act is a critical element of the work of Solent NHS Trust. This Policy has been produced to ensure that the Act is carried out equitably and to the highest professional standards.
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Amendments Summary:

Please fill the table below:

Amend No	Issued	Section	Subject	Action Date
1	February 2016	1.6	Include reference to Code of Practice (COP 2015)	February 2016
2	February 2016	1.7	Contact number update and change to guiding principles	February 2016
3	February 2016	1.8 to 1.13	New sections to cover Human Rights and Equality sections in revised Code of Practice.	February 2016
4	February 2016	3.8	Removed reference to appendix	February 2016
5	February 2016	3.11	Carers and advocates sentence added	February 2016
6	February 2016	3.14	Reference updated	February 2016
7	February 2016	3.15	Added to in light of the new Code (more guidance on what to include)	February 2016
8	February 2016	3.40	Reference update	February 2016
9	February 2016	3.42	Reference to appendix removed	February 2016
10	February 2016	3.60	Reference update	February 2016
11	February 2016	3.104 to 3.107	Removed as there is no longer an SLA with PHT in place	February 2016
12	February 2016	3.158	Removal of reference to a sample letter as this has been removed from the code	February 2016
13	February 2016	3.174	Update in light of new code: inclusion of case in which patient has no NR	February 2016
14	February 2016	3.175	Reference update	February 2016
15	February 2016	3.189	Reference to BNF qualified: the current BNF recommended in guidance and need for RCs to stay up to date	February 2016
16	February 2016	3.196	Removal of need for statutory consultee to complete form in light of changes to Code	February 2016
17	February 2016	3.215 (now 3.217)	Review of referral times changed to annual and not six monthly	February 2016
18	February 2016	3.231 to 3.234	Removed need to report AWOL to CQC in light of new regulations	February 2016
19	February 2016	3.238 (now 3.239)	Reference update	February 2016
20	February	3.240 (now	Reference update	February 2016

	2016	3.239)		
21	February 2016	3.241 to 3.245	Removal of guidance in relation to s17 in light of new case law. Inclusion of new 3.242 guidance	February 2016
22	February 2016	3.320 to 3.231	Removal of sections as OPMH now have the same RC for in and outpatient.	February 2016
23	February 2016	3.417 (now 3.412)	Removal of reference to appendix and changed to guidance.	February 2016
24	February 2016	3.424 to 3.426	Removal of guidance and inserted referral to COP ch 13 at 3.418	February 2016
25	February 2016	References	Removal of reference to CQC guidance as they have withdrawn this.	February 2016
26	February 2016	Appendixes	Guidance is removed from appendixes so it can be kept under review by the relevant lead and issued on an ongoing basis.	February 2016

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
2	February 2016	Richard Murphy	Divisional governance groups Policy Steering Group Assurance Committee	

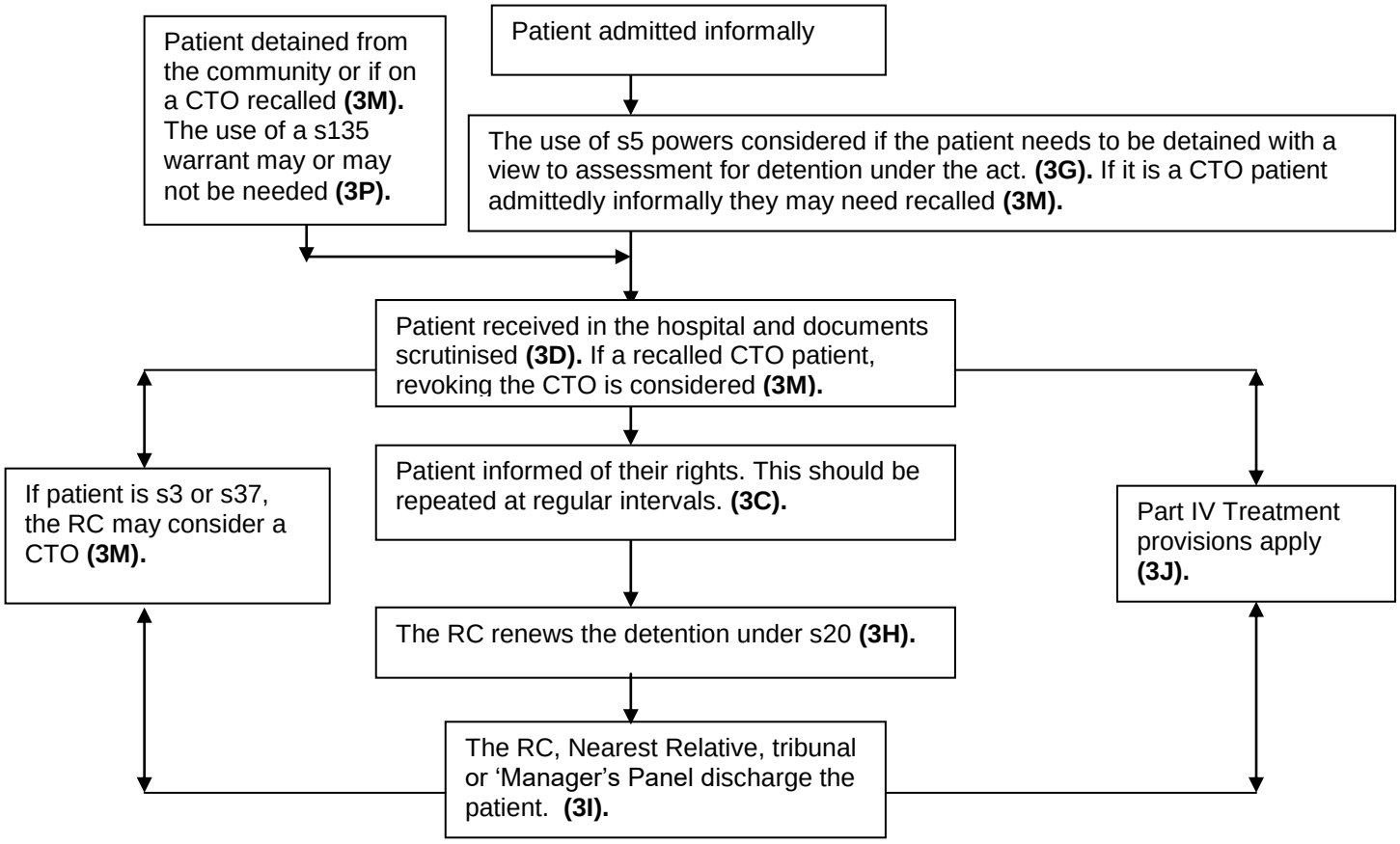
Table of Contents

Executive Summary

This policy sets out how the powers and duties of the Mental Health Act will be delegated and administered within Solent NHS Trust. This includes what safeguards will ensure that patients are only detained and treated as the law allows.

The various sections of the policy deal with different aspects of the Act. The patient journey below illustrates where they are relevant to the patient pathway.

The Patient's Journey



Parts of the policy that apply throughout the period of admission

3E Transfer of patients between wards or hospitals

3O Entry and Exit from the wards and visiting of patients

3N Information shared under the Domestic Violence Crime and Disorder Act

3L Reporting instances of AWOL and Deaths of detained patients to the CQC

3R Overlap between the Mental Capacity Act 2005, the Deprivation of Liberty Safeguards and the Mental Health Act 1983.

1. INTRODUCTION & PURPOSE

1.1 This policy is a reference document. It is not designed to be used as a step by step guide to a detained patient's journey. The topics in the policy were chosen as they constitute the specific duties for which the Board for Solent NHS Trust have a duty to delegate within the organisation. The flowchart on p6 may help staff to place the sections of the policy into the context of the patient's journey.

1.2 The Mental Health Act 1983 sets out the duties and powers that detaining authorities have in regard to detained patients. In doing so it places these duties and powers with the 'hospital managers'. For NHS trusts this term means the organisation itself. For Solent NHS Trust these are the ultimate responsibility of the board. In particular, the board 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. This policy outlines how the board delegates these and in doing so sets out Solent NHS Trust's scheme of delegation.

1.3 The Mental Health Act 1983 Code Of Practice sets out requirements for detaining authorities to have policies in place to cover a number of areas. This policy sets out these requirements and meets them or states how they are met by other Solent NHS Trust Policies.

1.4 The policy includes a delegation of a number of roles under the Mental Health Act to employees of Solent NHS Trust. However, Solent NHS Trust's power under s23 to discharge patients from detention can not be delegated to employees but only to volunteers who are members of a committee or sub-committee of the board or who are non-executive directors. The duties and related delegation in relation to this power is covered in section 3I of the policy.

1.5 The effective and efficient administration of the Mental Health Act is a critical element of the work of Solent NHS Trust. This policy has been produced to ensure that the Act is carried out equitably and to the highest professional standards.

1.6 This Policy has been written and compiled for professionals who are involved in the day to day procedures of the Mental Health Act 1983. It has been fully updated to comply with the requirements of the law as amended by the MHA 2007. However, it is not a comprehensive guide to the Mental Health Act 1983; for more information on the Act a list of reference books follows.

1.7 Responsible Clinicians can seek further advice and clarification from any of the staff members listed below. When completing statutory forms and if in doubt, they are encouraged to do so. Other members of staff, are also invited to contact with any specific queries.

Mental Health Act Policy Lead
St James Hospital 07703770032

Mental Health Act Administrator The Orchards St James' Hospital	023 9268 2526
Mental Health Act Administrator The Orchards St James' Hospital	023 9268 2525
First Tier Tribunal	0116 249 7255
Care Quality Commission	03000 616161

1.7 The following are the guiding principles as written in the Mental Health Act 1983 Code of Practice. All professionals undertaking duties under the Act must have regard to them and they should underpin all aspects of practice and decision making.

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.

Using the principles
All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998.

The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.

That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision. Any decision to depart from the principles should be recorded with clear reasons.

1.8 When making decisions under the Mental Health Act decision makers will also need to be clear of their responsibilities under Human Rights legislation and Equality legislation.

1.9 The HRA gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights. The Human Rights Act 1998 places a duty on public authorities to respect and protect people's human rights. A wide range of bodies carrying out public functions, including the delivery of public services by private and contracted-out providers, have legal obligations to respect and protect human rights.

In some instances, competing human rights will need to be considered, which may require finely balanced judgements. Such decisions and the reasons for them should be clearly documented. Decisions restricting a person's rights will need to be justifiable as necessary and proportionate in the circumstances of the specific case. Any restriction imposed should be kept to the minimum needed to meet the purpose and aim of the restriction.

1.10 The Equality Act makes it unlawful to discriminate (directly or indirectly) against a person on the basis of a protected characteristic or combination of protected characteristics.[1] Protected characteristics under this Act include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The protected characteristic of disability includes a mental impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities.

1.11 This may involve treating persons with mental health problems more favourably than others in order to achieve equality of access to services and outcomes.

1.12 The Equality Act places a duty on providers of services to the public to make reasonable adjustments for people with an impairment (including mental impairment) that constitutes a disability under the Equality Act. Providers must take reasonable steps to avoid putting a person with a disability at a substantial disadvantage compared with those who are not disabled.

1.13 The reasonable adjustments a person may need could be considered as part of a person-centred care planning process in all mental health service settings (see chapter 34). The duty applies where:

• a provision, criterion or practice puts disabled people at a substantial disadvantage compared with those who are not disabled;

• a physical feature puts disabled people at a substantial disadvantage compared with people who are not disabled; and

• not providing an auxiliary aid puts disabled people at a substantial disadvantage compared with people who are not disabled.

2. SCOPE & DEFINITIONS

Scope

2.1 This document applies to all directly and indirectly employed staff within the Trust and other persons working within the organisation in line with Solent NHS Trusts Equal Opportunities Document.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

Definitions

2.3 **Advance Decision to Refuse Treatment (ADRT)**: Defined in the Mental Capacity Act 2005. A person may at a time when they have the mental capacity to do so, make a decision to refuse specific treatment at a future date when they lack capacity to do so. IF the treatment is life sustaining treatment it must be written, witnessed and in a specific form. An ADRT does not apply to certain treatments given under the authority of the Mental Health Act 1983.

2.4 **Approved Clinician (AC):** A practitioner who has been specially approved to undertake certain functions under the Mental Health Act 1983, including the role of RC. Solent NHS Trust has a register of all practitioners who have been given this approval by the Strategic Health Authority. Only practitioners with this approval can act as a patient's Responsible Clinician.

2.5 **Approved Mental Health Professional (AMHP**): Professional Practitioners approved by the Local Authority Social Services to perform certain roles under the Act. These include coordinating Mental Health Act assessments, making applications for detention under the Act and considering if Community Treatment Orders meet the statutory criteria and should be made and if so, if they agree to the Responsible Clinician's conditions.

2.6 **Care Quality Commission (CQC):** The regulatory body of NHS Hospitals**.**

2.7 **Community Treatment Order (CTO)**: An amendment of the Mental Health Act, made in 2007, that enables the compulsory care of patients in the community without the need for an element of hospital treatment.

2.8 **Consent to Treatment Provisions**: The part of the Mental Health Act that sets out the requirements with regard to the treatment of detained patients and patients subject to Community Treatment Orders.

2.9 **Electro Convulsive Therapy (ECT)**: A specific form of treatment for mental disorder. There are additional safeguards regarding its use with detained patients.

2.10 **Independent Mental Health Act Advocate (IMHA):** Each detained patient has the right to support from an IMHA. They are independent of Solent NHS Trust and their role is to support the patient through the processes of accessing their rights and representing the patient's view, or supporting the patient to represent their own view.

2.11 **Lasting Power of Attorney (LPA):** The legal power of a person to appoint a donee or donees who, at a stage when the person lacks capacity, will have the power to make specified decisions on that person's behalf. There are welfare and property and affairs LPAs. The legal documents are available from the Office of the Public Guardian.

2.12 **Mental Capacity Act 2005 (MCA):** The statute in relation to matters concerning mental capacity including determining if a person is unable to make a specific decision at a specific time and the powers and duties others have to them. The Act also sets out the powers to make a Lasting Power of Attorney and an advance decision to refuse treatment.

2.13 **Nearest Relative (NR):** A specific role of an identified relative in relation to detained patients, persons where the making of an application under the Act is being considered and persons who are likely to have an application under the Act considered. Who the NR is is determined by very specific rules set out in in s26 of the MHA. It is not the same as 'next of kin'.

2.14 **Responsible Clinician (RC):** The Approved Clinician with overall responsibility for the patient's care. A patient can only have one RC at any one time. Only a practitioner with AC status can act as an RC. Every detained patient must have an RC appointed by Solent NHS Trust. An RC cannot delegate their roles with regard to s17 but Solent NHS Trust can direct another AC to temporarily take on the role if the normal RC is not available at the time a s17 leave decision needs to be made. This will be done in line with the Mental Health Act Procedures and Guidelines Policy.

2.15 **System One:** The electronic patient information system used within the organisation.

2.16 **Statutory Forms:** The Mental health Act requires statutory forms to be used when staff members undertake specific functions in relation to the Act. These are:

A1 Section 2 – application by nearest relative for admission for assessment

A2 Section 2 – application by an approved mental health professional for admission for assessment

A3 Section 2 – joint medical recommendation for admission for assessment

A4 Section 2 – medical recommendation for admission

for assessment

A5 Section 3 – application by nearest relative for admission for treatment

A6 Section 3 – application by an approved mental health professional for admission for treatment

A7 Section 3 – joint medical recommendation for admission for treatment

A8 Section 3 – medical recommendation for admission for treatment

A9 Section 4 – emergency application by nearest relative for admission for assessment

A10 Section 4 – emergency application by an approved mental health professional for admission for assessment

A11 Section 4 – medical recommendation for emergency admission for assessment

H1 Section 5(2) – report on hospital in-patient 4(1)(g)

H2 Section 5(4) – record of hospital in-patient 4(1)(h)

H3 Sections 2, 3, and 4 – record of detention in hospital 4(4) and (5)

H4 Section 19 – authority for transfer from one hospital to another under different managers

H5 Section 20 – renewal of authority for detention 13(1), (2) and (3)

H6 Section 21B – authority for detention after absence without leave for more than 28 days

G1 Section 7 – guardianship application by nearest relative

G2 Section 7 – guardianship application by an approved mental health professional

G3 Section 7 – joint medical recommendation for reception into guardianship

G4 Section 7 – medical recommendation for reception into guardianship

G5 Section 7 – record of acceptance of guardianship

application

G6 Section 19 – authority for transfer from hospital to guardianship

G7 Section 19 – authority for transfer of a patient from the guardianship of one guardian to another 8(1)(a), (d) and (e)

G8 Section 19 – authority to transfer from guardianship to hospital

G9 Section 20 – renewal of authority for guardianship 13(4) and (5)

G10 Section 21B – authority for guardianship after absence without leave for more than 28 days

M1 Part 6 – date of reception of a patient in England 15(2), (4)(a) and 16(2)

M2 Section 25 – report barring discharge by nearest relative

T1 Section 57 – certificate of consent to treatment and second opinion

T2 Section 58(3)(a) – certificate of consent to treatment 27(2)

T3 Section 58(3)(b) – certificate of second opinion 27(2)

T4 Section 58A(3) – certificate of consent to treatment (patients at least 18 years old)

T5 Section 58A(4) – certificate of consent to treatment and second opinion (patients under 18)

T6 Section 58A(5) – certificate of second opinion (patients who are not capable of understanding the nature, purpose and likely effects of the treatment)

CTO1 Section 17A – community treatment order

CTO2 Section 17B – variation of conditions of a community treatment order

CTO3 Section 17E – community treatment order: notice of recall to hospital

CTO4 Section 17E – community treatment order: record of patient's detention in hospital after recall

CTO5 Section 17F(4) – revocation of community treatment

order

CTO6 Section 17F(2) – authority for transfer of recalled community patient to a hospital under different manager

CTO7 Section 20A – community treatment order: report extending community treatment period

CTO8 Section 21B – authority for extension of community treatment period after absence without leave for more than 28 days

CTO9 Part 6 – community patients transferred to England 16(4) and (5)

CTO10 Section 19A – authority for assignment of responsibility for community patient to a hospital under different managers

CTO11 Section 64C(4) – certificate of appropriateness of treatment to be given to community patient (Part 4A certificate)

CTO12 certificate certifying capacity and consent of a CTO patient

3. PROCESS/REQUIREMENTS

3A Scheme of Delegation

3.1 The Solent NHS Trust Board have ultimate responsibility for the powers and duties carried out on its behalf under the Mental Health Act 1983. This policy sets out the delegation and governance of those duties. The main duties and powers and their delegation are summarised in Appendix 1.

3B Policy Requirements

3.2 The Mental Health Act 1983 Code of Practice requires Solent NHS Trust to have policies in relation to a number of areas relevant to the Mental Health Act 1983. These requirements are met by this policy and a number of other related policies. These requirements are monitored by the Mental Health Act Scrutiny Committee.

3C Information for patients, nearest relatives and others

3.3 Solent NHS Trust is required to keep all detained patients and patients subject to CTO informed of their rights under the Mental Health Act 1983. This duty is delegated to the most appropriate front line staff and monitored by the Mental Health Act Administration team and the Mental Health Act Scrutiny Committee.

3.4 The purpose of this section of the policy is to ensure that:

- the correct information is given to patients and their nearest relatives;
- information is given in accordance with the requirements of the MHA, at a suitable time and in an accessible format, where appropriate with the aid of assistive technologies and interpretative and advocacy services;
- people who give the information have received sufficient training and guidance;

- a record is kept of the information given, including how, when, where and by whom it was given, and an assessment made of how well the information was understood by the recipient; and
- a regular check is made that information has been properly given to each patient and understood by them.

3.5 A number of different professionals have duties to provide information under the Mental Health Act 1983: AMHPs, IMHAs, RCs and hospital and community staff. Some of these staff will be employees of Solent NHS Trust and others will not. Solent NHS Trust staff need to be clear that when they have a specific duty to provide information this can not be discharged by a member of another organisation providing information; nor, can a failure to provide information be excused by reference to a failure of another professional to provide similar information; when a member of Solent NHS Trust staff have a duty to provide information under the Act it is their duty to ensure it is discharged either by them or another appropriate Solent NHS Trust staff member on their behalf.

3.6 Information can be provided by staff who are members of a professional body or by other staff who have received appropriate training from the Mental Health Act Administration team.

3.7 The duty to provide information is delegated as follows

Situation	**Professional Initially responsible**	**Professional with ongoing responsibility**
Patient subject to new application or court order, recalled to hospital from s17 leave or CTO and patient revoked from a CTO.	Nurse receiving detention papers	Patient's Lead Nurse
Detained patient transferred to ward	Nurse receiving detention papers	Patient's Lead Nurse
Inpatient made subject to CTO	Patient's Lead Nurse Community Care Co-ordinator	Community Care Co-ordinator
Outpatient made subject ot a CTO	Community Care Co-ordinator	Community Care Co-ordinator
Patient first subject to treatment under s58 or s58A	Responsible Clinician (treatment provisions only)	Responsible Clinician (treatment provisions only)

3.8 These actions must be recorded on the appropriate patient's rights form and on System One; apart from the Responsible Clinician's duty to inform and keep the patient informed of the treatment provisions of the Act. This is to be recorded on System One and on the Consent to Treatment Forms.

3.9 The recording on System One must include:

- who gave the information,
- how the information was given,
- how well the information was understood, and
- when the information will be repeated.

3.10 All information is to be provided orally and in writing. All wards will have written information to provide patients with. Further written information in a number of different languages and easy to read formats is available on the Mental Health Act 1983 intranet site. If a person is unable to read or has difficulty reading then a staff member must read the information with or for the patient, unless the patient does not want this.

3.11 Staff discharging these duties must take every practicable step to ensure information is provided in a means the patient can understand. This includes consideration of the use of an interpreter, if the person's first language is not English. Carers and advocates should be involved where the patient wishes or if the patient lacks capacity to understand.

3.12 If the patient is unable to understand the information then consideration should be given to when it will be repeated. Hospital wards and community teams must have processes in place to ensure that these actions can be scheduled and monitored. However, it remains the responsibility of the lead nurse and care coordinator to ensure that the duty is discharged for their patients/ service users they are responsible for. A review of these duties should be a part of regular management supervision.

3.13 If the patient is unable to understand the information due to their mental disorder and this is likely to remain so permanently or for an extended period of time, then a referral can be made to the IMHA service to consider non-instructed advocacy. The advocate can review the case and ensure the provisions of the Act are complied with.

3.14 Chapter 4 of the Code of Practice sets out guidance on what information is to be provided and when. Staff undertaking these duties should be familiar with this guidance, which is summarised below.

Information to be provided

3.15 The reasons and consequences of detention:

- The factual and legal grounds of their detention: To enable the patient to challenge their detention, should they wish, they should be given the full facts surrounding it. They should be given the opportunity to view a copy of the detention documentation, unless the hospital managers are of the opinion (based on the advice of the authors of the documents) that the information disclosed would adversely affect the health or wellbeing of the patient or others. This includes the AMHP's report. It may be necessary to remove any personal information about third parties.
- The provisions of the Act under which they are detained or on CTO, and the effect of those provisions. Where the following apply, the patient should be informed:
    - 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 or CTO ends;

- that their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends
- the reasons for being recalled; and
- for patients subject to a CTO, the reasons for the revocation of a CTO.

- The rights (if any) of their nearest relative to discharge them (and what can happen if their responsible clinician does not agree with that decision).
- For patients under CTO, this should include the information outlined in the part of this policy covering community treatment orders.

3.16 Information about consent to treatment:

- The circumstances (if any) in which they can be treated without their consent – and the circumstances in which they have the right to refuse treatment.
- The role of second opinion appointed doctors (SOADs) and the circumstances in which they may be involved.
- Where relevant the rules on electro-convulsive therapy (ECT).

3.17 Information about seeking a review:

- The right of the responsible clinician and the hospital managers to discharge them (and, for restricted patients, that this is subject to the agreement of the Secretary of State for Justice).
- Their right to ask the hospital managers to discharge them.
- That the hospital managers must consider discharging them when their detention is renewed or their CTO extended.
- Their rights to apply to the Tribunal, the role of the Tribunal and how to apply.
- The rights (if any) of their nearest relative to apply to the Tribunal on their behalf.
- That they are likely to be entitled to legal aid if they apply to a Tribunal, how they can access legal advice and how they can access the IMHA service to support with this.

3.18 Information about the Care Quality Commission:

- That the Care Quality Commission is an independent regulatory body that over sees the implementation of the Mental Health Act 1983.
- That the commission makes unannounced visits to the hospital.
- That, during these visits, the patient may request to speak to the commissioner in private.
- How to make a complaint to the Care Quality Commission and that the IMHA service could support them to do this.
- How to make a complaint to Solent NHS Trust and that the IMHA service could support them to do this.

3.19 Information about Independent Mental Health Advocates (IMHA)

- Their entitlement to the support of an IMHA to understand and exercise their right sunder the Mental Health Act 1983.

3.20 With holding of Outgoing Post

- That section 134 entitles Solent NHS Trust to withhold any outgoing mail if requested to do so by the recipient. The process is outlined below.

Other duties regarding IMHAs

3.21 Some informal patients also have the right tot the support of an IMHA; they are patients:

- being considered for a treatment to which section 57 applies ("a section 57 treatment"); or
- under 18 and being considered for electro-convulsive therapy or any other treatment to which section 58A applies ("a section 58A treatment").

In these cases the RC is responsible for informing the patient of their rights to an IMHA.

3.22 The Code of Practice summarises the duties of an IMHA as helping a patient to understand and exercise their rights in the following areas:

- their rights under the Act;
- the rights which other people (eg nearest relatives) have in relation to them under the Act;
- the particular parts of the Act which apply to them (eg the basis on which they are detained) and which therefore make them eligible for advocacy;
- any conditions or restrictions to which they are subject (eg as a condition of leave of absence from hospital, as a condition of a community treatment order, or as a condition of conditional discharge);
- any medical treatment that they are receiving or might be given;
- the reasons for that treatment (or proposed treatment); and
- the legal authority for providing that treatment, and the safeguards and other requirements of the Act which would apply to that treatment.

3.23 The multi-disciplinary team should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA's visit but is unable or unlikely for whatever reason to request an IMHA's help themselves. If such a visit is requested it is done so on behalf of the RC. This should be done for patients who lack capacity to request an IMHA's support, unless there are clear and good reasons not to do so. These reasons must be recorded.

3.24 Before requesting an IMHA to visit a patient, they should, wherever practicable, first discuss the idea with the patient, and give the patient the opportunity to decide for themselves whether to request an IMHA's help. RCs should not request an IMHA to visit where they know, or strongly suspect, that the patient does not want an IMHA's help, or the help of the particular IMHA in question.

3.25 IMHAs must comply with any reasonable request to visit and interview a qualifying patient, if the request is made by the patient's nearest relative, an approved mental health professional (AMHP) or the patient's responsible clinician (if they have one). But patients may refuse to be interviewed and do not have to accept help from an IMHA if they do not want it.

3.26 IMHA's also have certain rights to access the patient's records and visit the patient. These are detailed in paragraphs 20.21 to 20.33 of the Code of Practice and section 3O of this policy. The RIO operating policy sets out a process for IMHA to access files. For the purpose of deciding what is

appropriate for the IMHA to view, in Solent NHS Trust the RC is the record holder and in the event of a dispute has the final view on this matter.

Process for with holding outgoing post

3.27 The Act only allows for outgoing post to be withheld if the recipient has made the request in writing.

3.28 The request should be made in writing and addressed to Solent NHS Trust; the patient's responsible clinician (if the patient has one) or the approved clinician with overall responsibility for the patient's case (if not); or the Secretary of State for Health or Justice.

3.29 With regard to outgoing mail, any such request should be clearly recorded on RIO. This should include who made the request, who received it and how long it remains valid for. A copy should be uploaded onto RIO.

3.30 If such a request is in force the addresses of post sent by the patient should be checked before it goes in the hospital mail. Any time mail is with held this should be recorded on RIO by the nursing staff involved and the patient informed.

3.31 The Mental Health Act Administration team must be made aware of any such request. The Mental Health Act Lead will report any such request to the Mental Health Act Scrutiny Committee.

3.32 Post sent to a patient detained in an NHS Solent Trust hospital may not be inspected, opened or withheld under any circumstances. Specific provisions in relation to this are made for special hospitals only. However, if either a detained or informal patient is sent articles of potential danger, such as weapons, explosives or matches, through the mail, section 3(1) of the Criminal Law Act 1967 and the common law provide authority for hospital staff to take reasonable measures to prevent the patient receiving or keeping the article in his / her possession. If there are concerns in this regard then further advice should be sought from the Mental Health Act Lead.

Review of patient's rights

3.33 Information giving to patients shall be repeated at regular intervals. All wards must have a set period of time in which a person's rights must be reviewed with them. This time period must be agreed with the Mental Health Scrutiny Committee. Those in charge of wards must ensure these are complied with. In addition, rights should be reviewed when:

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

Role of Mental Health Act Administrators

3.34 The Mental Health Act Administrator will then, as soon as practicable after commencement of the patient's detention, write to the patient and the nearest relative (unless the patient objects) informing them of the information set out in Section 132 of the Mental Health Act.

3.35 The Mental Health Act Administrators will also, unless the patient objects, keep the nearest relative informed of the renewal of a patient's detention, extension of CTO or transfer from one hospital to another.

3.36 Section 133 provides that, unless either the patient or nearest relative requests otherwise, the hospital managers will take such steps as are practicable to provide the nearest relative with at least seven days notice of the discharge of a patient from detention or CTO.

3.37 In circumstances where discharge from detention can be assured seven days in advance the above action will be taken by the Mental Health Act Administration team. However, the Trust accepts that often this is not feasible due to the patient being discharged immediately from section when the criteria for detention are no longer met.

3.38 In addition, there will occasionally be cases where the duty to inform a nearest relative, even in the absence of objection by the patient, does not apply because disclosing information about the patient to the nearest relative cannot be considered practicable, on the grounds that it would have a detrimental impact on the patient that is disproportionate to any advantage to be gained from informing the nearest relative. This would therefore be a breach of the patient's right to privacy under the European Convention on Human Rights. The risk of this is greatest where the nearest relative is someone whom the patient would not have chosen themselves.

3.39 The Mental Health Act Administration team will monitor and audit the provision of information to patients in line with this policy. This will be reported to the Mental Health Act Scrutiny Committee on a quarterly basis.

3D Receipt and Scrutiny of Detention Papers

3.40 The Code of Practice, Mental Health Act 1983, Chapter 35 gives guidance as to the receipt and scrutiny of Section papers. This Policy is drawn from that guidance. If there is any doubt then the Mental Health Act Lead should be consulted.

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

3.42 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 fundamentally undermine the authority to detain. In discharging this duty they must follow the processes and use the appropriate checklist.

3.43 All qualified nurses who act as senior nurse must receive education on the receipt of section documents.

3.44 The papers are then passed to the Mental Health Act Administrator who further scrutinises them for accuracy, arranges medical scrutiny and for any correctable errors to be amended.

3.45 Where a patient is admitted under the Act on the basis of an application by their nearest relative, the Mental Health Act Administrators must request the relevant local social services authority (LSSA) to provide them with the social circumstances report required by section 14.

Process for receiving Detention Papers

3.46 The nurse in charge will receive the detention papers from the AMHP and keep all Section forms with the patient's medical notes until all papers are completed.

3.47 The nurse in charge of the ward receiving the Section papers will check the accuracy of the papers with the AMHP before the AMHP leaves, ensuring there are no errors that would invalidate the authority to detain.

3.48 The authority to receive the papers by signing Form H3, MHA, for Section 2, 3, 4 and 5, is delegated to the nurse in charge. Although 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 Solent NHS Trust that it is completed at the time the patient and detention papers are received.

3.49 On completion of all papers, the nurse in charge will arrange for the papers to be collected/ taken immediately to the Mental Health Act Administration Department for scrutiny of MHA Section papers. 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.

3.50 The role of the Mental Health Act Administrator is to scrutinise all Section papers following the patient's admission or, if the patient is admitted outside of office hours, on the next working day.

3.51 The Mental Health Act Administrator will scrutinise the documents for errors. Some errors can be corrected under Section 15 of the Mental Health Act. A specific form to assist with this task will be provided to the service and kept up to date by the Mental Health Act Lead. However, other errors cannot be corrected and potentially invalidate the application for admission. In cases where the error cannot be corrected, the following steps must be taken:

- Where practicable, The Mental Health Act Lead should be consulted for a final view. Legal advice will be sought if necessary.
- The applicant and the patient must immediately be advised of the rejection of the application.
- The patient must be informed of the need for him/her to obtain legal advice.
- An appropriate note must be made in the patient's records.
- The authority to detain under the current section should not be relied on but, whilst they remain an in-patient, consideration should be given to the use of holding powers under Section 5(2) or (4).

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3.52 The Mental Health Act Administrators will arrange for any corrections, under s15, to be made to the forms. Details of these corrections with dates will be recorded on the appropriate form. All errors, both correctable and non-correctable, will be reported to the Mental Health Act Scrutiny Committee.

3.53 Mental Health Act Administrator will photocopy the Section papers and send them to the ward, where they will be filed in the patient's copy legal file.

3.54 The Section papers are sent by the Mental Health Act Administrator to an Approved Clinician for scrutiny of the medical recommendations to ensure that they show sufficient legal grounds for detention. If any errors are identified then the processes in 3.39 should be followed.

Identification of other errors or circumstances that cast doubt on the authority to detain

3.55 Errors to the paperwork may be identified at other times or circumstances that cast doubt on the authority to detain may come to light. For example, facts about the assessment process or potential conflicts of interest. In these situations the Mental Health Act Lead should be consulted for a view and legal advice will be sought if necessary.

3.56 If a view is taken not to rely on the authority to detain then the incident must be reported to the Mental Health Act Scrutiny Group by the Mental Health Act Lead.

Patients detained under Part III (Patients subject to Criminal Proceedings or under sentence)

3.57 These papers should be received by the Mental Health Act Administrators, ideally before the patient arrives. Where this is not practicable, the ward has the responsibility to deliver the papers to the Mental Health Act Administrators the next working day.

3.58 The Mental Health Act Administrators should check these for accuracy and clarify any conditions associated with the order or further actions needed. They should then photocopy papers and start a legal file for the ward.

Register of detained Patients and monitoring

3.59 The Mental Health Act Administrators are responsible for keeping a register of detained and Community Treatment Order patients that Solent NHS Trust are responsible for.

3.60 The Mental Health Act Lead will report statistics on the number of detained patients to the Mental Health Act Scrutiny Committee. This will include the use of s4, to monitor and take steps, when necessary, to prevent misuse of that section.

Receipt of other statutory documents

3.61 The table below sets out who, on behalf of Solent NHS Trust, are authorised to receive other statutory documents that are not mentioned elsewhere in this policy.

Statutory form	Person/ persons authorised to receive it
H5 Section 20 – renewal of authority for detention	The Mental Health Act Administrators
H6 Section 21B – authority for detention after absence without leave for more than 28 days	Lead nurse on the ward, Mental Health Act Administrators.
G8 Section 19 – authority to transfer from guardianship to hospital	Lead nurse on the ward, Mental Health Act Administrators.
M1 Part 6 – date of reception of a patient in England 15(2), (4)(a) and 16(2)	Lead nurse on the ward, Mental Health Act Administrators.

3E Transfer of detained Patients (including into Guardianship)

3.62 Before any transfer of a patient between wards or hospitals consideration should be given to the guiding principles of the Act and to whether the transfer is in the patient's best interest. Paragraphs 37.16 to 37.27 of The Code of Practice gives detailed guidance on factors to consider and who should be consulted.

3.63 Transfers should only occur if there is a good reason to do so. Wherever possible the patient should be involved in discussions about the transfer and their views recorded. It is important to explain the reasons for a proposed transfer to the patient and, where appropriate, their nearest relative and other family or friends, and to record them. Only in exceptional circumstances should patients be transferred to another hospital without warning.

3.64 A transfer to another hospital could potentially engage the patient's European convention of Human Rights Article 8, right to Private and Family life. Therefore, if it is done without the consent of the patient then it must be necessary to promote their recovery, health or manage risk to themselves or others and be a proportionate response to the situation.

3.65 A patient may themselves request a transfer. The professionals involved in their care should always be prepared to discuss the possibility of a transfer, and should raise the issue themselves with the patient if they think the patient might be interested in, or benefit from, a transfer.

3.66 Requests made by, or on behalf of, patients should be recorded and given careful consideration. Every effort should be made to meet the patient's wishes. If that cannot be done, the patient (or the person who made the request on the patient's behalf) should be given a written statement of the decision and the reasons for it.

3.67 Nearest relatives' consent to transfers is not a statutory requirement. However, unless the patient objects or there are reasons not to involve the nearest relative as outlined in paragraph 3.27 of this policy, the patient's nearest relative should normally be consulted before a patient is transferred to another hospital, and, in accordance with the regulations, they must normally be notified of the transfer (paragraph 3.24 of this policy).

S17 Leave or Transfer to another Hospital

3.68 A patient can be granted s17 leave to reside at another hospital or be transferred to that hospital. The decision to use either should be based on the most appropriate way to meet the patient's clinical needs and ensure their detention under the Mental Health Act is effectively managed and their rights ensured.

3.69 If s17 leave is used then the organisation that manages the hospital where the patient is detained remains responsible for the management of the person's detention under the Mental Health Act 1983, including continuing to discharge its duties and ensuring the patient continues to be aware of their rights and able to exercise them. When a patient is transferred the organisation that manage the hospital they are transferred to become responsible for the management of the person's detention under the Mental Health Act 1983.

3.70 Where a patient is granted leave of absence to another hospital, the responsible clinician at the first hospital should remain in overall charge of the patient's case. If it is thought that a clinician at the other hospital should become the responsible clinician, the patient should instead be transferred to that hospital. An approved clinician in charge of any particular aspect of the patient's treatment may be from either hospital. For example, if a detained patient is moved to a specialist unit for treatment of a mental disorder, then it is usually more appropriate to transfer the patient. Although, this could be after a period of trial s17 leave there.

3.71 When a patient is admitted to a general hospital managed by another organisation for a specific treatment and it is expected that they will return to the Solent NHS Trust hospital, it is normally more appropriate to use s17 leave to authorise the period of admission. For more information see the Section 17 Leave of Absence under the Mental Health Act Policy.

Process of Transfer

3.72 In order to ensure that a detained patient's documentation is in order and constitutes valid authority to detain, the Mental Health Act Administration team should be involved as soon as a transfer is being considered.

3.73 Before agreeing to a person being transferred to a Solent NHS Trust ward or hospital the nurse in charge, as far as is practicable, must ensure that the MHA administration team have received copies of the papers and are satisfied that they are legal and in order. Likewise, as far as is practicable, when a transfer from a Solent NHS Trust hospital or ward to a hospital or ward managed by another organisation is being considered, the Solent NHS Trust MHA administration team must be informed and they must liaise with their counterparts to ensure that both parties are satisfied with the legality of the paperwork before the person is moved.

3.74 On arrival of the patient they must ensure that the patient's original detention papers have been sent with them and that a Form H4 has been included. The senior nurse on the ward then completes the second part of the Form H4 accepting receipt of the patient and the detention order and signs it. The process in this policy for receiving detention documents and informing the patient and others of their rights should then be followed.

3.75 If the patient has come to the hospital on leave or trial leave, only a copy of his s17 leave form is required and details of the leave arrangements. The process for informing the patient and others of their rights outlined in this policy should then be followed.

3.76 For transfer of a non-restricted detained patient from one Solent NHS hospital or ward to another no formal authority or paperwork is necessary. For restricted patients the transfer can only occur if the conditions allow it.

3.77 For transfer of patients to a ward or hospital that is managed by another organisation, the authority to detain must be transferred to the new organisation. This is done using form H4. For patients detained under s35, 36 and 38 this requires the permission of the Court, for restricted patients detained under s37, s48 and s47 this requires the permission of the ministry of justice.

3.78 Patients detained under s4 and s5 can not be transferred. Patients detained under s135 and s136 can only be transferred in line with the s136 protocol.

3.79 All other non-restricted patients do not require any further authority, other than form H4.

3.80 Solent NHS Trust delegates the authority to authorise a transfer to all responsible clinicians, ward managers, senior nurses on the ward and duty managers.

Transfer from Detention into Guardianship

3.81 The Act allows the transfer of a patient detained under s2,3 or 37 (providing they are an unrestricted patient) into Guardianship. This is an alternative to discharge.

3.82 Solent NHS Trust delegates this power to the Responsible Clinician for the patient. No other staff member is entitled to use this power.

3.83 If this power is to be used then a member of the community team supporting the patient will be requested to complete a social circumstances report and submit it, alongside the transfer documentation to the Local Authority for approval.

Conveyance of a patient from one hospital to another

3.84 Providing there is valid authority to transfer a patient they may be transferred by any employee of Solent NHS Trust, any employee of the organisation whose hospital they are being transferred to or anyone authorised by the organisation that manages the hospital the person is being transferred to.

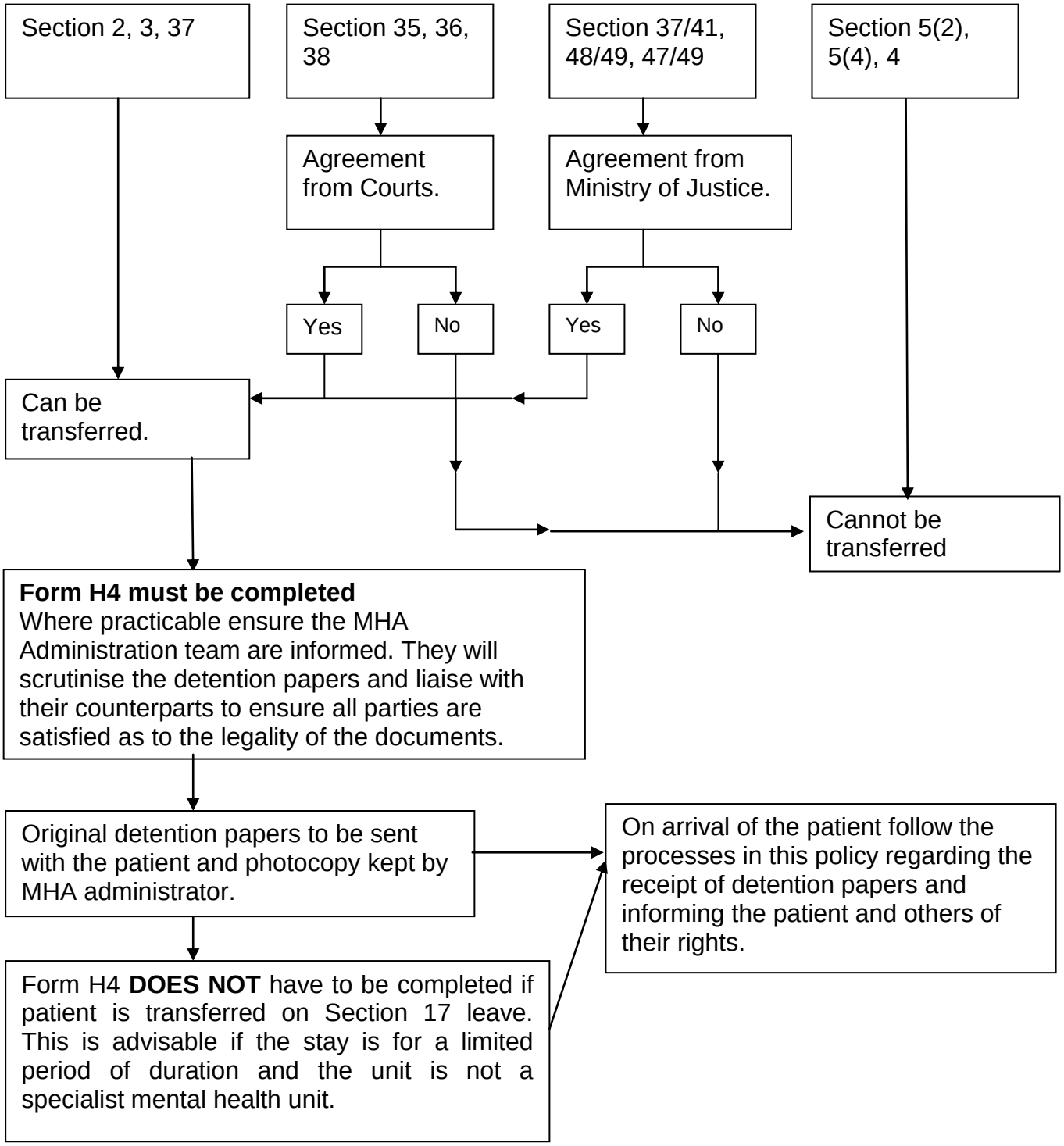
3.85 It is the responsibility of the person authorising a transfer to ensure it is thoroughly risk assessed and conducted in a safe manner and in line with the guiding principles of the Code of Practice. The form of transport could include an escort, the use of Solent NHS Trust provided transport, the use of Hampshire ambulance or the use of a private organisation. Any funding implications need to be authorised by the associate director or their nominee. Out of Hours this will be the on call duty manager.

3.86 Solent NHS Trust delegates the power to authorise non-Solent NHS Trust employees to undertake transfers to all responsible clinicians, ward

managers, senior nurses on the ward and duty managers. Any such authorisation made must be clearly recorded in the patient's file and the reasons for it clearly recorded as part of the risk assessment.

3.87 Whilst being transferred the person is in the custody of those authorised to transfer them. If they abscond they should be considered to be AWOL.

Transfer of Patients from one Hospital to another that is managed by a different organisation.



3F Identifying the Responsible Clinician (RC), Transfer of Responsible Clinicians and an Approved Clinician (AC) temporarily stepping into the shoes of the Responsible Clinician (RC)

Background

3.88 Every detained patient, under the Mental Health Act 1983, that Solent NHS Trust are responsible for must be allocated a Responsible Clinician (RC) by the Trust. The only exceptions are patients detained under section 5, 135 and 136, as they do not have an RC.

3.89 This person will have overall responsibility for the patient's care. There are certain functions that only the RC is able to undertake. These functions are: granting and revoking section 17 leave, making, recalling and revoking a CTO, varying or suspending discretionary conditions attached to a CTO, renewing detention or extending a CTO, and exercising their power of discharge with regard to a detained patient or a patient subject to guardianship or a CTO.

3.90 These functions can not be delegated. However, Solent NHS Trust can direct that another Approved Clinician ("AC") temporarily becomes the RC. They do ot need the approval of the current RC to do this.

3.91 The Code of Practice states that Trusts should keep a list of ACs and should have clear protocols to:

- ensure that the patient's RC is the available AC with the most appropriate expertise to meet the patient's main assessment and treatment needs;
- ensure that it can be easily determined who a particular patient's RC is;
- ensure that cover arrangements are in place when the RC is not available (e.g. during non working hours, annual leave etc);
- include a system for keeping the appropriateness of the responsible clinician under review. (the Code paragraph 14.3)

3.92 The processes to meet these requirements are set out in this policy.

Allocation of an RC

3.93 If the patient has an inpatient AC already in charge of their care the RC will be that person. If the patient does not then they will be allocated an RC based on the GP surgery they are registered with and whether they are admitted to the older person's wards, a learning disability ward or the adult mental health wards. If they are not registered with a GP then the 'difficult to allocate rota' will be used.

3.94 The only exception to these rules is when there is prior agreement that it is more clinically appropriate for a different AC to become the RC. For example the patient is allocated to a specialist team and an AC from that team is in charge of that person's care.

3.95 If there is disagreement about whom the RC is then the inpatient AC covering that GP surgery will be the RC until the disagreement is resolved.

3.96 Who the RC is will be clearly documented in the patient's notes and on the appropriate clinical computer system in use.

Review of RC

3.97 The appropriateness of the RC remaining so will be reviewed by the multidisciplinary team through the Care Programme Approach ("CPA") process, or equivalent. The appropriateness of the RC will be decided on a clinical basis, having considered the importance of continuity to the patient's care. If the patient is to be transferred to another RC then the current RC is responsible for negotiating this.

Other transfers of RC

3.98 As patients move between the community and the hospital they may need to be transferred to another RC. In Older Persons Mental Health the person has the same RC unless they are transferred as described in the 'Review of RC' above.

3.99 In Adult Mental Health the Supervised Community Treatment (" CTO") RC pathway will determine who the RC is and when transfers occurs. This will only be departed from in line with the "Review of RC" process above.

3.100 Learning Disability patients will transfer to the community RC on discharge from hospital.

3.101 When a patient is transferred to another hospital then the RC to take over the care should be identified as soon as is possible after the transfer has been agreed. The current RC is responsible for liaising with the RC at the other hospital about the patient's care.

3.102 For community patients who are under the provisions of the Act and are to be transferred to another area the RC will be responsible for making contact with the RC from the other area and arranging transfer.

3.103 When a patient is to be transferred into Guardianship under s19 of the Act it is the responsibility of the inpatient RC to agree transfer to the community RC.

Temporary transfer to a different RC

3.104 Temporary transfer of an RC will occur when a decision needs to be made, that only the RC can make, and the current RC is not available. Whether a decision can wait or not will be the clinical decision of the Multi-Disciplinary Team in charge of the patient's care.

3.105 In all cases of temporary transfer the 'normal RC' remains the AC in charge of any treatment they have directed under Part IV of the Act; unless an urgent treatment decision needs to be made and it can not wait for 'the usual' AC to be available. Whether a treatment decision can wait or not will be the clinical decision of the Multi-Disciplinary Team in charge of the patient's care.

3.106 If a decision is deemed not to be able to wait for the current RC then the AC to be allocated for the decision to be made will be determined by following the processes below.

3.107 Although, the new RC will be allocated when the MDT determine a decision can not wait, the new RC can not be directed as to what decision to make; the decision remains theirs. This can include not making any changes.

3.108 When an RC is away for an extended period due to sickness or leave then they should consider agreeing transfer of the patient to another RC for this period. What is considered an extended period will depend on the circumstances of each case and can change over time. However, the RC is responsible for consulting with the MDT and ensuring patient safety and clinical standards when considering if transfer is appropriate. They are responsible for informing the Mental Health Act Administration team of this and the Multi-Disciplinary Team (MDT) in charge of the patient's care. If for any reason the RC has been unable to agree transfer to another RC, the MDT in charge of care consider it necessary, and the process below does not meet the patient's need for a consistent RC then the MHA administration team will identify an RC for the patient to be transferred to.

3.109 At other times when such a decision has to be made in the RC's absence then the following pathways should be used to identify the AC responsible for stepping into the shoes of the RC.

3.110 If there are any disputes then the Mental Health Act Administration team, and if need be the Mental Health Act Lead will determine who the RC is.

3.111 For the purpose of the flow charts out of hours means bank holidays and outside of 9am to 5pm Monday to Friday.

3.112 For Older Person's Mental Health (OPMH)

1) Out of hours the on call psychiatrist will be responsible for temporarily stepping into the role of the RC.
2) In normal working hours the nominated AC will step into the role of the RC.
3) The nominated AC will be determined in the order below, subject to availability. An AC will be considered not eligible to fulfil the role if they are not available to do so within the time limit that the MDT deems the decision is necessary to be made in.

i) An AC who had agreed to undertake the role with the RC.
ii) The next senior AC available in the OPMH Solent NHS Trust team.
iii) The Lead Consultant in the Trust.

4) If an AC has agreed to undertake the role in the RC's absence then it will be the responsibility of the RC to agree this with the Mental Health Act Administrator and inform the MDT who this person is.
5) The nominated AC will become the RC for the period required to consider the case, make any required decisions, and undertake any follow up actions required to ensure patient safety and clinical standards. The role of RC will then transfer to the AC normally in overall charge of the patient's care.

3.113 For Adult Mental Health (AMH) and Neuro-Psychiatric Service

1) Out of hours the on call psychiatrist will be responsible for temporarily stepping into the role of the RC.
2) In hours the nominated AC will step into the role of the RC.
3) The nominated AC will be determined in the order below, subject to availability. An AC will be considered not eligible to fulfil the role if they are not available to do so within the time limit that the MDT deems the decision is necessary to be made in.

i) An AC who had agreed to undertake the role with the RC.

ii) The AC on the Emergency Psychiatric Service rota or the equivalent arrangement for learning disability services.
iii) The next senior AC available in Adult Mental Health.
iv) The Lead Consultant in the Trust.

4) If an AC has agreed to undertake the role in the RCs absence then it will be the responsibility of the RC to agree this with the Mental Health Act Administrator and inform the MDT who this person is.

5) The nominated AC will become the RC for the period required to consider the case, make any required decisions, and undertake any follow up actions required to ensure patient safety and clinical standards. The role of RC will then transfer back to the AC normally in overall charge of the patient's care.

3G Use of s5 Holding Powers

3.107 Section 5(2) provides approved clinicians and doctors with holding powers to enable detention under the Mental Health Act to be considered; section 5(4), for certain nurses. The intent of this policy is not to set out a full description of these powers but to set out how specific features of them apply to Solent NHS Trust. The Code of Practice ch18 sets out a fuller description of the powers and should be consulted by those applying them. Practitioners also need to be mindful that for psychiatric inpatients there is a duty under the European Convention of Human Rights Article 2, to take reasonable steps to prevent a risk to life when the practitioners know about or should know about a real and immediate risk to the person's life. That is, a risk which is more than remote or fanciful and which is present and continuing. A part of this duty is considering the appropriateness of the s5 holding powers and ensuring any risk assessment is thorough and contemporaneous.

3.108 Section 5 holding powers apply to inpatients. An inpatient is defined as:

- a person with capacity who has accepted the offer of a bed, appeared on the ward, cooperated with the admission processes and is on hospital premises,
- a person who lacks capacity to consent to admission, is on hospital premises and did not object to the admission process, or
- a person who lacks capacity and is an-inpatient by virtue of the Mental Capacity Act Deprivation of Liberty Safeguards.

3.109 A person should not be admitted as an informal patient solely for the purpose of applying the s5 holding powers.

3.110 Section 5 powers cannot be used for a person under section 2, 3 or 4 of the Act, or who is an informal patient on a CTO. If an informal patient on a CTO needs to be prevented from leaving the hospital then the process for recalling them should be followed.

3.111 Doctors and approved clinicians may leave instructions with ward staff to contact them (or their nominated deputy) if a particular patient wants or tries to leave. But they may not leave instructions for their nominated deputy or nurse to use their powers under section 5, nor may they complete a section 5 report in advance to be used in their absence.

3.112 A section 5 holding power can not be renewed. However, there is nothing to prevent the power being used at a later date in respect of the same patient. Whether to do so or not needs to be determined by the professional whose responsibility it is at the time and the decision based on the circumstances

they are presented with at that time. Their responsibility is to ensure the safety of the patient and others at that time.

3.113 The use of section 5 is monitored by the Mental Health Act Administrators. In order to prevent a person being in effect Deprived of their Liberty, any instance where s5 powers are used in respect of the same patient more than once during any single period of admission will be identified. the Multi-Disciplinary Team will then be asked to consider the issue in a care plan. This should address the following issues:

- Is the patient in effect deprived of their liberty?
- What is the patient's views of the incidents that led to the use of s5?
- Are there any steps that can be taken to reduce the risk of s5 being used in the future?
- Is there any guidance to support staff who may need to consider the use of s5 in the future?

3.114 The Mental Health Act Lead will report the following to the Mental Health Act Scrutiny Committee:

- any instances where s5 powers have been used more than once with respect of the same patient during the same admission,
- how quickly patients are assessed for detention and discharged from the holding power,
- the attendance times of doctors and approved clinicians following the use of section 5(4),
- the outcome of a patient after being placed under s5,
- the proportion of cases in which applications for detention are, in fact, made following use of section 5, and
- any other issues in relation to s5 that support the scrutiny of the Act.

Section 5(4)

3.115 Nurses of the "prescribed class" may invoke section 5(4) of the Act in respect of a hospital in-patient who is already receiving treatment for mental disorder. At the time of publication of this policy they are nurses registered in sub-parts 1 or 2 of the register maintained by the Nursing and Midwifery Council whose entry in the register indicates that their field of practice is either mental health nursing or learning disability nursing.

3.116 This power may be used only where the nurse considers that:

- the patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital either for the patient's health or safety or for the protection of other people; and
- it is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2).

The nurse should consider the following before using the power:

- the likely arrival time of the doctor or approved clinician, as against the likely intention of the patient to leave. It may be possible to persuade the patient to wait until a doctor or approved clinician arrives to discuss it further, and

- the consequences of a patient leaving the hospital before the doctor or approved clinician arrives – in other words, the harm that might occur to the patient or others.

- Further guidance is given at 18.30 to 18.32 of the Code of Practice.

3.117 It can be used only when the patient is still on the hospital premises.

3.118 The use of the holding power permits the patient's detention for up to six hours, from when it is invoked, or until a doctor or approved clinician with the power to use section 5(2) arrives, whichever is the earlier. It cannot be renewed.

3.119 The patient may be detained from the moment the nurse makes the necessary record (Form H2). The record must then be received by the senior nurse on the ward. The senior nurse is then responsible for ensuring the report is delivered to the Mental Health Act Administrator and that the patient's rights are explained to them both orally and in writing. This must be recorded on RIO and on the patient's right's form.

3.120 The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else. However, in considering to use the power the nurse should have regard to any concerns the doctor had about a patient leaving or instructions that they, or their deputy, are to be contacted if the patients decides to leave the ward.

3.121 The reasons for invoking the power should be entered on System One. The approved clinician in charge of the patient's care or their deputy should be contacted by the nurse as soon as practicable after s5(4) is used. The use of section 5(4) is an emergency measure, and the doctor or approved clinician with the power to use section 5(2) in respect of the patient should treat it as such and arrive as soon as possible. The doctor or approved clinician should not wait six hours before attending simply because this is the maximum time allowed.

3.122 Details of any patients who remain subject to the power at the time of a shift change should be given to staff coming on duty.

3.123 If s5(4) lapses before the doctor arrives this should be considered a serious lapse, be reported as a serious risk incident via the electronic risk reporting system, and a report given to the Mental Health Act Scrutiny Committee.

3.124 If the doctor or approved clinician arrives before the end of the six hour maximum period, the holding power lapses on their arrival. But if the doctor or approved clinician then uses their own holding power, the maximum period of 72 hours runs from when the nurse first made the record detaining the patient under section 5(4).

3.125 Following the doctors arrival and the outcome of their assessment, the nurse in charge of the ward is responsible for ensuring the following is recorded on RIO:

- the time section 5(4) was instigated and the reasons,
- the time s5(4) ended,

- the reason why the patient is no longer detained under the power, and the outcome (for example patient is informal, detained under s5(2), or discharged with or with out the support of a specific team).

Section 5(2): Doctors or ACs holding Power

3.126 Section 5(2) authorises the detention of the patient in the hospital for a maximum of 72 hours so that the patient can be assessed with a view to an application under Part II of the Mental Health Act being made.

3.127 It can be used by the AC with overall responsibility for the patient's care or, in situations where they are not available, their deputy. Solent NHS Trust policy is that the duty ward doctor on call is the deputy of the AC.

3.128 The power can be used when the professional assessing concludes that an application for detention under the Act should be made. It authorises the detention of the patient in the hospital for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made.

3.129 Section 5(2) should only be used if, at the time, it is not practicable or safe to take the steps necessary to make an application for detention without detaining the patient in the interim. Section 5(2) should not be used as an alternative to making an application, even if it is thought that the patient will only need to be detained for 72 hours or less.

3.130 Doctors and ACs should use the power only after having personally examined the patient.

3.131 If the doctor used the s5(2) holding power they must hand the report (Form H1) to the senior nurse on the ward who will receive it on behalf of Solent NHS Trust. The senior nurse is then responsible for ensuring the report is delivered to the Mental Health Act Administrator and that the patient's rights are explained to them both orally and in writing. This must be recorded on RIO and on the patient's right's form.

3.132 The period of detention starts at the time the patient was placed on s5(4), or if they had not been on s5(4), the time the doctor hands the report to the senior nurse on the ward to receive.

3.133 The doctor or AC assessing the patient must include the following on RIO:

- The time the patient was assessed,
- the outcome of the assessment and reason, including the risks considered, and
- if placed on s5.2, the time this occurred.

Actions following an assessment under s5.2

3.134 If the assessing doctor was the AC, who would be the patient's RC if they were detained under s2 or s3, and s5(2) powers were used then a referral should be made by the ward to the Crisis Resolution and Home Treatment Team for an AMHP to arrange a Mental Health Act Assessment.

3.135 If the assessing doctor was the nominee and s5(2) powers were used then the ward should make a referral for a Mental Health Act Assessment to the Crisis Resolution and Home Treatment Team and make arrangements for the AC who would become the RC to assess the patient as soon as possible. If

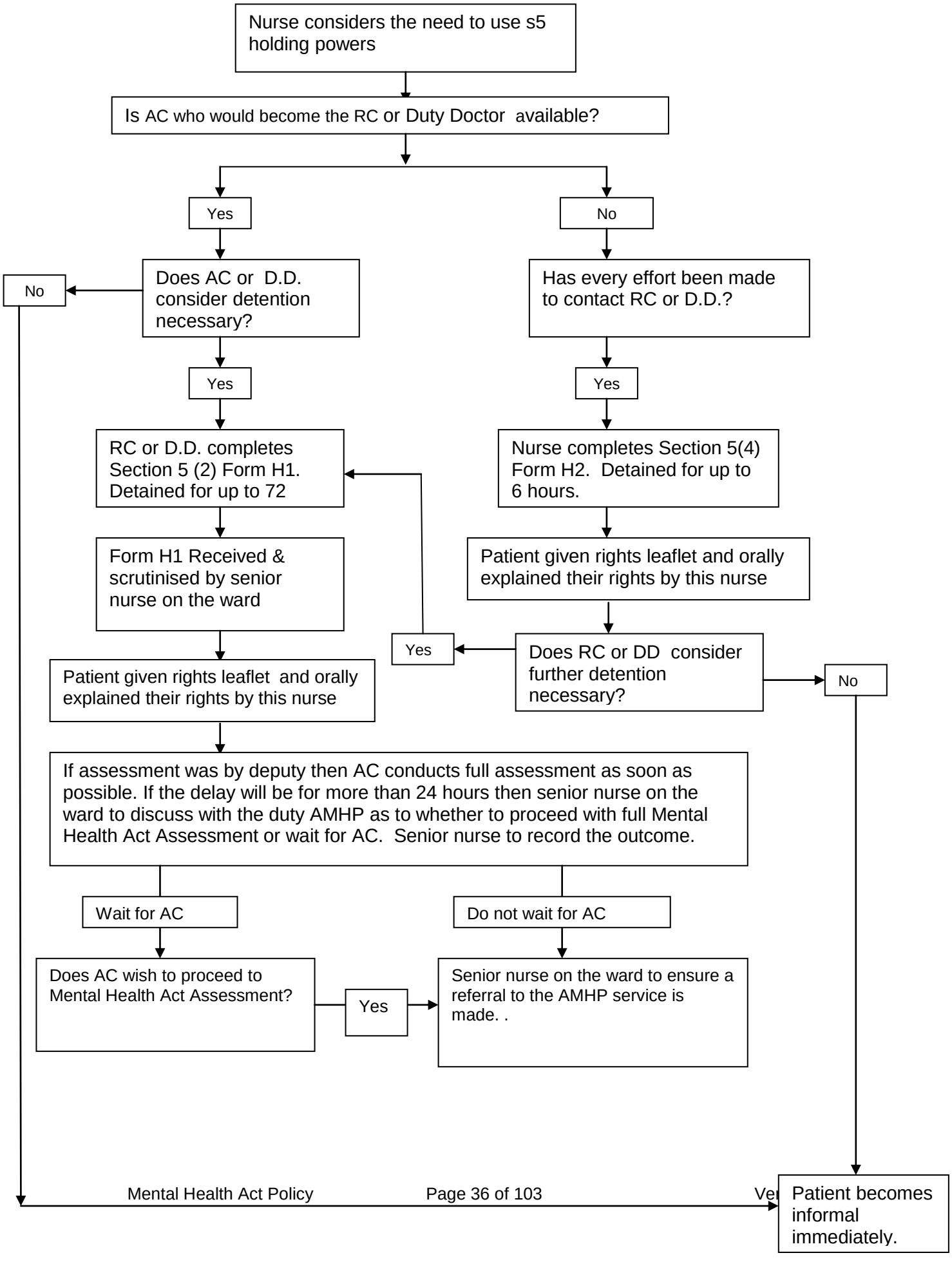
this will create delay over 24 hours then the senior nurse on the ward should discuss how to proceed with the on call AMHP: to wait for the RC or for the AMHP to identify two different doctors and proceed. The outcome of this conversation should be recorded on RIO.

3.136 When assessing the patient, the AC who would become the RC decides if an assessment under the Mental Health Act is to be pursued. If they decide it is not, the s5(2) holding power ceases to have effect. If they decide it is, the holding power remains in force until the assessment under the Mental Health Act is concluded or the 72 hour period has expired.

3.137 The AC who would become the RC must record the time and outcome of their assessment on RIO and as far as practicable be available to be contacted by the AMHP.

3.138 The AC must, as far as is possible, explain the outcome of their assessment to the patient, the patient's legal status and the next steps in their care.

The Use of s5 holding powers



3H Guidance regarding the second professional involved in renewing a detention under s20

3.139 Section 20 gives the RC the power to renew a s3 and a s37 providing:

- they have personally examined the patient in the two months prior to the detention expiring;
- they are satisfied that:
  - the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in a hospital; and
  - it is necessary for the health or safety of the patient or for the protection of other persons that they should receive such treatment and that it cannot be provided unless they continue to be detained; and
  - appropriate medical treatment is available for them;
- a second professional involved in the patient's care has agreed the above criteria are met; and
- the RC and the second professional have certified the above on Form H5.

3.140 This policy is not a comprehensive description of the power of renewal but is limited to how the role of the Second Professional will operate in Solent NHS Trust. Chapter 32 of the Code of Practice discusses s20 power of renewal and professionals undertaking roles in relation to s20 must have regard to this guidance.

3.141 Before examining patients to decide whether to make a renewal report, responsible clinicians should identify and record who the second professional is to be.

3.142 This second professional must be professionally concerned with the patient's treatment and must not belong to the same profession as the responsible clinician.

3.143 Possible professional groups that the second professional may come from include: Nurses, Social workers, Occupational Therapists, Psychologists, Psychotherapists, or Physiotherapists. This list is not exhaustive. The person must have a professional qualification, be registered with a professional body and currently involved in the patient's care in that professional role.

3.144 The involvement of a second professional is intended to provide an additional safeguard for patients by ensuring that:

- renewal is formally agreed by at least two suitably qualified and competent professionals who are familiar with the patient's case;
- those two professionals are from different disciplines, and so bring different, but complementary, professional perspectives to bear; and
- the two professionals are able to reach their own decisions independently of one another.

3.145 Accordingly, second professionals should:

- have sufficient experience and expertise to decide whether the patient's continued detention is necessary and lawful, but need not be approved clinicians (nor be qualified to be one);

- have been actively involved in the planning, management or delivery of the patient's treatment; and
- have had sufficient recent contact with the patient to be able to make an informed judgement about the patient's case.

3.146 For the second professional to act as a real safeguard they must give their role due diligence and reach an independent decision.

3.147 Second professionals should satisfy themselves that they have sufficient historical and contemporaneous information on which to make the decision. The Act does not state that this requires a separate clinical interview or examination of the patient. However, when considering whether to undertake a separate clinical interview the second professional should consider:

- their duty to have regard to all the facts of the case and to be satisfied that the criteria are met before stating so;
- the nature of the contact that the second professional already has with the patient; and
- the other circumstances of the case.

3.148 The second professional must record the following on System One:

- their professional qualification;
- their involvement with the patient;
- if they undertook a separate clinical interview and their reason for doing so or not; and
- why they agree each criteria stated in paragraph 3.139 are met.

3.149 Unless there are exceptional circumstances, the decision of the identified second professional should be accepted, even if the responsible clinician does not agree with it.

3.150 If, in exceptional circumstances, it is decided by the RC the agreement of a different second professional should be sought, that decision should be drawn to the attention of the Mental Health Act Administrators if, as a result, a renewal report is made. the Mental Health Act Administrators will inform the Associate Hospital Manager's panel to consider the case, who may wish to receive written and/or oral evidence from the original second professional.

3.151 A decision by a second professional not to agree to the renewal does not bring the current period of detention to an end before it would otherwise have expired; however the responsible clinician should reconsider if the criteria for detention continue to be met and record their view.

3l 'Hospital Managers' and Nearest Relatives s23 Power of Discharge. Including, displacement of a Nearest Relative

3.152 When a person's detention is renewed or if a person chooses to appeal to an 'Associate Hospital Manager's panel' then Solent NHS Trust must ensure that an 'Associate Hospital Manager's panel' consider whether to exercise the s23 power of discharge on behalf of Solent NHS Trust.

3.153 All Associate Hospital Managers and Non Executive Directors (NED) sitting on these panels will be members of the Mental Health Act Scrutiny Committee and its subgroup, the Associate Hospital manager Group. Which with the support of the Mental Health Act Lead, the Mental Health Act Scrutiny Committee will scrutinise their appointment, review and training.

3.154 Associate Hospital Managers will, with the support of the Mental Health Act Lead, be appointed and/ or re-appointed for a fixed term by the Governance and Nominations committee.

3.155 The Mental Health Act lead will produce and review guidance on the role of Associate Hospital Managers, Associate Hospital Manager's Panels, and NEDs sitting on such Panels. This will ensure compliance with the legal requirements and the Code of Practice. The guidance will be reported to and scrutinised by the Mental Health Act Scrutiny Committee.

Nearest Relative Power of Discharge

3.156 A nearest relative may discharge a patient detained under s2,3, 4 or under CTO by making a written discharge order. Before giving a discharge order, nearest relatives must give Solent NHS Trust not less than 72 hours' notice in writing of their intention to discharge the patient. They will be informed of this right as part of the provision of information to them and as detailed in this policy. Please see section 3C of this policy for more information.

3.157 Neither the discharge order, nor the notice of it, has to be given in any particular form. Although in theory the order should not be served until 72 hours after the notice has been given, in practice it is appropriate to accept a discharge order as also being notice of intention to discharge the patient after 72 hours.

3.158 All Solent NHS Staff working with Nearest Relatives should offer them any help they require in exercising this power, such as providing them with a standard letter to complete.

3.159 The notice (and the order for discharge itself) must be delivered at the hospital to an officer of Solent NHS Trust authorised by them to receive it or be sent by prepaid post to Solent NHS Trust at the hospital the patient is detained at. The officers authorised to receive such notice are the Mental Health Act Administrators or the staff member in overall charge of the ward at that time.

3.160 If the Nearest Relative contacts a staff member and wishes to use this power, they should be informed of the means of serving it. If they wish to deliver the notice by hand they should be informed of who is authorised to receive it. On receiving such notice, the authorised officer or the recipient of a letter should record the time on the patient's file and forward it to the Mental Health Act Administrators without delay.

3.161 The 72 hour period starts to run from the time when the notice is received by the authorised person, or when it is received by post at the hospital to which it is addressed. the Mental Health Act Administrators are responsible for recording this time and informing the RC of the time when the 72 hours will expire and the patient be discharged.

3.162 If the RC consider that, if discharged, a patient is likely to act in a manner dangerous to other persons or themselves, they may make a report to that effect under section 25 using Form M2 and send it to the Mental Health Act Administrators before the end of the 72 hour notice period. This is sometimes known as a "barring report". If this report needs to be accepted by Solent NHS Trust out of hours or before a Mental Health Act Administrator is available a

trained member of staff on the ward where the patient is detained or at the responsible hospital for a CTO patient may receive it.

3.163 Unlike other statutory forms used in connection with the Act, a notice given on Form M2 may be formally served by faxing it to or by e-mailing (or otherwise sending them) a scanned version, or other electronic reproduction, of the completed and signed form. However, it may not be signed electronically.

3.164 The effect of such a report is to veto the nearest relative's decision to discharge the patient. It also prevents the nearest relative from discharging the patient from detention at any time in the six months following the date of the report.

3.165 If such a report is issued in respect of a patient detained on the basis of an application for admission for treatment under section 3 or under CTO, the Mental Health Act Administrators will inform the nearest relative in writing without delay. The nearest relative may then apply to the Tribunal for the patient's discharge instead. However, there is no right to apply if the patient is detained for assessment under section 2 or 4.

3.166 If such a report is issued in respect of a patient detained under s2, 3 or under CTO the Mental Health Act Administrators will arrange for a Manager's Panel Hearing to occur as soon as is possible.

3.167 If the responsible clinician does not make a report within the relevant period, the patient must be discharged in accordance with the nearest relative's order.

3.168 The Mental Health Act Administrators are responsible for keeping a record of any instances of the Nearest Relative exercising their power of discharge. The Mental Health Act Lead will report these to the Mental Health Act Scrutiny Group.

3.169 Nearest relatives may not discharge Part 3 patients, but can make applications to the Tribunal instead in respect of unrestricted Part 3 patients.

Displacement of the nearest relative

3.170 The displacement of a nearest relative will engage their and the patient's Article 8 rights. It should therefore be given careful consideration before any action is taken.

3.171 The following people may make an application to the county court to displace the nearest relative and appoint another person to act in that role:

- the patient
- any relative of the patient;
- any other person with whom the patient is residing (or, if the patient is then an in-patient in a hospital, was last residing before he was admitted); or
- an AMHP

3.172 The grounds that must be met for a nearest relative to be displaced are:

- that the patient has no nearest relative within the meaning of this Act, or that it is not reasonably practicable to ascertain whether he has such a relative, or who that relative is;

- that the nearest relative of the patient is incapable of acting as such by reason of mental disorder or other illness;
- that the nearest relative of the patient unreasonably objects to the making of an application for admission for treatment or a guardianship application in respect of the patient;
- that the nearest relative of the patient has exercised without due regard to the welfare of the patient or the interests of the public his power to discharge the patient under this Part of this Act, or is likely to do so.; or that the nearest relative of the patient is otherwise not a suitable person to act as such.

3.173 If the multi disciplinary team are of the view that the grounds to displace the nearest relative are met and it is appropriate to do so then a referral should be made to the AMHP service and the RC discuss the issue with the allocated AMHP.

3.174 If the patient has no nearest relative or seeks to displace their nearest relative then they may benefit from the support of an advocate or further advice from the AMHP service. In some situations the Local Authority may take the view that they, rather than the patient, are the more appropriate applicant.

3J Part IV Consent to Treatment Provisions

3.175 The Code of Practice chapters 23 to 25 give specific guidance on treatment provisions of the Mental Health Act and practitioners carrying out functions in relation to them should have regard to this guidance. In addition, the Reference Guide to the Mental Health Act gives a detailed description of these provisions and can be a useful tool for practitioners.

3.176 Mental Health Act Administrators are responsible for keeping a list of Approved Clinicians and will ensure they are in charge of treatment when the Act requires it.

3.177 It is essential that all staff prescribing or administering treatment under the Act must comply with the safeguards in Part IV. If they are not, then staff members may, depending on any negative effects of the treatment and how it is administered, be in breach of:

- Article 3 (Inhumane and degrading treatment)
- Article 8 (Right to private and family life)

3.178 Regarding, the use of medication to manage disturbed behaviour, the Code gives the following guidance:

> Wherever practicable, the circumstances (if any) in which medication is to be used as a response to episodes of particularly disturbed behaviour should be established in advance in each patient's treatment plan. The use of medication as an unplanned response to disturbed behaviour should be exceptional. Medication should never be used to manage patients as a substitute for adequate staffing.

3.179 This policy sets out the main provisions, how they will be administered in Solent NHS Trust and gives further guidance to practitioners seeking to determine if it is appropriate to administer specific treatments under the

Mental Health Act 1983. However, it is not a complete explanation of the provisions. If there is doubt then further advice should be sought, initially via the Mental Health Act Lead.

3.180 Although the Mental Health Act permits some medical treatment for mental disorder to be given to detained patients, without consent, the patient's consent should still be sought before treatment is given, wherever practicable. The patient's consent or refusal should be recorded, as should the treating clinician's assessment of the patient's capacity to consent. Where practicable this should be done on admission, reviewed at first ward round and kept under regular review.

3.181 The Trust policies with regard to Consent to Treatment and the Deprivation of Liberty Safeguards and the Mental Capacity Act clarify how consent to treatment is to be sought and recorded and how capacity to consent is to be assessed and recorded and will need to be read alongside these guidelines.

3.182 Part IV of the Act applies to detained patients, with some exceptions. Part IVA applies to community patients subject to CTO that have not been recalled to hospital. These are detailed in the table below.

In this chapter "detained patients" means	Exceptions (When Part IV does not apply)
Patients who are liable to be detained in hospital under any section of the Act (including those on leave of absence or absent without leave)	Patients detained on the basis of an emergency application under section 4 unless or until the second medical recommendation is received Patients held in hospital under the holding powers in section 5 Patients remanded to hospital for a report on their mental condition under section 35 Patients detained in hospital as a place of safety under section 135 or 136 Patients temporarily detained in hospital as a place of safety under section 37 or 45A, pending admission to the hospital named in their hospital order or hospital direction Restricted patients who have been conditionally discharged (unless or until they are recalled to hospital)
CTO patients who have been recalled to hospital	

3.183 The Table below sets out when specific treatments can be given. See also, the flowcharts in appendix 2.

Type of patient (and relevant part of the Act)	When treatment can be given	Notes
Detained patient	If sections 57, 58 or 58A apply, treatment may be given only in accordance with those sections. Otherwise, treatment may be given: • with the patient's consent; or • without the patient's consent under section 63, if the treatment is by or under the direction of the approved clinician in charge.	Neurosurgery for mental disorder and other treatments to which section 57 applies cannot be given without the patient's consent and must always be approved by a SOAD. ECT and other treatments to which section 58A applies cannot be given to a patient who has capacity to consent but refuses to do so. They can be given to patients who lack capacity (or who are under 18) only if approved by a SOAD. Medication to which section 58 applies can be given without the patient's consent, but only with the approval of a SOAD. Sections 57, 58 and 58A do not apply in emergencies, where treatment is defined in section 62 as immediately necessary.

3.184 The table below sets out the types of treatments that s57, s58 and s58A apply to.

Section	Forms of treatment covered
Section 57	Neurosurgery for mental disorder Surgical implantation of hormones to reduce male sex drive
Section 58	Medication (after an initial three-month period) – except medication administered as part of electro-convulsive therapy (ECT)
Section 58A	ECT and medication administered as part of ECT

3.185 The table below states how Part IV of the Act applies to other inpatients.

Type of patient (and relevant part of the Act)	When treatment can be given	Notes (for further detail see COP chapter 24)
Other Patients	Treatment is not regulated by the Act, except that: • where section 57 applies, patients can be given treatment only if they consent and the other rules in section 57 are followed; and • patients under 18 cannot be given ECT or other treatments to which section 58A applies, unless it is approved by a SOAD. (Sections 57 and 58A do not apply in emergencies.)	

3.186 Provided a treatment does not fall within the provisions of section 57, section 58 or section 58A, and it is given under the direction of an AC, for a mental disorder, the consent of the patient is not required. However, it still must be appropriate for it to be given and in situations in which there is no consent it must be in the best interest of the patient (note this is not the same as the MCA best interest test) and if it involves significant adverse effects be medically necessary. See the graph and further guidance in appendix 3

3.187 When treatment is a s57, 58 or 58A treatment then it can only be prescribed or administered with the appropriate treatment certificate. A copy of any statutory forms authorising treatment must be kept with the medication card for the period it continues to authorise the treatment. The exception to this is when it is prescribed as urgent treatment under s62.

3.188 For s58 treatment (medication after 3 months) in situations in which the patient has capacity to consent and consents the Form T2 must be completed by the RC, or AC directing the treatment. That person must also complete the relevant form provided by the Mental Health Act administration team.

3.189 All the relevant drugs should be listed, including medication to be given “as required” (prn), either by name or by the classes described in the British National Formulary (BNF) that is being used at the time. The specific BNF being used may change and professionals will need to ensure they are up to date with current guidance. If drugs are specified by class, the certificate should state clearly the number of drugs authorised in each class, and whether any drugs within the class are excluded. The maximum dosage and route of administration should be clearly indicated for each drug or category of drugs proposed. This can exceed the dosages listed in the BNF, but particular care is required in these cases.

3.190 Solent NHS Trust has issued guidance on recording the following on T2s and medicine cards: the use of high dose anti-psychotics, unlicensed medication and medication that can be prescribed for a mental disorder or another reason. This is in appendix 4 and ACs should follow this when completing T2 certificates.

3.191 If there is a permanent change of RC then a new T2 must be completed. However, the previous T2 can be used whilst this is being done.

3.192 For s58 treatment (medication after 3 months) in situations in which the patient has capacity to consent but does not consent or lacks capacity to consent a SOAD must be requested to approve the treatment plan on a form T3. the Mental Health Act Administrators will monitor detained patients and alert RCs 4 weeks before the end of the 3 month period. It is the responsibility of the RC to inform the patient and to provide the Administrators with the SOAD referral if required. Ideally, this should be three weeks before the expiry of the 3 month period to ensure any certificate is in place in time. the Mental Health Act Administrators will forward the request to and liaise with the CQC SOAD service.

3.193 When the SOAD attends the ward they will consult with two other persons involved in the patients care: statutory consultees. The statutory consultees whom the SOAD proposes to consult should consider whether they are sufficiently concerned professionally with the patient’s care to fulfil the function. If not, or if a consultee feels that someone else is better placed to fulfil the function, they should make this known to the clinician in charge of the treatment and to the SOAD in good time.

3.194 Statutory consultees may expect to have a private discussion with the SOAD and to be listened to with consideration. Among the issues that the consultees should consider commenting on are:

- the proposed treatment and the patient’s ability to consent to it;
- their understanding of the past and present views and wishes of the patient;
- other treatment options and the way in which the decision on the treatment proposal was arrived at;
- the patient’s progress and the views of the patient’s carers; and
- where relevant, the implications of imposing treatment on a patient who does not want it and the reasons why the patient is refusing treatment.

3.195 If the SOAD wishes to speak to the statutory consultees face to face, the consultee and their manager should takes steps to ensure that the SOAD is able to do so.

3.196 If the SOAD approves the treatment plan they have a duty to provide written reasons. This may be on the treatment certificate or a separate form. The certificate may be acted on even though the SOAD's reasons have yet to be received. But if there is no pressing need for treatment to begin immediately, it is preferable to wait until the reasons are received, especially if the patient is likely to be unhappy with the decision.

3.197 It is the personal responsibility of the clinician in charge of the treatment to communicate the results of the SOAD visit to the patient. This need not wait until any separate statement of reasons has been received from the SOAD. But when a separate statement is received from the SOAD, the patient should be given the opportunity to see it as soon as possible, unless the clinician in charge of the treatment (or the SOAD) thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person. This clinician must record on System One details of their discussion with the patient about the reasons or their justification for not informing the patient.

3.198 Currently, s58A treatment only relates to ECT and the administration of medication as a part of the ECT. If the patient has capacity and consents then the RC must complete Form H4 and the relevant form provided by the Mentla Health Act Administration Team. In all other situations a SOAD will be requested to complete Form H6. The same requirements regarding statutory consultees consultation and recording and the AC giving the patient the SOAD's reasons and recording this relate to this as detailed above in relation to medication after 3 months.

3.199 Solent NHS Trust have given guidance and agreed process for other situations when ECT may be administered. These are in appendix 5.

3.200 The AC directing treatment that has been authorised by a SOAD must submit a report to the CQC at specified intervals (known as a s61 report):

- on the next and subsequent occasions that the authority for the patient's detention is renewed under Section 20(3), 20A(4) or 21B(2);
- at any other time if so required by the Care Quality Commission;
- for CTO patients, if they have been treated under Part IV during a period of recall during that period of CTO, when the CTO is renewed under s20A; and
- in the case of patients subject to a restriction order, at the end of the first six months, if treatment began during this period, and subsequently on each occasion that the responsible clinician is statutorily required to report to the Secretary of State.

The Mental Health Act Administration team will monitor these periods and inform the relevant AC. It is the responsibility of the AC to complete the CQC's standard report form and submit it to the CQC via the Mental Health Act Administrators.

3.201 A treatment certificate only remains valid providing the facts it describes remain the case. In these situations valid authorisation should be sought. A certificate will no longer be valid if:

- the patient's capacity to consent changes,
- the patient with draws consent, or
- the treatment changes so that it is no longer authorised.

Treatment Immediately Necessary (s62)

3.202 Section 62 enables the authorisation of s57, 58 and 58A treatment without the certificate in specifically defined situations where the treatment is immediately necessary.

3.203 This applies only if the treatment in question is immediately necessary to:

- save the patient's life;
- prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed;
- alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard; or
- prevent patients behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

It also applies if there was a certificate authorising the treatment but it is no longer valid because the consent is withdrawn or no longer valid or the CQC have withdrawn a valid certificate; and the AC consider the discontinuation of the treatment or treatment under the plan would cause serious suffering to the patient. I have requested a SOAD visit for a further certificate. (s62(2))

3.204 If the treatment is ECT (or medication administered as part of ECT) only the first two categories above apply.

3.205 If s62 is to be prescribed the AC must complete the form provided by the Mental Health Act administration team and forward it to the Mental Health Act Administrators. If the treatment is being given pending a SOAD certificate then the MHA administration team must ensure that the appropriate referral has been made. This treatment should continue only as long as it is immediately necessary.

3.206 The Mental Health Act Lead will report all instances of the use of s62 to the Mental Health Act Scrutiny Committee.

Covert Medication

3.207 Medication given covertly is by nature given without consent. This should only be done in exceptional circumstances.

3.208 Before the use of covert medication the Responsible Clinician, or if they are not a doctor the Approved Clinician prescribing the treatment must consider:

- the person's level of understanding that they would be receiving medication and its purpose,

- what are the risks of giving the medication non-covertly both in terms of risks associated with administering it and likelihood of the person not receiving treatment,
- what is the risk to the patient or others if they don't receive treatment and the benefits if they do, and
- considering this why covert administration of medication is or is not a proportionate response.

3.209 In considering these issues the clinician should have regard to the reason the person is detained and the fact that a tribunal may, in the interest of justice, rule the disclosure to the patient of the administration of the medication. The clinician must also consider the review of the decision to administer covertly. This should be at least 1 month, then 3 monthly, then 6 monthly and then yearly. These decisions should be recorded on the appropriate form. The form below should be completed.

Audit and Assurance

3.210 Hospital wards must have processes in place to regularly audit the treatment of detained patients and to ensure that any exceptions are addressed as soon as possible.

3.211 Any instances in which treatment is administered without proper authority will be reported as risk incidents via the electronic risk reporting system. The ward manager and the Lead Consultant Psychiatrist will be informed to address with the appropriate nurse and doctors accordingly.

3.212 The Mental Health Act Administrators will audit the treatment of detained patients as part their audit of inpatient units. These audits will be reported to the Mental Health Act scrutiny Committee.

3K Tribunal Appeals and Referrals

3.213 Having reliable systems in place to ensure automatic referrals and patients appeals to the First Tier Tribunal are carried out in a timely manner is essential in ensuring detained patients are afforded their rights under Article 5 of the European Convention of Human Rights.

3.214 Informing patients of their rights to appeal to the Tribunal is an essential part of Solent NHS's duty under the Act to inform patients of their rights. It is essential that when staff are discharging this duty every effort is made to support patients to apply and to access legal advice when requested. Staff members must inform detained patients of their right to present their own case to the Tribunal and their right to be represented by someone else. This is especially important for CTO patients who may not have daily contact with professionals. Staff members also need to be aware that the IMHA service can offer patients further independent support in accessing their rights to apply to the tribunal and seek legal advice. However, receiving IMHA support does not replace a patient's rights to full legal advice.

3.215 The Mental Health Act Administration team are responsible for monitoring periods of patient's detention and making automatic referrals to the Tribunal office, in line with the Act. A summary of when to refer is provided in the Mental Health Act Reference Guide. The team must keep records of:

- the detention and discharge of the patients for whom Solent NHS Trust are responsible;

- applications made by those patients to the Tribunal; and
- applications and references to the Tribunal made by other people in respect of those patients.

3.216 A patient detained under s2 of the Mental Health Act can apply for a tribunal within the first 14 days of their detention. The Tribunal office will only process the request if they receive the application on the 14th day, or next working day, if it was not a working day. Therefore, if a patient informs a staff member they wish to apply for a tribunal on the 14th day, it is the responsibility of that staff member to either personally liaise with the Mental Health Act Administrators to ensure the tribunal office receive the application in time, or if the Mental Health Act Administrators are unavailable, to send the application themselves by safe haven fax or secure email.

3.217 The Mental Health Act Administrators will audit the time taken to make automatic referrals on an annual basis and the Mental Health Act Lead will report this to the Mental Health Act Scrutiny Committee.

3.218 Solent NHS Trust may also request the Secretary of State to refer a patient for a tribunal. the Mental Health Act Administrators are responsible for raising cases, with the Mental Health Act Lead, of any patients whose rights under Article 5(4) of the European Convention on Human Rights might otherwise be at risk of being violated because they are unable (for whatever reason) to have their cases considered by the Tribunal speedily following their initial detention or at reasonable intervals afterwards. The Mental Health Act Lead is responsible for considering asking the Secretary of State to make a reference in respect of the patient and for recording the reasons for making or not making such a request.

3.219 The Secretary of State should normally be requested to make a reference where:

- a patient's detention under section 2 has been extended under section 29 of the Act pending the outcome of an application to the county court for the displacement of their nearest relative;
- the patient lacks the capacity to request a reference; and
- either the patient's case has never been considered by the Tribunal, or a significant period has passed since it was last considered.

3.220 Any instances in which the Secretary of State has been requested to refer a patient's case to the Tribunal office will be reported to the Mental Health Act Scrutiny Committee by the Mental Health Act Lead.

3.221 The Code of Practice identifies a number of other duties that Solent NHS Trust has in connection with Tribunals. How these will be discharged is detailed below.

3.222 Staff members responsible for a patient's day to day care must inform the Mental Health Act Administrators immediately of any events or changes that might have a bearing on Tribunal proceedings – for example, where a patient is discharged or one of the parties is unavailable. The Mental Health Act Administration team will liaise with the tribunal office accordingly. An

application will also be considered to be withdrawn if the patient is discharged.

3.223 The Mental Act Administrators are responsible for informing responsible staff members the deadline for submitting reports. The responsible staff members are the Responsible Clinician, the lead nurse and the care co-ordinator. If the lead nurse or the care co-ordinator are unable to undertake the report then the team manager is responsible for allocating to another team member. The reports must be submitted by the deadline unless prior agreement is given by the Tribunal office to submit at an alternative date.

3.224 Late submissions of reports can result in delays to the tribunal and have a significant impact on the patient's article 5 rights being met. The Mental Health Act Administrators are responsible for monitoring the submission of reports, co-ordinating them and submitting them to the Tribunal office on time. Any instances in which the Tribunal office issue directions for late reports will be reported, by the Mental Health Act Lead to the Mental Health Scrutiny Committee.

3.225 Responsible staff members must ensure that their reports are up-to-date and written in accordance with the tribunal's rules and procedures. The Mental Health Act Lead will produce and review guidance on report writing that encompasses these rules. These can be found on the Mental Health Act intranet site. Where ever possible the contents of reports must be shared with the patient and their views recorded. When this is not done clear reasons for not doing so must be recorded. The IMHA service may be able to support a patient to understand the reports written about them.

3.226 All professionals who attend Tribunal hearings must be adequately prepared. They must know their reports and be in a position to provide the tribunal with any updates not in the reports.

3.227 It is the responsibility of the detaining authority to demonstrate that the grounds for detention are met. The Responsible Clinician should be clear in both their report and their evidence how these grounds are met. If other staff presenting reports have a different view then it is important that they have discussed this with the Responsible Clinician before the tribunal and allowed them to consider these views.

3.228 The tribunal chair may ask the Responsible Clinician if he is representing the detaining authority. It is the decision of the RC as to whether they wish to undertake this role. However, if there are specifics of the case that justify formal legal representation, the RC should discuss these with the Mental Health Act Lead well in advance of the tribunal and formal legal representation can be considered.

3.229 Where the patient is under the age of 18 and the responsible clinician is not a child and adolescent mental health service (CAMHS) specialist, the Mental Health Act Administrators will request a report from a CAMHS specialist.

3.230 A medical member of the Tribunal may want to examine the patient at any time before the hearing. Ward managers must ensure that the medical member can see patients who are in hospital in private and Mental Health Act Administrators must ensure they can examine their medical records. It is

important that the patient is told of the visit in advance so that they can be available when the medical member visits.

3.231 It is essential that every effort is made to enable patients to engage in the process and for them to fully participate in their Article 5 rights. The Tribunal service will provide such services of sign language interpreters, lip speakers or palantypists as may be necessary. The staff responsible for reports are also responsible for identifying any specific needs at an early stage and liaising with the Mental Health Act Administrators, who will liaise with the Tribunal office.

3.232 The Tribunal will normally communicate its decision to all parties orally at the end of the hearing. Provided it is feasible to do so, and the patient wishes it, the Tribunal will speak to them personally. Otherwise, the decision will be given to the patient's representative (if they have one). If the patient is unrepresented, and it is not feasible to discuss matters with them after the hearing, the Mental Health Act Administrators will liaise with the ward manager who must ensure that the patient is told the decision as soon as possible.

3L Reporting to the Care Quality Commission (CQC)

3.233 Solent NHS Trust have a duty to report the death of detained patients and certain instances of Absence Without Leave (AWOL) to the Care Quality Commission. The latter does not apply to Solent NHS Trust as they do not manage any wards to which the requirements apply.

3.234 It is the responsibility of ward managers to ensure the Mental Health Act Administrators and the Quality and Risk team are informed of any of these instances. The Quality and Risk Team will then make the appropriate report to the CQC.

3.235 The Mental Health Act Lead will inform the Mental Health Act Scrutiny Committee of any such reports made to the CQC.

3M Supervised Community Treatment (Community Treatment Orders)

Overview

3.236 The term Supervised Community Treatment refers to all the provisions surrounding a Community Treatment Order (CTO), including the powers within the order itself. The Code of Practice gives extensive guidance with regard to CTO and must be consulted by practitioners. There is no lower age limit to the use of CTO.

3.237 Supervised Community Treatment is intended to give a statutory framework to support and increase the likelihood of patient's compliance with treatment once they have been discharged from hospital. It is intended that this will reduce the likelihood of relapse and any harm resulting from this. It has:

- 2 compulsory conditions,
- enables the RC to set further conditions,
- has a power for the RC to recall the patient to hospital for up to 72 hours,
- and, during a period of recall, a power for the RC to revoke the CTO and the patient to return to being detained in hospital.

A CTO, therefore, impacts upon the everyday rights and freedoms of the person and is likely to engage their article 8 rights to private and family life in

a number of ways. The impact of these rights being engaged is that any infringement of them must be in line with the provisions of the Mental Health Act 1983, necessary to achieve the risks it is used to manage, and a proportionate response to the situation. The principles in the Code of Practice would also require the measure in question be the least restrictive way of achieving the necessary end.

3.238 The conditions attached to a CTO cannot amount to a deprivation of liberty. If it is necessary to impose a care plan that amounts to a deprivation of liberty for a person that lacks capacity to consent then consideration should be given to using the Deprivation of Liberty Safeguards or making an application to the Court of Protection, either on their own or in conjunction with a CTO. If a person has capacity to consent to conditions then conditions, that otherwise would amount to a deprivation of liberty, can only be imposed with the consent of the patient. This consent must be real.

3.239 Regarding the purpose of CTO, the Code of Practice states the following:

- The purpose of CTO is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. (COP 29.5)

- CTO provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary. (COP 29.6)

3.240 The following criteria must be met for a CTO to be made:

1. The patient is detained in hospital for treatment under section 3 or a Part III order without restriction; and

2. all the following criteria are met.
    - the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;

    - it is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;

    - subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital;

    - it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) of the Act to recall the patient to hospital; and

    - appropriate medical treatment is available for the patient.

3.241 In deciding if recall is necessary the Act states the RC should 'consider, having regard to the patient's history of mental disorder, and any other relevant factors, what risk there would be of deterioration of a patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).'s17A((6).

3.235 The Code states 'CTO may be used only if it would not be possible to achieve the desired objectives for the patient's care and treatment without it' and that the key factor in the decision is whether the patient can safely be treated for mental disorder in the community only if the responsible clinician can exercise the power to recall the patient to hospital for treatment if that becomes necessary.

3.236 Alternatives to CTO include, s17 leave, guardianship, or discharging as an informal patient. Discharging as an informal patient is clearly the least restrictive alternative. However, it may not be sufficient to manage the specific risks of the case. CTO, s17 leave and guardianship are separate regimes, have different qualifying requirements and different powers. Identifying the most appropriate one involves clarifying the necessary aims that need to be achieved to safely manage risk and promote recovery and considering how these relate to the specific powers of each regime and the least restrictive way of achieving those aims.

3.237 When considering the suitability of a CTO, it may be helpful to consider the person's understanding and view of the power of recall and how the power of recall is likely to affect their behaviour.

3.238 The Code, further, identifies the following as relevant factors when considering the necessity of having a power of recall to ensure a patient receives treatment:

- The fact that a relapsing history may indicate the need for CTO but a relapsing history does not have to be proved for the criteria to be met. What else is considered will depend on the case but could include the patient's insight, attitude to treatment, current mental state and social circumstances.
- The risk of deterioration is a significant factor but needs to be considered alongside the seriousness of the risk associated with the deterioration: risk of deterioration alone would not meet the criteria for a CTO.
- The patient does not have to formally agree to a CTO but some level of co-operation, even if reluctant, is necessary for it to work. In particular, unlike s17 leave CTO does not give the authority to treat a patient with capacity to consent to treatment, who refuses treatment; recall should be considered in this instance.

3.239 The treatment includes medication but can also include out-patient appointments, visits by doctors, mental health practitioners, OT work etc. A CTO may not be able to ensure engagement with all of these. However, not all of these will be essential to ensure safe maintenance and monitoring in the community. For example, ensuring compliance with a depot may be significant whereas ensuring engagement with activities may be desirable in promoting recovery but not essential in preventing relapse. Each case will be different and the facts of that case will need to be considered.

3.240 Chapter 31 of the Code gives further advice to consider when choosing between the regimes and practitioners should be familiar with this guidance. It can be summarised in the tables below.

Factors suggesting longer-term leave	**Factors suggesting CTO**
• Discharge from hospital is for a specific purpose or a fixed period. • The patient's discharge from hospital is deliberately on a "trial" basis. • The patient is likely to need further in-patient treatment without their consent or compliance. • There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for CTO.	• There is confidence that the patient is ready for discharge from hospital on an indefinite basis. • There are good reasons to expect that the patient will not need to be detained for the treatment they need to be given. • The patient appears prepared to consent or comply with the treatment they need – but risks as below mean that recall may be necessary. • The risk of arrangements in the community breaking down, or of the patient needing to be recalled to hospital for treatment, is sufficiently serious to justify CTO, but not to the extent that it is very likely to happen.

Factors suggesting guardianship	**Factors suggesting CTO**
• The focus is on the patient's general welfare, rather than specifically on medical treatment. • There is little risk of the patient needing to be admitted compulsorily and quickly to hospital. • There is a need for enforceable power to require the patient to reside at a particular place.	• The main focus is on ensuring that the patient continues to receive necessary medical treatment for mental disorder, without having to be detained again. • Compulsory recall may well be necessary, and speed is likely to be important.

3.241 Section 17 leave has a number of additional powers that CTO does not have, these include:

- the RC does not need agreement of an AMHP when setting conditions,
- a condition can be set that the person must remain at a residence and be in a person's custody whilst there. This enables the person to be taken into custody and returned there if necessary,
- the person remains subject to Part IV treatment provisions, and
- the RC does not need agreement before revoking the leave and this can be done without first recalling the patient to hospital.

Conditions

3.242 The following 2 conditions are mandatory and apply to all CTOs:

1) Patients must make themselves available for examination by his/her Responsible Clinician when needed to for consideration of the extension of the CTO.
2) Patients must make themselves available for examination if necessary, to allow a SOAD to provide a Part 4A certificate authorising treatment.

Responsible Clinicians may also, with the AMHP's agreement, set other conditions which they think are necessary or appropriate to achieve one of these 3 purposes:

• ensure that the patient receives medical treatment for mental disorder;
• prevent a risk of harm to the patient's health or safety;
• protect other people.

3.243 Conditions may be set for any or all of these purposes, but not for any other reason. The AMHP's agreement to the proposed conditions must be obtained before the CTO can be made.

3.244 The RC varies conditions by completing a CTO2. Although the RC may vary conditions without the AMHP's agreement, they should not normally include a condition that an AMHP has previously objected to, unless there has been a change in circumstances. It would be good practice to seek the AMHP's view in this circumstance.

3.245 In considering what conditions might be necessary or appropriate, the responsible clinician should always keep in view the patient's specific cultural needs and background. The patient, and (subject to the normal considerations of patient confidentiality) any others with an interest such as a parent or carer, should be consulted.

3.246 The conditions should:

- be kept to a minimum number consistent with achieving their purpose;
- restrict the patient's liberty as little as possible while being consistent with achieving their purpose;
- have a clear rationale, linked to one or more of the 3 purposes stated above; and
- be clearly and precisely expressed, so that the patient can readily understand what is expected.

3.247 The breaking of a condition, other than the two mandatory conditions, does not in itself give sufficient authority to recall a patient. It should lead to a review. The power to recall, as discussed below, is dependent on certain criteria being met and it is these criteria that the patient and situation should be reviewed against. In light of this, it may be helpful to see conditions as a way of negotiating with the patient, the RC communicating his view of the minimum the patient needs to do to prevent relapse and an increase in risk and support the patient towards recovery and self-management.

Care Planning

3.248 Patients do not need to agree to be under CTO. However, there will need to be a certain amount of engagement, even if that is reluctant engagement, for CTO to work in practice. CTO should be used in conjunction with the CPA

process, should be done, as much as possible, in partnership with the patient, should be informed by the guiding principles of the Act and should appropriately involve carers.

3.249 Patients under CTO are entitled to s117 aftercare and therefore the s117 aftercare policy should be consulted.

3.250 CTO is more likely to be effective if the care co-ordinator is involved in planning and seeks to maximise partnership working with the patient.

3.251 CTO should not be seen as a permanent solution and from the outset professionals should be working with the patient to identify what needs to be achieved for the patient to be discharged. Where ever possible this should be communicated to the patient and form a part of the CPA process.

3.252 All patients on CTO are subject to CPA or the equivalent. They must have an up to date care plan, risk assessment and crisis and contingency plan. For the purpose of CTO these must:

- record any conditions attached to the CTO
- clearly state the relapse indicators, factors that may lead to recall, and any potential risks associated with the recall process;
- identify plans to manage these;
- identify any risks and or benefits of the involvement of the person's family and social network and their views; and
- record the person's views and if they have a signed copies of the plans or a reason why not.

3.253 The RC is responsible for monitoring the patient on the CTO. In order to ensure this occurs the care co-ordinator must inform the RC of any significant increase in risk or deterioration in mental state, any time a condition is breached or treatment is refused. The RC and care co-ordinator will review the situation and record their plan and reasons.

Process of making a CTO

3.254 The application is made by the Responsible Clinician on form CT01. An AMHP must sign to state that the criteria are met, it is appropriate to make the order, and the conditions are necessary or appropriate for the purposes specified. When considering a CTO the RC is responsible for ensuring a referral is made to the AMHP service in sufficient time for the AMHP to fully consult the multi-disciplinary team and other relevant parties involved, the patient, review any notes and attend any CPAs.

3.255 The CTO1 must state the date that the CTO commences. This can be a future date.

3.256 On completing the CTO1 it must be forwarded to the Mental Health Administration team, who will scrutinise and receive it on behalf of Solent NHS Trust.

3.257 Section 3C of this policy sets out the requirements to provide information to patients and who is responsible for discharging these. It applies to patients subject to CTO.

Consent to Treatment Rules

3.258 Patients subject to CTO come under Part IVA of the Mental Health Act and are no longer subject to Part IV. No treatment certificate is required until the later of; the first month the patient is on CTO or for the first three months after the date the patient was admitted under the initial detaining section. The Mental Health Act Administrators will monitor these time periods and inform the RC at least three weeks before a treatment certificate is required.

3.259 For patients who lack capacity to consent the certificate requirement is met by a CTO11. This is discussed below. For patients who have capacity to consent to the treatment, and do consent, the certificate requirement is met by a CTO12. This is completed by the AC directing the treatment.

3.260 It is the responsibility of the RC to complete the appropriate forms to apply for a Treatment Certificate and for the Mental Health Act Administration team to make the referral for a SOAD service.

3.261 The Mental Health Act Administrator will liaise with the SOAD and the care co-ordinator. The care co-ordinator is responsible for informing and reminding the patient of the time, date and place of the SOAD visit and if necessary, taking appropriate steps to support them to attend. The care co-ordinator must record any steps taken in this regard as the SOAD will require this evidence if the patient does not attend.

3.262 On visiting the SOAD will need to speak to two statutory consultees. The guidance stated earlier in the policy applies to these consultees.

3.263 A copy of any certificate to treat a patient should be kept with the treatment card, in the patient's notes and the original with the Mental Health Act Administration team. The Mental Health Act Administrators will inform the GP, in writing, of the medication that has been approved by the SOAD and inform them that before prescribing medication for mental disorder outside of this they must discuss it with the RC, as a new SOAD referral will be required.

3.264 The Mental Health Act Administration team will review patient's under CTO to ensure that all relevant patients have a SOAD certificate in place.

3.265 The CTO11 treatment certificate states that treatment in the community is appropriate. However, it does not, in itself, provide the authority to treat patients in the community.

3.266 In summary**,** whereas Part IV enables a patient to be treated in the absence of consent, Part IVA contains no such provisions. It contains safeguards for patients but does not give any specific authority to treat. For adult patients, this authority will come from the patient's consent or the Mental Capacity Act 2005. Therefore, if a patient is objecting to treatment the RC should consider if it is appropriate to use their power of recall and if the associated criteria are met. However, they should be aware that refusing treatment in itself does not give authority to recall; the criteria must also be met.

3.267 Treatment rules for children are different than those for adults. The Mental Capacity Act 2005 does not apply to anyone under 16 when assessing their ability to consent to treatment. Their competence to consent should be assessed instead. Chapter 36 of the Code of Practice gives guidance on this. A child who is competent to consent can not be treated under CTO if they do

not consent. Children who are not competent to consent can be treated under the same circumstances as an adult who does not have capacity to consent. However, a person with parental responsibility can not consent on their behalf.

3.268 There are no provisions in Part IVA to treat, in the community, a patient who has capacity and refuses treatment. However, s64G does give certain powers to treat a patient under CTO in the community who lacks capacity to consent but objects. Certain conditions must be met:

- the person giving the treatment must reasonably believe the patient lacks capacity to consent,
- treatment is immediately necessary,
- if force is to be needed, the treatment is necessary to prevent harm to the patient and the use of such force is proportionate to the seriousness and likelihood of the patient suffering harm that is it used to prevent.

3.269 In order to be immediately necessary medication which is treatment for the mental disorder must meet the following criteria:

a) it is immediately necessary to save the patient's life; or
b) it is immediately necessary to prevent a serious deterioration of the patient's condition and is not irreversible; or
c) it is immediately necessary to alleviate serious suffering by the patient and is not irreversible or hazardous; or
d) it is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous.

3.270 For the purpose of ECT, only conditions a) and b) apply.

3.271 The form provided by the Mental Health Act Administration team should be used to authorise any treatment under s64(G).

3.272 The CTO11 can authorise treatment on recall to hospital. In order to do so the SOAD must specifically state this on the form. Once recalled to hospital the patient comes under Part IV of the Act and if it authorises treatment the CTO11 will form the authority to treat. If the form is relied on for authority to treat then the RC, when renewing the CTO, must provide a report on the treatment to the CQC. The Mental Health Act Administrators will remind them of such.

3.273 If there is no CTO11 authorising treatment on recall and it is outside the initial three months under which a treatment certificate is not needed for s58 type treatment under Part IV and outside the first month of the CTO then the treatment can only be given in the following circumstances:

- the patient has capacity to and consents and there is a valid certificate in place;
- the patient is treated under s62 urgent treatment provisions (complete form provided by the Mental Health Act Administration team);
- it is a s58 or s58A type treatment and the AC considers the discontinuation of the treatment or treatment under the plan would cause serious suffering to the patient and has requested a SOAD visit for a further certificate. (s62(2)) (complete form provided by the Mental Health Act Administration team); or

- it is a treatment that comes under s63 and does not need a certificate.

Although a T3 valid during a period directly before the CTO was enacted is still technically still valid the Code states it would not be good practice to rely on it and the CQC support this view. In the absence of the above conditions being met the treatment can only proceed once a valid treatment certificate is sought.

Recall and Revocation of a CTO

3.274 The RC may Recall a patient if:

- the patient requires medical treatment in hospital for his mental disorder; and
- there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.

3.275 The RC may also recall a patient if one of the two mandatory conditions are broken by the patient. However, good practice would suggest that they first consider if there is a less restrictive alternative way of safely managing the situation.

3.276 Breaking a condition that the RC has set does not in itself provide authority to recall. It may be taken into account and must lead to a review of the patient and situation against the criteria for recall. The RC must record the outcome of their review, the plan and their reasons. At the same time, the criteria for recall may be met even though no conditions have been broken.

3.277 On admission to hospital a recalled patient comes under Part IV. However, a SOAD certificate under Part IVA, as detailed above, can authorise treatment on recall to hospital.

3.278 In order to recall a patient the RC must complete form CTO3 and this must be served on the patient. Depending on how it is served will alter when in law it can be considered to be served and therefore when the patient is deemed to be recalled. This is summarised in the table below.

3.279

Method of Serving form CTO3	Notice effective
Form served by hand to the patient	Effective Immediately
Deliver form by 1st class mail to address where patient is believed to be	Served on the 2nd working day after posting (e.g. posted Friday effective from Tuesday)
Deliver form by hand to patient's usual or last known address If appropriate, consider	Notice deemed to be served after midnight on the day it was delivered. It does not matter whether it

whether s135(2) warrant should be sought	is a working day, a weekend or a holiday. It does not matter whether it is actually received by the patient or not

3.280 The RC has overall responsibility for co-ordinating recall of the patient. Further guidance will be provided to services and kept up to date, in line with local changes, by the Mental Health Act Lead.

3.281 If the patient does not return on their own and needs to be taken into custody and returned to the hospital this can only be done by any nurse at the hospital, an AMHP, a police officer or any person authorised in writing by the RC, the staff nurse in charge of the ward, a qualified member of the community mental health team or a member of the Crisis Resolution and Home Treatment team. The Mental Health Act enables the RC to authorises this person in their own right; the Mental Health Act enables the other staff members named to authorise this person as nominated people acting on behalf of Solent NHS Trust.

3.282 The RC is responsible for ensuring a copy of the CTO3 is given to the nurse in charge of the ward. On admission to hospital the senior nurse on the ward will complete CT04 and forward it the Mental Health Act Administration team with the CTO3.

3.283 If a patient is recalled to a hospital other than the responsible hospital then the RC must inform, in writing, the organisation that manages the responsible hospital of the name and address to which the patient is recalled.

3.284 The nurse completing the CTO4 is responsible for ensuring the patient is informed orally and in writing of their rights as a recalled patient and of the consent to treatment provisions which apply.

3.285 Once a patient has been recalled the RC will need to consider if the CTO needs to be revoked. If they consider it so, then they are responsible for ensuring a referral is made to the AMHP service.

3.286 In order to revoke the CTO the RC must be satisfied that in his opinion, the conditions mentioned in section 3(2) are satisfied in respect of the patient; and an AMHP agrees with that opinion and that it is appropriate to revoke the order. The AMHP and RC must complete CTO5 within 72 hours of recall.

3.287 If the 72 hours expires before a patient is discharged back onto the CTO or revoked then they are no longer a recalled patient and should be considered back under CTO.

3.288 Mental Health Act Administrators are responsible for monitoring the periods of time a patient is a recalled patient for. The Mental Health Act Lead will report this to the Scrutiny Group and identify any instances when they were held for longer than 72 hours.

3.289 If a patient's CTO is revoked the patient becomes detained under the original section they were detained under - s3 or a Part III order without restrictions.

The form CT05 will be scrutinised and received by the senior nurse on the ward and forwarded to the Mental Health Act Administration team for further scrutiny.

3.290 If a patient's CTO is revoked and the patient is detained in a hospital other than the one which was the responsible hospital at the time of recall, the Mental Health Act Administrators of the new hospital must send a copy of the revocation form to the managers of the original hospital.

Inpatient Staff and patient's subject to CTO

3.291 An CTO patient may be an inpatient either because they have been recalled or because they have agreed to an informal admission. Recalling the patient is not about where the person is but their legal status.

3.292 A patient subject CTO and admitted informally can only be treated in line with the CTO11. Section 5.2 or s5.4 cannot be used. In such situations, the RC must be contacted and consideration given to recalling the patient. Out of hours this is the on-call consultant. They cannot delegate this. If the RC of that moment is not available to assess recall immediately then the person may consent to remain on the ward until the RC can consider the issue, or there are a number of other powers that provide sufficient authority to keep the person on the ward to prevent them causing harm to themselves, others or property as long as the force used is both necessary and proportionate to the harm threatened. The most common are:

- the common law of necessity if preventing them leaving is a proportionate step to protect themselves or others from the immediate risk of significant harm; or

- if they lack capacity, as defined by the Mental Capacity Act 2005, they could be prevented from leaving if it is in their best interest, providing that the restraint is necessary and proportionate to the seriousness and likelihood of harm to self it is used to prevent.

When making this decision the nursing staff members need to be mindful of their duty to take reasonable steps to prevent a risk to the person's life, arising from self-harm, that they knew or should have known about. These powers can only be used to cover a delay in the RC being able to consider recall. They can not be used instead of the RC considering recall. The effect of this is that when contacted the RC must give a high priority to take steps to decide if the person needs recalled.

3.293 A recalled patient is covered by Part IV treatment provisions. This means that the same rules apply for observation, searches and restraint as any other detained patient. The person can also be granted s17 leave. This would not be a usual occurrence but could be used, for example, if the person needs urgent treatment at an acute hospital.

3.294 The effect of the treatment provisions are that, a recalled patient can only receive medication for their mental disorder if:

- it is authorised on the CTO11 in the section that states the medication that can be given on recall,
- it is the continuation of a treatment that the RC believes needs to continue, as stopping it would cause serious suffering to the patient,

and arrangements are being made to seek the appropriate Treatment certificate
- it has not been three months since the person was first detained before prior to being on the CTO or has not been on a CTO for one month
- an AC authorises it as an emergency treatment under s62.

3.295 A person whose CTO has been revoked is on the section they were on before being placed on a CTO. They can only receive medication for their mental disorder if:
- it is authorised on the CTO11 in the section that states the medication that can be given on recall, and the appropriate treatment certificate is being sought (T2 or T3),
- it is the continuation of a treatment that the RC believes needs to continue, as stopping it would cause serious suffering to the patient, and arrangements are being made to seek the appropriate treatment certificate,
- it has not been three months since the person was first detained before going onto a CTO or has not been on a CTO for one month
- an AC authorises it as an emergency treatment under s62.

Transfer of a recalled patient to another hospital

3.296 A recalled patient can be transferred from one hospital to another. When both hospitals are managed by Solent NHS Trust no formal procedure is needed. When the hospital is managed by a different organisation the procedure below must be followed.

3.297 Before transferring any patient from one hospital to another the factors set out in Part 3E of this policy should be considered.

3.298 Solent NHS Trust authorise the patient's RC, the nurse in charge of the ward, the ward manager or their deputy to transfer recalled patients to another hospital and make any necessary records on their behalf. Transfers are authorised by completing form CTO6.

3.299 When a patient is transferred from a Solent NHS Trust hospital the nurse in charge for the ward or the Mental Health Act Administrators must give the managers of the new hospital a copy of the record of the time the patient was detained as a result of being recalled to hospital (ie Form CTO4). This must be done before or at the time that the patient is transferred.

3.300 When a patient is transferred to a Solent NHS Trust hospital the nurse in charge of the ward must record the time of the patient's admission there using the same Form CTO6 on which the transfer was originally authorised.

3.301 If a NHS patient is recalled to an independent hospital by Solent NHS Trust and Solent NHS Trust has contracted to act as the Responsible Hospital, the patient's transfer to another hospital under different management may be authorised by a ward manager, their deputy or an AC.

3.302 A transfer between hospitals while a patient is recalled does not change the responsible hospital; the procedure below should be followed.

3.303 Patients whose transfer has been authorised may be conveyed to the new hospital by an employee of Solent NHS Trust, a person authorised by the managers of the other hospital or by any person authorised by the managers of the hospital to which to patient is being transferred. This may only be done during the 72 hour period for which the patient may be detained on the basis of the recall. It is the responsibility of any Solent NHS Trust staff member authorising transfer to unsure that safe arrangements are made for the transfer.

3.304 The Mental Health Act Administration team will keep a register of any such transfers. the Mental Health Act Lead will report any such transfers to the Mental Health Act Scrutiny group.

Transfer of Responsible Hospital

3.305 The responsible hospital is the hospital that has overall responsibility for the lawful discharge of duties and powers under the Mental Health Act, in respect of a CTO patient.

3.306 Solent NHS Trust may authorise the transfer of a CTO patient's responsible hospital to a hospital managed by a different organisation.

3.307 Solent NHS Trust delegate this function to the patient's RC, the nurse in charge of the ward, the ward manager or their deputy. The transfer is authorised by completing Form CTO10 (even if the new responsible hospital is in Wales). They may only do so if the managers of the new hospital agree to the assignment and specify a date on which it is to take place.

3.308 If responsibility is to be assigned from a hospital in Wales, the procedures in the equivalent Welsh regulations apply instead (and the equivalent Welsh form must be used).

3.309 Once responsibility is assigned, the new hospital becomes the responsible hospital.

3.310 A change of responsible hospital does not change the date on which the CTO is due to expire, nor the period for which it could (if appropriate) be extended.

3.311 If a patient's responsible hospital is transferred to a Solent NHS Trust hospital the patient must be notified of the reassignment of responsibility either before or as soon as practicable afterwards. This is delegated as set out in section 3.7 of this policy. The patient should also be re-informed of their rights.

3.312 Unless the patient has requested otherwise (or does not have a nearest relative), Solent NHS Trust must also take whatever steps are reasonably practicable to have the person they think is the patient's nearest relative informed, again either before or as soon as practicable after the reassignment. Information given to a nearest relative must be in writing, but may be communicated by electronic means (eg e-mail) if the nearest relative agrees. This is delegated to the Mental Health Act Administrators.

3.313 If Solent NHS Trust is acting as the responsible hospital for an independent hospital then transfer of responsible hospital to a hospital managed by a different organisation may be authorised as set out above.

3.314 The Mental Health Act Administration team will keep a register of any such transfers. The Mental Health Act Lead will report any such transfers to the Mental Health Act Scrutiny group.

Extension of the CTO

3.315 The Mental Health Act Administrators will monitor patients detained under CTO and inform RCs of their duty to consider extending it.

3.316 In the two month period before the CTO is due to expire the RC must examine the patient and determine if the grounds for the CTO continue to be met and if it should be extended. In doing this they must consult one or more professionals involved in the patient's medical treatment. After doing this, if they consider the grounds are met and an AMHP agrees with this opinion and that it is appropriate to extend the CTO it can be extended by the AMHP and RC completing form CTO7.

3.317 The RC is responsible for ensuring that a referral is made to the AMHP service in plenty of time for the AMHP to take all appropriate steps to consider the case and form their view. If the CTO is to be extended, the form CT07 will be completed by the RC and AMHP and forwarded to the Mental Health Act Administration team who will receive it and scrutinise it. They will then make any necessary arrangements with regard to manager's panel hearings and the first tier tribunal as indicated by the Mental Health Act and set out in this policy.

Concerns by and involvement of family members

3.318 Subject to the normal considerations of patient confidentiality, good planning should involve a patient's social network, particularly those who play a part in the care or monitoring of the patient.

3.319 Undue reliance should not be placed on carers and the impact of any care plan, on them, should be taken into consideration. However, where possible, significant people in a patient's social network should be involved in care planning, including relapse and prevention, and know who to contact to express concerns.

3.320 Carers are often the first to identify if a person is relapsing or failing to comply with conditions. If carer's express such concerns then:

- As much detail as possible should be gathered about the concerns, how it is affecting compliance with conditions, the mental state of the patient and any risks.

- The level of involvement of the carer, their relationship with and knowledge of the patient and the patient's mental health difficulties, current risk assessments, risk management plans and evidence from other sources should be considered when risk assessing this information and considering what weight to give it.

The concerns, alongside the weight to be given them and the course of action to be taken, should be clearly recorded in the patient's record.

Reviewing the need for and discharging a CTO

3.321 A patient being subject to CTO should not be seen as a permanent solution. It is important that from the beginning the RC and other professionals are involved ask what needs to be achieved for the CTO to be discharged and the patient given responsibility for their own management. As far as is possible, this should be done in partnership with the patient and expectations clearly communicated to them.

3.322 The RC has a legal responsibility to keep the criteria under review and to discharge the CTO when it is no longer necessary or the criteria are no longer met.

3.323 The RC discharges CTO by completing a report and submitting it to the Mental Health Act Administrators.

3.324 If an RC discharges the CTO they are responsible for ensuring the patient is informed of the discharge and its implications.

Effect of a further application under Part II of the Act on CTO

3.325 If a s2 application is made in respect of an CTO patient the CTO does not cease to have effect. In this situation the RC should consider using their power of recall and discharging the CTO. If the patient is detained in a hospital other than the responsible hospital and has a different RC in relation to the s2 then the two RCs should consult and agree the best way forward. This must be recorded on the patient's file.

3.326 If a s3 application or guardianship application is made in respect of an CTO patient then the CTO ceases to have effect.

Audit of CTO patient's files

3.327 Community teams are responsible for establishing systems to ensure the ongoing monitoring of CTO patient's files and ensuring that, in line with this policy, such patients:

- are informed of their rights;
- receive treatment only as the act allows;
- have their statutory paperwork duly completed; and
- have care plans that meet the required standard.

3.328 The Mental Health Act Administration team will audit CTO patient's files as part of the rolling audit of wards. This will be reported to the Mental Health Act Scrutiny Committee.

3N Domestic Violence, Crime and Victims Act 2004: Duties of Solent NHS Trust towards certain victims of crime

3.329 Solent NHS Trust has certain duties towards victims of violent or sexual offences (specified offence) in certain situations when the offender is an unrestricted patient detained by Solent NHS Trust.

3.330 These duties apply when the patient;

- was convicted of a specified offence (or found not guilty by reason of insanity, or to be under a disability but to have done the act or made

the omission charged against them) on or after 1 July 2005 and are then given an unrestricted hospital order on or after 3 November 2008;
- was convicted and given a prison sentence of at least 12 months for a specified offence on or after 1 July 2005 and who are then given an unrestricted transfer direction on or after 3 November 2008;
- was already a restricted patient (jn relation to a specified offence), and who ceases to be subject to restrictions on or after 3 November 2008.

3.331 Such patients are referred to below as relevant patients.

Ensuring Relevant Patients are identified

3.332 It is the responsibility of Mental Health Act Administrators to identify such patients, record this on their file and inform the RC and care team involved.

3.333 With regard to such patients Solent NHS Trust will be contacted in the following circumstances:
- Probation services will routinely notify hospital managers of cases where a victim has expressed a wish to make representations or receive information.
- When the Secretary of State makes an unrestricted transfer direction, the Ministry of Justice Mental Health Unit (MHU) will tell the hospital managers if the patient is one to whom thee provisions apply.
- The MHU will also tell the hospital managers if a restricted patient is such a patient when it lifts the restrictions on the patient, or the restrictions lapse, but the patient remains detained.
- Victims may also approach hospital managers directly to make representations or ask to receive information. When this occurs, legally, it is for Solent NHS Trust to decide whether the person requesting information, or asking to make representations, is in fact a victim for the purposes of the 2004 Act. the Mental Health Act Administrators will do this in consultation with the Mental Health Act Lead. In cases of doubt, probation services will be able to advise on how they identify eligible victims.

3.334 All correspondence should be forwarded to the Mental Health Act Administrators.

3.335 If Mental Health Act Administrators are approached directly by a victim after the patient has been transferred (or, in the case of an CTO patient, assigned) to another hospital under different managers, they should offer to pass on the victim's request to the new managers. If the patient has been discharged, and is therefore no longer a relevant patient, the hospital managers should explain that to the victim.

3.336 The probation service's Victim Liaison Officer has a duty to take the initial steps following a relevant offender's trial to establish: if the victim of the offence wishes to make representations about what conditions the patient should be subject to if discharged from hospital onto CTO, and whether the victim wishes to receive information about those conditions in the event of the patient's discharge onto CTO.

3.337 When such an offender becomes liable to be detained in hospital as an unrestricted patient, the Victim Liaison Officer is required to notify Solent

NHS Trust if the victim wishes to receive information and make representations and inform them of the name and address of the victim. They will also notify the victim of the name and address of the hospital.

3.338 If a relevant restricted patient subsequently becomes an unrestricted patient, the Victim Liaison Officer has a duty to inform Solent NHS Trust if any victims have asked to receive information or make representations, and give the managers a contact address for the victim. The Victim Liaison Officer will also tell the victims the name and address of the hospital.

3.339 The Victim Liaison Officer should be referred to the Mental Health Act Administrators; whom must ensue this information is recorded on the patient's file and the RC and care co-ordinator informed.

Discharging duties to inform victims and consider their representations

3.340 When an RC is considering discharging a relevant patient from detention or CTO the Mental Health Act Administrators must pass that information on to any victims who have asked to make representations about conditions to be attached to the patient's discharge (or who have since actually made any representations). They should ask the victims if they wish to make any representations (or new representations) to be passed on to the patient's RC. This should be done in writing and, if appropriate, by telephone.

3.341 Although, the Tribunal does not have the power to discharge patients onto CTO, they may recommend that the RC considers it. As a result, victims' representations on the conditions to which a patient should be subject if discharged onto CTO are not directly relevant to the Tribunal's decision, and do not have to be passed on to the Tribunal by Solent NHS Trust. the Mental Health Act Administrators should explain this to the victim and if they wish to make representation they should be advised to contact the Tribunal office directly.

3.342 Mental Health Act Administrators will inform the RC, and the Victim Liaison Officer, if any victims or their family wish to make representation or receive information and any information shared. The RC is responsible for ensuring the patient is informed.

3.343 The Mental Health Act Administrators must also inform, in writing, victims that wish to receive information:

- if the patient is to be discharged from detention (whether by a Manager's Panel Hearing, the RC, or the tribunal;),
- if the patient's detention is to expire because the responsible clinician has decided it should not be renewed and, if so, the date on which it will expire (the RC is required to inform Mental Health Act Administrators if this is to occur)
- if the patient is to be discharged onto CTO, or
- if the RC is considering varying the conditions attached to a relevant patient's community treatment order.

3.344 If the patient is to be discharged onto CTO, the Mental Health Act Administrators must also give victims details of any conditions to be included in the patient's community treatment order which relate to contact with the victim or the victim's family.

3.345 Once a patient has been discharged onto CTO, Mental Health Act Administrators must also tell victims: the details of any subsequent variation of the conditions which relate to contact with the victim or the victim's family; and the date on which the patient's CTO is to end, whether because the patient is to be discharged from CTO, their CTO expires without being extended, their community treatment order is revoked, or for any other reason (the RC is required to inform Mental Health Act Administrators if this is to occur).

3.346 Solent NHS Trust also has a duty to consider using their discretion to give victims additional information (eg about patients' leave of absence, absconding, or transfer to another hospital). This is to give Solent NHS Trust discretion to give information intended to reassure victims. It is not intended to permit the disclosure of any information which would otherwise be treated as confidential patient information.

3.347 The Mental Health Act Administrators will inform the RC and care co-ordinator of this duty. If a significant event occurs that could impact on the victim the care co-ordinator and RC must liaise and record if 'considering all circumstances of the case it is appropriate to share the information' or not. The decision should be recorded. They must inform the Mental Health Act Administrators of their decision; whom will share an appropriate information. In the case of transfer it is likely to be appropriate in most cases to inform the victim of the details of the new hospital.

3.348 If a relevant patient is transferred, or assigned, to a new hospital under a different set of hospital managers, the Mental Health Act Administrators will alert the new managers, in writing to:

- the fact that the patient is a relevant patient under these provisions
- the names and addresses of any victims who have asked to receive information or make representations; and
- any representations those victims have already made.

3.349 If the victims make representations (or have already done so), the Mental Health Act Administrators must pass them on to the RC. If the RC is actively considering discharge to CTO, the representations must also be passed on to the AMHP who is considering whether to agree to the proposed community treatment order.

RC duties

3.350 In order to perform their duties, Mental Health Act Administrators require RCs to inform them:

- when they are considering discharging a relevant patient from detention or CTO;
- when they are considering discharging a relevant patient onto a CTO
- when they are considering varying the conditions of a relevant patient's community treatment order;
- the date on which a relevant patient's detention is to expire, if they examine the patient with a view to making a report renewing the patient's detention, but decide the criteria for renewal are not met;
- if they decide to discharge a relevant patient from detention;

- if they decide to discharge a relevant patient onto CTO, and if so, what conditions are to be included in the patient's community treatment order;
- about any variations of the conditions of a relevant patient's community treatment order;
- if they decide to discharge a relevant patient from CTO, the date on which that is to happen;
- if they decide to revoke a relevant patient's community treatment order, the date on which that happens; or
- the date on which relevant patient's CTO is to end for another reason (eg that it is to expire without being extended).

3.351 RCs must consider any representations made by victims when deciding what conditions to include in a patient's community treatment order. Victims might, for example, want RC to consider imposing a condition that the patient stays away from the area in which the victim lives. RCs must record their reasons.

3.352 If victims make representations about conditions after a patient has already been discharged onto CTO, RC should consider whether the conditions ought to be varied as a result. RCs must record their reasons.

3.353 This duty does not affect the rule in section 17B(2) of the 1983 Act that RCs may only include conditions in a patient's CTO which they think are necessary or appropriate for ensuring the patient receives medical treatment, preventing risk of harm to the patient's health or safety, or protecting other people.

3.354 Any duties carried out under this section will be reported, by the Mental Health Act Lead to the Mental Health Act Scrutiny Committee.

3O Entry and exit from wards; requirements for units with enhanced levels of security; and visiting of patients

3.355 Patients admitted to psychiatric wards, whether or not they are formally detained there, will have complex and specific needs. In such an environment, ward staff must balance competing priorities and interests when determining what safety measures are necessary to control entry and exit from wards. Solent NHS Trust has duties to ensure the safety of these patients and the public. In taking steps to ensure their and others safety, the patient's Article 8 rights are likely to be engaged. The aim of these measures, therefore, must be to protect patients, in particular those who are at risk of suicide, self-harm, accidents or inflicting harm on others unless they are prevented from leaving the ward. The measures should not impose any unnecessary or disproportionate restrictions on patients and aim not to make them feel as though they are subject to such restrictions. In certain situations, it may also be necessary to have in place arrangements for protecting patients and others from people whose mere presence on a ward may pose a risk to their health or safety.

3.356 All patients have the right to maintain contact with and be visited by anyone they wish to see, subject to carefully limited exceptions. If these rights are being restricted then the care team must ensure they have legal authority to do so, the restrictions are kept to only what is necessary and proportionate and the requirements of this policy are met.

3.357 If the restrictions imposed on individual patients amount to a deprivation of liberty, their Article 5 rights will be engaged and it must be ensured that the detention is lawful and authorised either under the Mental Health Act, the Deprivation of Liberty Safeguards or via a Court of Protection Order.

3.358 In order to ensure safe and effective management of entry and exit from the ward it will need to be considered what measures are most appropriate to the service user group on that ward and in what situations they should be used. These may include locking doors, placing staff on reception to control entry to particular areas, the use of electronic swipe cards, electronic key fobs, infrared technology or other suitable means.

3.359 It should, also, be borne in mind that the nature of engagement with patients and of therapeutic interventions, and the structure and quality of life on the ward, are important factors in encouraging patients to remain in the ward and in minimising a culture of containment. As is exploring and reflecting on patient's reasons for leaving a ward without agreement or proper authorisation.

3.360 Wards offering accommodation with enhanced levels of security must have written guidelines, setting out the categories of patients for whom it is appropriate to use physically secure conditions and those for whom it is not appropriate. The wards must have adequate staffing levels to ensure appropriate use of restrictions.

3.361 Treatment in conditions of enhanced security should last for the minimum period necessary. Where RCs have taken the decision to transfer a patient within a hospital to a ward with enhanced security, they should ensure that arrangements are made to facilitate the patient's prompt return to a less secure ward when that enhanced security is no longer required.

3.362 Before deciding if a patient needs to be transferred to a ward with enhanced security the RC and MDT must ensure:

- they have carefully weighed the patient's individual circumstances and the degree of risk involved; and
- they have assessed the relative clinical implications of placing the patient in an environment with enhanced physical security, in addition to or as opposed to providing care by way of intensive staffing.

3.363 When RCs believe that patients no longer require conditions of enhanced security (or the current level of security), they should take steps to arrange their transfer to more appropriate accommodation.

3.364 If the use of locked doors or physical barriers, to prevent entry and exit, are not a part of a ward's operating policy but are used then they will need to implement a protocol concerning entry and exit from the ward. This protocol must ensure:

- if locked external doors (or other physical barriers) are considered to be an appropriate way to maintain safety, it is identified who will regularly review the arrangements to ensure that there are clear benefits for patients and that it is not being used for the convenience of staff;
- if a locked door is being used to prevent a specific patient from leaving the ward that there is legal authorisation in place with regard to this

patient, that the impact on other patients is considered and minimised and the time scales for review and who will undertake this are clear;

- it should never be necessary to lock patients and others in wards simply because of inadequate staffing levels;
- the mix of patients (there may, for example, be some patients who ought to be in a more secure environment), staffing levels and the skills mix and training needs of staff are reviewed.
- the ward arrangements for entry and exit from the ward are clearly set out, it is clear who is responsible for explaining this to patients and carers (as far as is possible) on admission and the information is kept in a place accessible to them;
- there are signs on any locked doors stating why they are locked and arrangements for entry and exit;
- and that who is responsible for keeping the legal status of each patient under review, in order to ensure there is no unauthorised deprivation of liberty.

3.365 Where necessary, this information must be made available to those whose first language is not English.

Visiting of Patients

3.366 All patients have the right to maintain contact with and be visited by anyone they wish to see, subject to carefully limited exceptions. Visits should be encouraged and made as comfortable and easy as possible for the visitor and the patient. Reasonable and flexible visiting times, access to refreshment and pleasant surroundings will all contribute to a sense of respect for the patient's entitlement to be visited.

3.367 In addition to visits, every effort should be made to assist the patient, where appropriate, to maintain contact with relatives, friends and advocates in other ways. In particular, patients should have readily accessible and appropriate daytime telephone facilities.

3.368 The Act gives certain people the right to visit patients in private if they wish. This includes second opinion appointed doctors (SOADs), independent doctors or approved clinicians appointed to examine the patient in relation to an application or reference to the Tribunal, people visiting on behalf of the Commission, and independent mental health advocates (IMHAs). Ward managers must ensure that such visits can take place in private, if that is what the person concerned wants. However, if there are particular concerns for the security of the visitor, they should be discussed with the visitor with a view to agreeing suitable security arrangements.

3.369 Ward managers must also ensure that patients can communicate with their legal representatives in private, and should facilitate visits by those representatives when they request them.

Exclusion or restriction of visitors

3.370 There are circumstances where Solent NHS Trust may restrict visitors, refuse them entry or require them to leave. If this occurs then this policy must be complied with. Patients should also be given access to the policy and, if requested, the support of an IMHA.

3.371 There are two principal grounds which could justify the restriction or exclusion of a visitor: clinical grounds and security grounds. Clinical grounds include safeguarding concerns.

3.372 The decision to prohibit a visit, on an ongoing basis, by any person whom the patient has requested to visit or has agreed to see should be regarded as a serious interference with the rights of the patient. There may be circumstances when a visitor has to be excluded, but these instances should be exceptional and any decision should be taken only after other means to deal with the problem have been considered and (where appropriate) tried. Any such decision should be fully documented and include the reasons for the exclusion, it should be made available for independent scrutiny by the Care Quality Commission and the Mental Health Act Administration team informed. It should be reported as a risk event.

3.373 If such a person's visiting is being restricted and agreement cannot be reached by keeping restrictions to a minimum and only what is proportionate and necessary, then Solent NHS Trust must ensure that the requirements of Article 8, with regard to both parties are met. Advice should be sought, initially from the Mental Health Act Lead, as to whether the hospital has sufficient authority to take these actions or if the matter needs to be brought before the Court of Protection and if the Deprivation of Liberty Safeguards need to be invoked. Relevant issues to consider will include: the person's capacity to consent to contact, the length of time the restrictions are in place for, the reason for restricting contact and the impact upon the patient.

Restriction or exclusion on clinical grounds

3.374 From time to time, the patient's responsible clinician may decide, after assessment and discussion with the multi-disciplinary team, that some visits could be detrimental to the safety or wellbeing of the patient, the visitor, other patients, or staff on the ward. In these circumstances the RC may:

- make special arrangements for the visit,
- impose reasonable conditions,
- or if necessary exclude the visitor.

3.375 In any of these cases, the RC must ensure there is sufficient legal authority to take the action and the reasons and plan are recorded and explained to the patient and the visitor, both orally and in writing (subject to the normal considerations of patient confidentiality). This should be reported as a risk incident and a copy of this letter must be forwarded to the Mental Health Act Administrators.

3.376 If the reasons include safeguarding concerns then the Trust Adult Safeguarding Lead must be informed and the Safeguarding Adult's policy complied with.

Exclusion on security grounds

3.377 The behaviour of a particular visitor may be disruptive, or may have been disruptive in the past, to the degree that exclusion from the hospital is necessary as a last resort. Examples of such behaviour include:

- incitement to abscond;

- smuggling of illicit drugs or alcohol into the hospital or unit;
- transfer of potential weapons;
- unacceptable aggression; and
- attempts by members of the media to gain unauthorised access.

3.378 A decision to exclude a person on an ongoing basis, for these reasons, can be taken by the RC, the ward manager or the ward manager's deputy. Consideration must be given to the impact this has on the patient's Article 8 rights to a private and family life and if it leads to the patient being deprived of their liberty. The person undertaking the exclusion must ensure there is sufficient legal authority to do so.

3.379 A decision to exclude a visitor on an ongoing basis on the grounds of their behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate, the reason for the decision should be communicated to the person being excluded (subject to the normal considerations of patient confidentiality and any overriding security concerns). This should be reported as a risk incident and a copy of the reasons must be sent to the Mental Health Act Administrators.

3.380 The Mental Health Act Lead will report any restriction on visiting to the Mental Health Act Scrutiny Group.

Terminating or refusal of one off visiting

3.381 The nurse in charge of the ward or staff observing during visits may need to refuse a visit or terminate a visit at any stage due to clinical or security reasons. The person concerned and when appropriate the visitors should be given reasons for this and when practicable alternative visiting agreed. The RC must be informed of this event and if ongoing visiting is restricted the above processes followed.

Children visiting informal and detained patients

Background

3.382 For the purpose of this policy a child is considered as anyone under the age of 18.

3.383 Visiting arrangements for child patients in the hospital will be an essential part of the assessment of the suitability of the accommodation for that child. Where a child or young person is being detained, it should not be assumed simply because of their age that they would welcome all visitors, and like adults their views should be sought.

3.384 The Trust lead for children's safeguarding has been consulted about this policy and ensured it has been agreed by the local children's board. Any ward protocols in relation to it must be forwarded to this lead for agreement.

3.385 The Trust lead for safeguarding children has responsibility for agreeing this part of the Mental Health Act policy at each review.

3.386 Each member of staff on the ward must have completed mandatory safeguarding children training. It is the responsibility of the ward manager to ensure staff members on the ward are aware of the policy and its requirements.

3.387 All staff members should ensure that the best interests and safety of the children and young people concerned are paramount in decision making and that visits by or to children and young people are not allowed if they are not in their best interests. However, within that overarching framework, staff should do all they can to facilitate the maintenance of children's and young people's contact with friends and family and offer privacy within which that can happen.

3.388 In carrying out this policy staff members should swiftly ascertain the desirability of contact between children and patients, efficiently identify concerns and assess any risks of harm to the child. Where concerns are identified, regarding contact, this policy must be followed and every effort made to facilitate contact in a safe manner. Concerns could relate to

- the patient's history and family situation;
- the patient's current mental state (which may differ from an assessment made immediately prior to or after admission);
- the response by the child to the patient or his/her mental illness;
- the wishes and feelings of the child;
- the age and overall emotional needs of the child;
- consideration of child's best interests;
- the views of those with parental responsibility;
- the nature of the unit and the patient population as a whole.

3.389 Where there are child protection concerns regarding any child who is likely to visit then the Trust Child Protection Lead and the Local Authority children's services must be contacted.

Procedures

3.390 Information regarding children visiting will be displayed in a prominent position on the unit. The information will set out the procedure for children visiting on that ward.

3.391 Each ward will have a senior member or members of staff given the responsibility to authorise children visiting. This can be all staff members taking on a particular role; for example, nurse in charge of the ward.

3.392 For patients admitted following a Mental Health Act assessment, the AMHP will have completed a social circumstances report. This should, as far as was practicable for the AMHP, identify any dependent children and children that may visit, any concerns regarding children, any previous arrangements for visiting and contact and the views of those with parental responsibility or the child. Those members of staff making decisions about visiting should consult this report.

3.393 Visitors will be asked to contact the unit on each occasion, prior to children visiting. The matter will be referred to a person with the authority to authorise visiting, who will consult with other members of the multi-disciplinary hospital team, taking into account the initial assessment of the patient's needs for treatment and care and reflected in the formulation of the care plan, before taking a decision on whether a visit by a child is appropriate.

3.394 When a visit by a child is anticipated, the multi-disciplinary team should swiftly and simply identify any concerns about child visiting which may be present in a limited number of cases. This task can be delegated to any qualified member of staff on the ward. Where practicable there findings should be

brought to the next ward patient planning meeting for consideration. Where this is not practicable they should be reviewed at the next ward patient planning meeting.

3.395 When there is an unexpected visit by a child when no previous decision has been taken the nurse in charge of the ward is responsible for agreeing it. They are responsible for assessing the safety of the visit at that time and ensuring the safety of the child is paramount. The matter should then be referred to a person with responsibility to authorise a visit.

3.396 In the vast majority of cases where no concerns are identified, arrangements should be made to support the patient and child and to facilitate contact. If concerns are identified, a thorough risk assessment must be completed before any child visits.

Supervision of the child during visits

3.397 Children should be accompanied by a responsible adult at all times. The responsible adult will identify him or herself to the Nurse in Charge. The patient can only take on this role if a qualified member of staff has assessed them as safe to do so, any decision in this regard must be based on the needs and safety of the child. A member of staff cannot take on this role.

Additional Supervision of the Patient during visits

3.398 Decisions about the additional supervision of visits should be based on a risk assessment of the patient and their circumstances and be recorded on their file. The additional supervision of visits could include:

- Direct 1:1 staff presence in private. (Family rooms are available or quiet rooms on the unit, if the patient has no leave in terms of being formally detained under the Mental Health Act 1983).

- A planned visit at a specified time and place. Clinical staff would be informed to monitor progress of the visit at regular intervals.

- Supervision as arranged by other agencies such as Social Services.

3.399 Where a request is made to conduct the visit within the grounds of the Unit/Hospital the clinical team should actively consider the safety of the children and make arrangements for appropriate supervision ***at all times***.

3.400 Levels of supervision required during the visits of children should be clearly stated in the patients' Care Plan and reviewed in line with changing circumstances and risk assessment processes.

Communication

3.401 Information posters which clearly state the unit's individual protocol on the Children Visiting must be displayed on the ward and made available to patients and family members. This should also be available to all agencies and professionals including Social Services.

3.402 Patients and family members should also be made aware of this on admission through face to face communication with the patient and his/her family conducted by the trained nurse/key worker. Where necessary, interpreter services should be used.

Suspension of / Denial of visits

3.403 The Nurse in Charge of the unit can suspend/deny a visit ***at that time*** before or during a visit if:

- the Unit has become too disturbed and there are no alternative facilities for the visit to continue,
- the visitors/children are obviously distressed by the visit,
- there are other risk issues to the child or others and alternative arrangements cannot be made at that time.

3.404 Any decision to suspend/deny a visit must be fully explained to the patient and/or the responsible adult in charge of the children and where possible arrangements should be made for future visits. Any decision should be fully documented in the patient's notes. If requested, the patient and person responsible for the child should be given reasons in writing. The person responsible for agreeing visits should be informed and asked to review arrangements. The incident should be reported as a risk incident.

3.405 Where ever possible attempts must be made to resolve any concerns in order to facilitate safe visiting that is in the child's best interest. Decisions to refuse visits on an on-going basis will only be taken exceptionally. When this is done reasons must be given in writing as well as orally and will need to be supported by clear evidence of concerns. Reasons must include why it was felt that the provision of support and/or the supervision of visits were thought to be insufficient to alleviate these concerns. The incident must be reported as a risk incident. A copy of the reasons must be forwarded to the Trust Safeguarding children's Lead and the Mental Health Act Administrators.

3.406 The patient and person responsible for the child should be informed of the complaints procedure and how to access advocacy services, including the IMHA service. If a complaint is received an independent review of the decision must be arranged.

3.407 The Mental Health Act Lead will report any refusals to visit to the Mental Health Act Scrutiny committee.

3P Processes and guidance for obtaining warrants from the court

3.408 Solent NHS Trust staff may be required to obtain s135(2) warrants when a patient is absent without leave and access is being denied to a property in which it is believed they are.

3.409 This could occur either when a patient is absent without leave from the ward, failed to return from or had their s17 leave revoked or when a person has been recalled from CTO but failed to return.

3.410 Guidance on this process will be provided to the services and kept up to date by the Mental Health Act Lead. For clarification, when a patient is AWOL from the ward the shift leader is responsible for allocating the task. Further practical advice can be sought form the oncall AMHP, the AMHP manager or the Mental Health Act Lead.

3Q Age Appropriate Accommodation

3.411 The Mental Health Act places a statutory duty on Solent NHS Trust to provide age appropriate accommodation for people under 18 years of age who are admitted to hospital.

3.412 To ensure this duty is met guidance will be agreed and reviewed by the AMH, LD and CAHMS services. The relevant associate directors are responsible for ensuring this guidance remains under review. The guidance will include:

- ensuring whenever possible specialist CAMHS hospital units are used,
- defining exceptional circumstances when those aged 16-18 can be admitted to an adult or learning disability unit,
- identify time scales for assessments when a young person is admitted to an adult ward in a crisis,
- identify procedures for keeping the suitability of the placement under review,
- agreeing how specialist CAHMS workers will support the risk and needs assessment to ensure accommodation continues to be age appropriate. This will include consideration of whether the patient can mix with individuals of their own age, can receive visitors of all ages and has access to education. Hospital managers have a duty to consider whether a patient should be transferred to more appropriate accommodation and, if so, to arrange this as soon as possible, and
- identify how CAHMS specialists will support the RC, in situations in which it is not possible to allocate a specialist CAHMS AC to be RC.

3.413 The Mental Health Act Lead will report any admissions of under 18s, whose care Solent NHS Trust manage, to the Mental Health Act Scrutiny Committee. This will include both those admitted to Solent NHS Trust wards and wards managed by other organisations.

3R The Mental Capacity Act 2005, The Deprivation of Liberty Safeguards (DOLS) and the Mental Health Act 1983

3.416 The Link between the Mental Capacity Act 2005 , The Deprivation of Liberty Safeguards and the Mental Health Act 1983 can be complex and if unsure practitioners are advised to seek further guidance form the Mental Health Act Lead.

3.414 A person detained under the Mental Health Act 1983 may also receive treatment for unrelated physical disorders under the Mental Capacity Act 2005. Section 3J and appendix 3 give further guidance on identifying the appropriate statute under which a person is treated.

3.415 Furthermore, a detained patient may have or lack capacity with regard to wider issues in their life; for example, residence, finances, or personal relationships. There are no powers within the Mental Health Act 2005 to make decisions on a person's behalf in these areas. If there are concerns regarding a person's capacity to make decisions in relation to any of these matters, they need to make a decision in relation to them, and there are concerns they may lack capacity then a capacity assessment and, if they lack capacity at that time in relation to the issue to be decided, a best interest decision should be undertaken in line with the Deprivation of Liberty and Mental Capacity Act 2005 policy.

3.416 An inpatient who is deprived of their liberty has rights under Article 5 of the European Convention of Human Rights. One of those is that the deprivation of liberty is authorised under an appropriate statute and they are afforded the safeguards of that statute. The Deprivation of Liberty and Mental Capacity Act Safeguards policy sets out the process professionals must follow in identifying

the correct statute to use, the Mental Health Act or the Deprivation of Liberty Safeguards, and should be referred to for further information. In addition Chapter 13 of the Code of Practice gives details guidance about which Act applies in which situations.

4. ROLES & RESPONSIBILITIES

4.1 **Chief Executive:** The Chief Executive has overall responsibility for the strategic and operational management of the Trust including ensuring that there are processes in place for seeing that the requirements of the Mental health 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.

4.2 **Director of Nursing and Quality and Medical Director:** The Director of Nursing & Quality and Medical Director have joint delegated Executive responsibility for ensuring that appropriate standards for detention, treatment and care of patients under the Mental Health Act 1983 are followed.

4.3 **Chief Operating Officer and Clinical Associate Directors:** The Chief Operating Officer is responsible for ensuring that the clinical Associate Directors take clinical ownership of the policy and that all staff comply with this policy.

4.4 **Heads of Clinical Services:** The responsibilities of the Heads of Clinical Services are to:

- Manage this policy and its implementation ensuring that staff are fully conversant with the policy
- Ensure that adequate resources are in place to allow for the safe and effective care of patients under the Mental Health Act.
- Monitor the completion of audits associated with the monitoring of this policy's implementation
- Develop and maintain local operating procedures relating to discharge of duties under the Mental Health Act 1983.
- To support staff in any corrective action or interventions if an incident occurs.
- To ensure any staff with training needs in relation to this policy have these training needs met.

4.5 **All Staff involved in the care of patients under the Mental Health Act:**

- To be familiar with and act in accordance with the guiding principles of the Mental health Act Code of Practice.
- To know and carry out their duties in accordance with this policy.
- Report to line managers any deficits in relation to their knowledge, resources or processes in place to effect the proper care and treatment of patients in line with the Mental health Act or the occurrence of incidences that may have resulted from a deficit in any of these areas.

4.6 **The Mental Health Act Scrutiny Committee:** With the support of the Mental Health Act Lead and the Mental Health Act administrators, to oversee and scrutinise the administration of the Mental Health Act in Solent NHS Trust and report to the Board in line with its Terms of Reference.

4.7 **NHSLA & Operational Policy Steering Group:** The NHSLA & Operational Policy Steering Group is responsible for developing this policy and ensuring it represents best practice and current evidenced based information.

5. TRAINING

5.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis (TNA) on the intranet. All records of attendances and DNA's will be sent to L&D and recorded onto the Trust central database (Oracle Learning Management), all DNA's will be managed as per the DNA process within the Trust's Learning and Development Policy.

5.2 Training will be delivered by the Mental Health Act Lead. A day's training on the Mental Health Act is mandatory requirement for all inpatient staff working with detained patients. It must be repeated three yearly.

5.3 Lead Mental Health Act practitioners have been identified for each inpatient unit. They will receive extra support, either individually or as a group, from the Mental Health Act Lead. Their role will include overseeing the administration of the Act on the ward.

5.4 The Mental Health Act Lead is supported to undertake appropriate training in relation to Mental Health Act Law and receives support from the Trust solicitors as required.

6. EQUALITY & DIVERSITY AND MENTAL CAPACITY ACT

6.1 The Equality Impact assessment and Mental Capacity Act assessment identified that this policy is unlikely to lead to discrimination against any particular group and that it takes the situations of service users who lack capacity to make decisions into account. The impact study is in Appendix 6.

7. SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THE DOCUMENT

7.1 The policy will be initially reviewed after one year by the Mental Health Act Lead. A variety of audit tools will be used to enable the Mental Health Act Administration team undertake audits of inpatient wards and CTO patient files. The results of this will be considered alongside complaints, SIRIs and visit reports from the CQC (MHAC). The results will be shared with the operational service groups that work with detained patients and with the Mental Health Act Scrutiny Committee. All will be consulted during any review of the policy.

7.2 The Mental Health Act Scrutiny Committee will have a role in on-going monitoring of the policy as described above.

7.3 Non-compliance with this policy should be reported immediately to the service manager concerned and Mental Health Act Lead.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after twelve months and thereafter on a bi-annual basis.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

Links to other Solent NHS Trust Policies

Absence Without Leave Policy

Advance Decisions to Refuse Treatment policy

Adult Safeguarding policy

Children's Safeguarding Policy

Deprivation of Liberty and Mental Capacity Act policy

Missing Persons Policy

Medicines Management Policy

Observation of Psychiatric Patients Policy

Legislation

Children Act 1989

Domestic Violence, Crime and Victims Act 2004

Mental Health Act 1983

Mental Capacity Act 2005

USEFUL PUBLICATIONS

Department of Health 1983/2007 **Mental Health Act 1983** London TSO

Department of Health 2008 **Mental Health Act 1983 Code of Practice** London TSO

Department of Health 2008, **The Reference Guide to the Mental Health Act 1983** London TSO

Richard Jones **Mental Health Act Manual (13th Edition)** Sweet and Maxwell

Duties of Managers for the Review of Detention under the Provisions of the MHA 1983 NAHAT, ISBN 1-85947-039-4

Care Quality Commission reports and advice to practitioners
http://www.cqc.org.uk/

LAC (99)32: Mental Health Act 1983 code of practice : guidance on the visiting of psychiatric patients by children

Glossary of Abbreviations

Advance Decision to Refuse Treatment (ADRT):

Approved Clinician (AC):

Approved Mental Health Professional (AMHP):

Care Quality Commission (CQC)

Community Treatment Order (CTO)

Electro Convulsive Therapy (ECT)

Independent Mental Health Act Advocate (IMHA)

Lasting Power of Attorney (LPA)

Mental Capacity Act 2005 (MCA)

Nearest Relative (NR)

Responsible Clinician (RC)

10.Appendixes

Appendix	Title
1	Scheme of Delegation
2	Medical Treatment with special provisions flowchart
3	Medical Treatment under the Act flowchart
4	Guidance on completing T2 certificates
5	Guidance on the Administration of ECT
6	Covert Medication form
7	Equality Impact report

Appendix 1

Scheme of Delegation

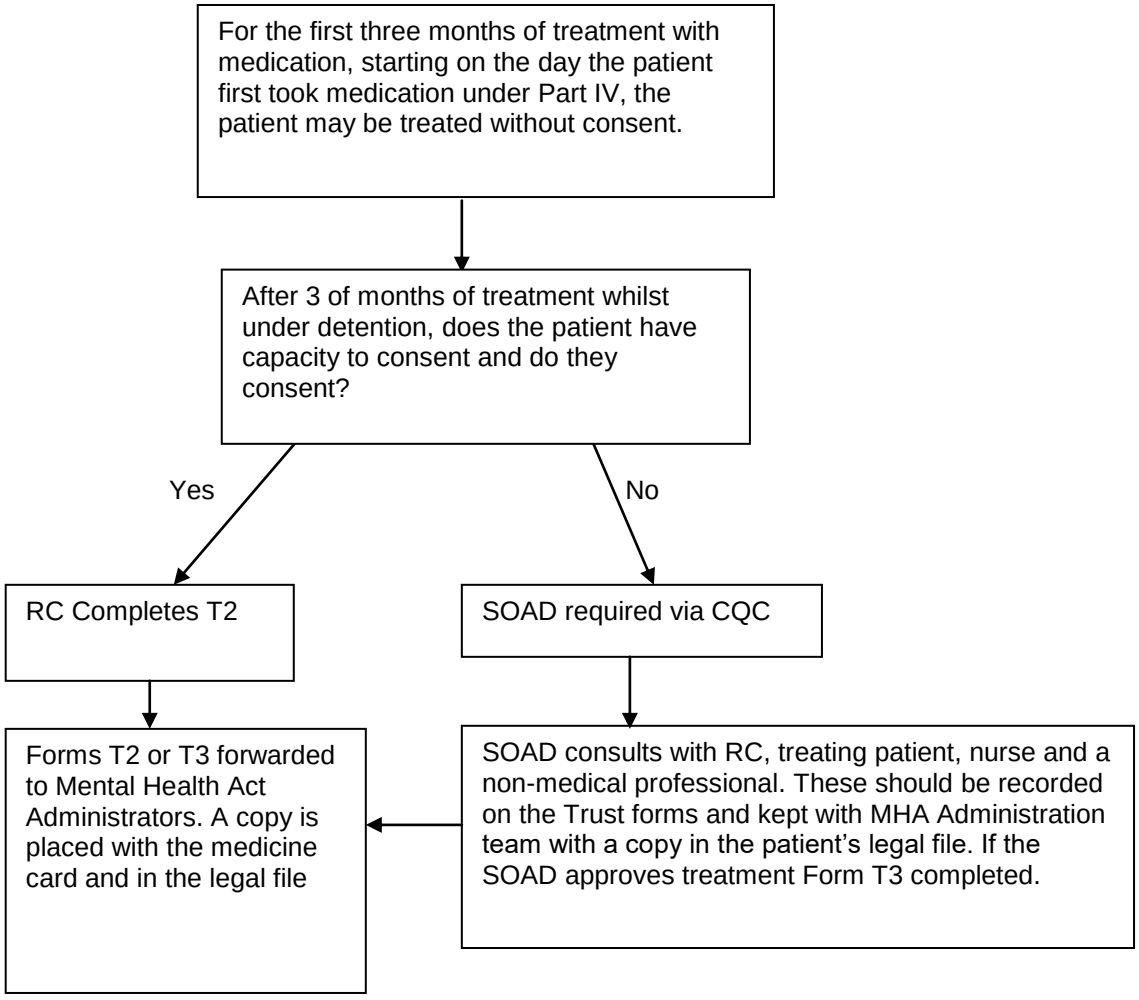
Duty	Delegated to	Monitoring
Provision of information to detained patients and their nearest relative	Scheme of delegation set out in 3.7 of the main policy.	Monitored by ward managers. Audited by the Mental Health Act Administration team. Reported to the Mental Health Act Scrutiny Committee.
Receive a request to withhold outgoing post	RC	Any instances where his power has been used will be reported to the Mental Health Act Scrutiny Committee by the Mental Health Act Lead.
Receipt and Scrutiny of detention papers	Received by senior nurses on the ward. Scrutinised by Mental Health Act Administrators.	Audited by Mental Health Act Administrators. Ward audits and errors in detention paperwork reported to the Mental Health Act Scrutiny Committee.
Transfer of Detained patients	Transfer to another hospital: all responsible clinicians, ward managers, senior nurses on the ward and duty managers. Transfer into Guardianship: RC only.	Any such transfers of detained patients will be reported to the Mental Health Act Scrutiny Committee.
Solent NHS Trust's power of discharge under s23	Managers Panel Hearings: 3 member panel. The panel members can be either Non-Executive Directors, Associate Hospital Managers or a mix of the two. Appointments to be by the Nominations & Governance committee and be for 3 years.	Training, recommendation for appointment and review to be carried out by the Mental Health Act Lead and reported to the Mental Health Act Scrutiny Committee.
Authorised to receive Nearest Relatives notice of discharge	Mental Health Act Administrators or the nurse in overall charge of the ward at the time.	Mental Health Act Administrators to keep a record of any instance of the Nearest Relative using their power of discharge. the Mental Health Act Lead to report this to the Mental Health Act Scrutiny Committee.
Register of Approved Clinicians and ensuring they are in overall charge of treatment when the Act requires it	Mental Health Act Administrators	No monitoring required as all detained patients have an AC in overall charge of all their treatment as a matter of course.
Alert RC at least 4 weeks before the 'three month' treatment period for detained patients lapses	Mental Health Act Administrators	Wards are responsible for establishing systems to monitor regularly compliance with the treatment provisions of the Act. The Mental Health Act Administrators undertake an audit of a different ward each

		month. This audit is reported to the Mental Health Act Scrutiny Committee.
Alert RC to the need to submit a s61 report to the CQC	Mental Health Act Administrators	Wards are responsible for establishing systems to monitor regularly compliance with the treatment provisions of the Act. The Mental Health Act Administrators undertake an audit of a different ward each month. This audit is reported to the Mental Health Act Scrutiny Committee.
Referring patient's cases to the Tribunal Office	Mental Health Act Administrators	Six monthly audit by the Mental Health Act Administrators reported to the Mental Health Act Scrutiny Committee.
Reporting the death of detained patients and certain instances of AWOL to the CQC	Mental Health Act Administrators	The Mental Health Act Lead will report these to the Mental Health Act Scrutiny Committee.
Inform the RC, at least three weeks in advance, of the need to seek a Part IVA certificate (CTO11) from the Care Quality Commission	Mental Health Act Administrators	Community Teams will establish systems to ensure patients who are under CTO are treated only as the Act allows. The Audit of CTO files will form a part of the ward audits undertaken by the Mental Health Act Administration team. This will be reported to the Mental Health Act Scrutiny Committee.
To liaise with the patient and the SOAD to ensure, as much as is possible, CTO patients are seen by the SOAD for the purpose of completing a CTO11	Mental Health Act Administrator: liaise with the Care Coordinator and SOAD. Care Coordinator: informing and reminding the patient of the time, date and place of the SOAD visit and if necessary, taking appropriate steps to support them to attend.	As above
Monitoring use of s64(G) : urgent treatment powers of patients in the community and subject to CTO	Mental Health Act Administrators	Any use of these powers will be reported, by the Mental Health Act Lead to the Mental Health Act Scrutiny Committee.
Authorising the taking into custody and return of a recalled CTO patient	The RC, the staff nurse in charge of the ward, any member of the community mental Health Team and any member of the Crisis Resolution and Home Treatment Team	Ward audits
Monitoring the period of time an CTO patient is a recalled	Mental Health Act Administrators	The Mental Health Act Lead will report these to the Mental

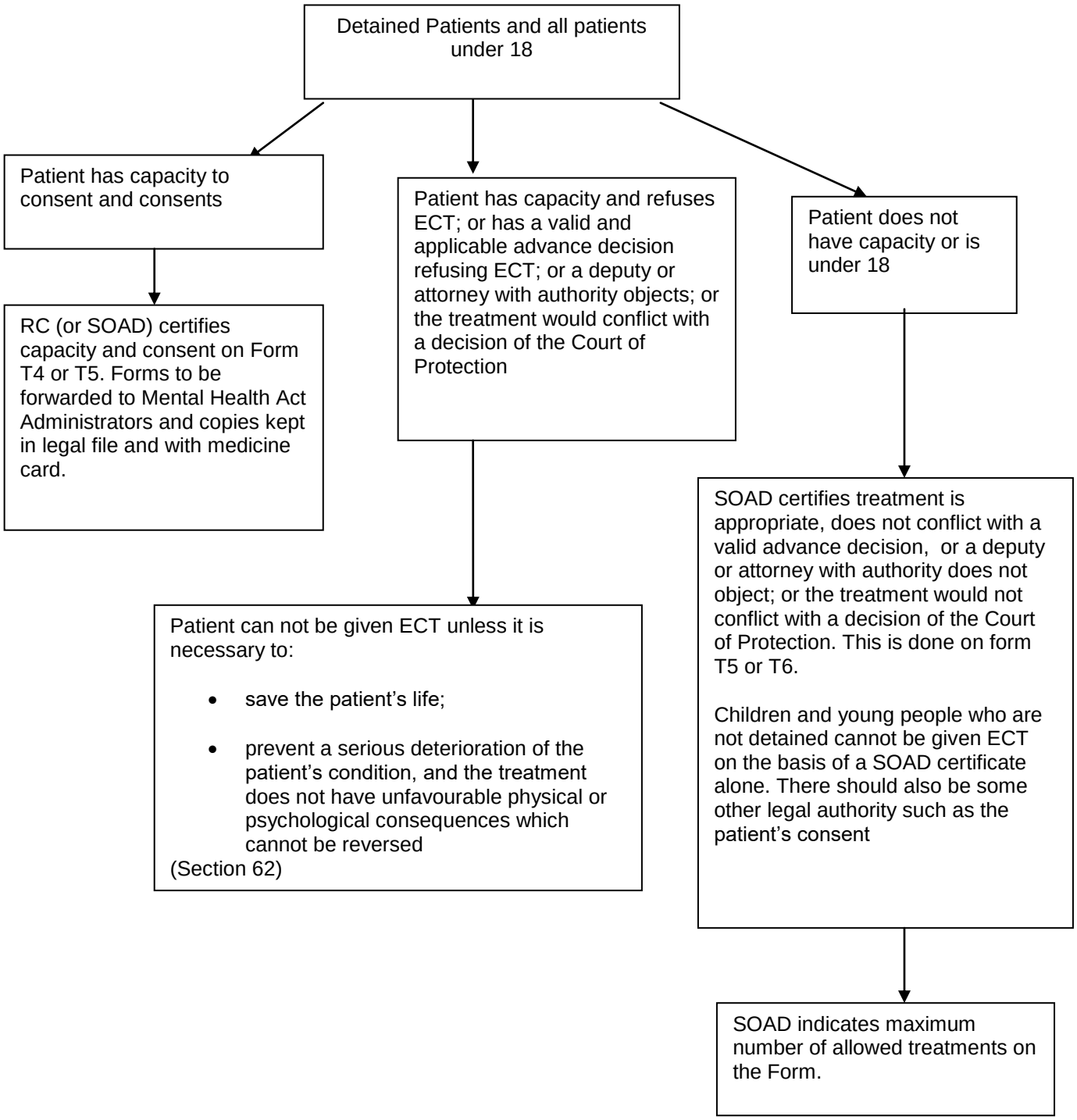
patient for		Health Act Scrutiny Committee.
Transferring recalled patients to a hospital with different managers	The patient's RC, the nurse in charge of the ward, the ward manager or their deputy	Any such transfers of detained patients will be reported to the Mental Health Act Scrutiny Committee.
Transferring the responsible hospital to a hospital with different managers	The patient's RC, the nurse in charge of the ward, the ward manager or their deputy	Any such transfers of detained patients will be reported to the Mental Health Act Scrutiny Committee.
Identify victims with rights under the Domestic Violence, Crime and Victims Act 2004: duties of Solent NHS Trust towards certain victims of crime.	Mental Health Act Administrators	Any duties undertaken under this section will be reported to the Mental Health Act Scrutiny Committee by the Mental Health Act Lead.
Sharing information with vicitims under the Domestic Violence, Crime and Victims Act 2004.	Mental Health Act Administrators	Any duties undertaken under this section will be reported to the Mental Health Act Scrutiny Committee by the Mental Health Act Lead.
Considering representation of victims in line with the Domestic Violence, Crime and Victims Act 2004.	RC	Any duties undertaken under this section will be reported to the Mental Health Act Scrutiny Committee by the Mental Health Act Lead.
Restricting adult visitors to the ward.	RC, ward manager or their deputy	Any powers used under this section will be reported to the Mental Health Act Scrutiny Committee by the Mental Health Act Lead.
Restricting children visiting the ward.	Senior member or members of staff on each ward nominated to authorise children visiting.	Any powers used under this section will be reported to the Mental Health Act Scrutiny Committee by the Mental Health Act Lead.
Reviewing arrangements to ensure Age Appropriate Accommodation.	Associate Directors for AMH, LD and CAMHS	The Mental Health Act Lead will report any admissions of under 18s, whose care Solent NHS Trust manage, to the Mental Health Act Scrutiny Committee.
Other tasks as detailed in the policies in appendix 1	Detailed in the appropriate policy	Detailed in the appropriate policy.

Appendix 2: Medical Treatments with Special Provisions Flowcharts

Section 58
Treatment Requiring the Consent of the Patient or a Second Opinion



Section 58A
Electro-Convulsive Therapy and Medication Administered as Part of ECT



Section 59
Plan of Treatment

Any certificate of consent to treatment obtained for the purpose of Section 57 or 58 can relate to a plan of treatment which can involve one or more of the treatments specified under the same section and can include a time scale for the appointed CQC doctor who will consider the whole plan and accept or reject it as a whole.

An outline of the plan will appear on the certificate and should be described in detail on the patient's medical notes.

Section 60
Withdrawal of Consent

The MHA Administration team must be informed of any withdrawal of consent to ensure the requirements of law are followed. If a patient withdraws his previously given consent to treatment:

1 For any treatment given under Section 57 – **treatment must not be given.**
2 For any part of a plan of treatment authorised under Section 58 – **the treatment must cease** (unless any of the criteria for urgent treatment are met – see Section 62).
3 For any treatment under Section 58 (including plan of treatment which includes treatment under Section 58) **the CQC must be contacted by the RC and until their doctor comes the RC must not administer treatment.** (unless any of the criteria for urgent treatment are met – see Section 62)

Change of Treatment
If the RC wishes to change the drug treatment to a treatment that is not already authorised by a SOAD certificate, or one the patient has not consented to; then the following **must** occur:

If a patient has previously consented the patient's consent must be sought again (Form T2).

If the patient does not consent the CQC must be called.

If the CQC doctor was called because the patient refused to consent or did not have capacity to give consent then the SOAD procedure should be followed including Form T3.

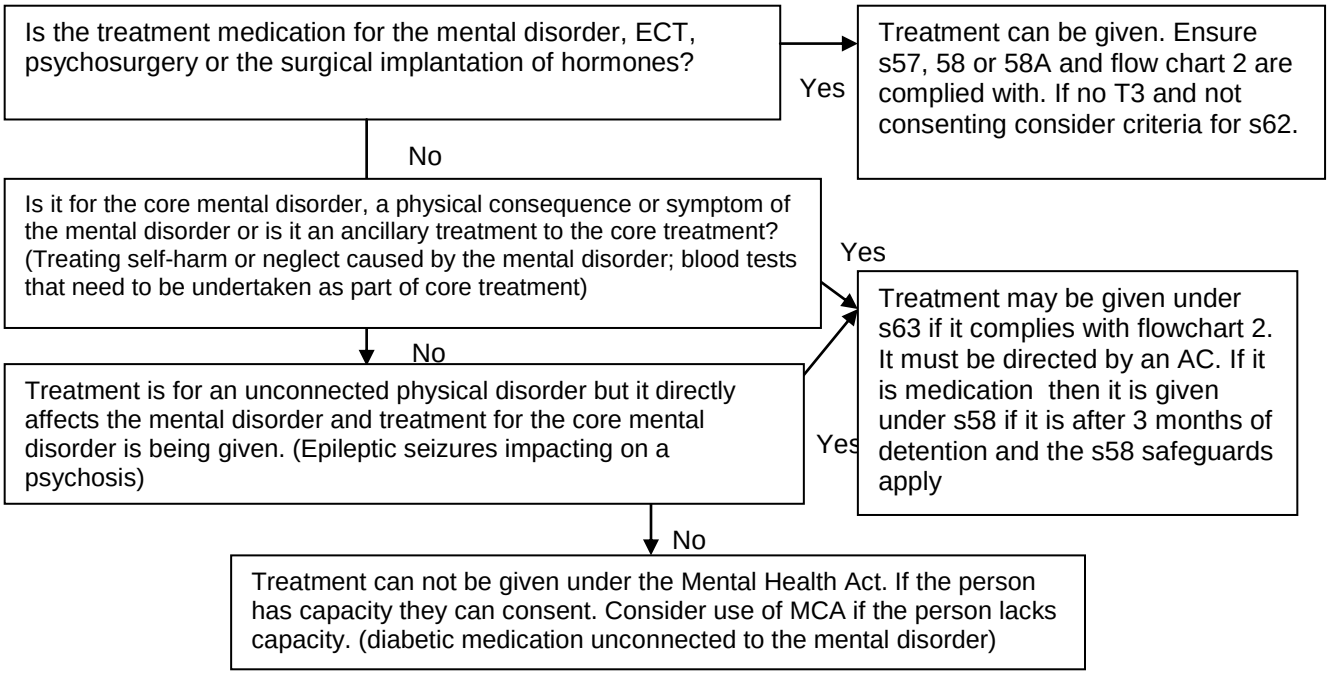
Section 63
Treatment Not Requiring Consent

Provided a treatment does not fall within the provisions of Section 57, Section 58, or Section 58A and it is given under the direction of the RC, for a mental disorder, the consent of the patient is not required.

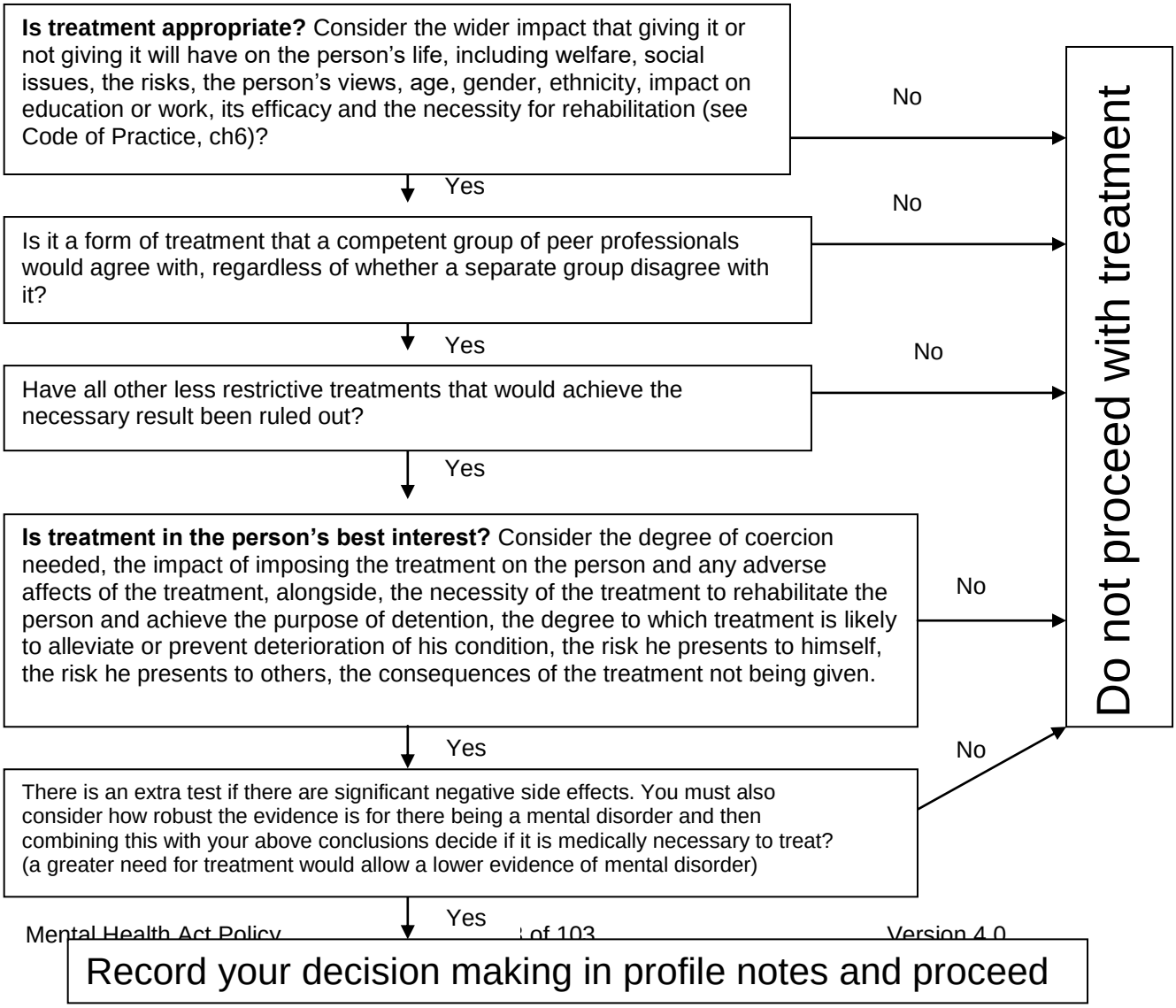
Appendix 3: Treatment under The Act flowchart and guidance

Treatment under the Mental Health Act 1983 Key points

Flow chart 1: Questions to ask about the type of treatment and if it can be given



Flow Chart 2: Further Tests from Case Law and the Code of Practice



Treatment under the Mental Health Act

When Treatment is administered under Part IV of the Mental Health Act 1983 it must meet three tests:

1) Mental Health Act. For a patient detained under a treatment section, overall the treatment should be appropriate. For all patients each treatment needs to be for the purpose of alleviating or preventing a worsening of the disorder, or one or more of its symptoms or manifestations. (s145(1)) . Whether treatment is appropriate will depend on considering the wider impact that giving it or not giving it will have on the person's life, including welfare and social issues, and the risks.

    a. The following types of treatment can be given under the Act:
        i. A range of acts ancillary to the core treatment, treatment for symptoms of the mental disorder and physical consequences of the mental disorder (this includes self-harm, neglect etc).
        ii. However, treatment for an unconnected physical disorder could only come within the definition if it directly affected the mental disorder[1].
        iii. Furthermore, where there is 'no proposed treatment for the core mental disorder it will not be lawful to detain a patient to treat the physical consequences of his disorder'
        iv. If the treatment is not medication, ECT, psychosurgery or the surgical implantation of hormones then the treatment comes under s63 and must be directed by an approved clinician (AC).

2) Case law has determined that for treatment under the MHA, when there is no consent, it must be in the person's best interest. However, the test is different than the one defined in the Mental Capacity Act. In terms of the Mental Health Act this includes both those who lack capacity and those who have capacity and are refusing. The courts have held that the level of coercion needed to administer the treatment is more significant than whether the person has capacity. The High Court stated that there are two parts to this test. Firstly, is it a form of treatment that a competent Committee of peer professionals would agree with, regardless of whether a separate group disagree with it. Then it should be decided if it is the best treatment. In order to decide this it needs to be asked, if there is any other less restrictive treatment that could achieve the same benefit and, then consider the following in the context of why the person is detained and their need for treatment/ rehabilitation:

    > (a) his resistance to treatment, (b) the degree to which treatment is likely to alleviate or prevent deterioration of his condition, (c) the risk he presents to himself, (d) the risk he presents to others, (e) the consequences of the treatment not being given and (f) any possible adverse effects of the treatment.[2]

    When Considering the issues the Court of Appeal stated the following should be considered:

[1] *GJ v Foundation Trust* [2009] EWHC 2972 (Fam) para 52. The summary above is taken from paragraphs 49 to 57. Charles J also considers *C. (Adult: Refusal of Treatment)* [1994] 1 W.L.R. 290 in his analysis, as it was used in Croydon as an example of physical treatment being entirely unconnected with the mental disorder.

[2] ***R. (on the application of PS) v G (Responsible Medical Officer)***[2003] EWHC 2335 (Admin) paragraph 143

whether there is a less intrusive treatment that would achieve the same result, the distress caused to the patient if the treatment was imposed and the significance of the purpose for which the person is detained[3]

3) The Human Rights Act.
    a. For Article 8 (Right to private and family life) the treatment must be in line with the Mental Health Act, proportionate and necessary for the person's health or risks to them or others.
    b. Article 3 (prohibition of torture) will need to be considered if the effect of giving it on the patient has significant negative side effects. If it does, it will need to be medically necessary; this involves two parts:
        i. considering the evidence for the mental disorder
        ii. considering the necessity of the treatment. (this will involve asking questions similar to the best interest test, above.)

Over all the medical necessity must be convincingly shown. This does not mean that the evidence for each question, on its own, needs to meet this threshold. However, considered together the evidence must meet this threshold.

Completed by Richard Murphy, Mental Health Act Lead
Date: 05/08/2011

[3] *R. (on the application of B) v Dr SS, Dr G and the Secretary of State for the Department of Health* [2006] EWCA Civ 28; [2006] M.H.L.R. 131 The judgement gave considerable weight to the purpose of detention under the Act in determining best interest. This is discussed below.

Guidance on Completing and Interpreting Treatment plans for T2 and T3 Forms

This guidance sets out the standards that Solent NHS Trust Employees will be expected to comply with in regard to completing and interpreting T2 and T3 forms. Regarding T3, these are completed by CQC instructed doctors who may not follow this guidance. Where there is ambiguity in the meaning of a T3 then clarification should be sought from the CQC.

The Consent to Treatment Summary Form or a typed T2 certificate must be completed and attached to the medication chart, along with a copy of the T2 or T3, so as to ensure all information is clear and simple to read. If a doctor does not complete this then one must be asked to sign to state it matches the T2 or T3.

Unlicensed use of Medication:

If medication is to be administered for a different purpose than that for which it has a licence, then the Form T2 should indicate the medication by generic name, specific dosage and the purpose for which it is to be administered. Alternatively, if it is listed in the BNF for a different use than that intended, it could be indicated on Form T2 by BNF category and limits with a comment summarising the purpose for which it is to be administered (for example, “One oral 4.81.1 anti-epileptic drug used as a mood stabilizer, within BNF limits”).

Medication that could be used for mental disorder or physical health:

If a medication is being used to treat a physical disorder but it could also be used to treat a mental disorder it should be clearly stated on the prescription card for which purpose it is prescribed (for example amitriptyline used for neuropathic pain). This is to ensure that when interpreting T2 and T3 forms it is not mistakenly identified as treatment for a mental disorder.

Prescribing of high dose medication:

- Solent NHS Trust supports the implementation of, Consensus statement on high-dose antipsychotic medication, Royal College of Psychiatrists (Approved by Council: October 2005, Council Report CR138). **See Annex A**
- In order to ensure compliance with this Solent NHS Trust has taken the view that if:

  A) one antipsychotic is prescribed above BNF max or

  B) more than one anti-psychotic is prescribed as regular medication with combined percentage above BNF max (as worked out in line with the above Royal College’s guidance)

  The agreed limit above BNF max dose for either single drug or combined must be stated on the T2 (for example single or combined antipsychotic doses including PRN not to exceed 150% of BNF max)
- Patients prescribed antipsychotics above the BNF max dose limits must be made aware of the agreed limit above BNF max.
- The rational for the prescribing regime must be documented and safeguards put in place for monitoring.
- All staff are expected to comply with this guidance.

Annex A

Recommendations of the RCPsych consensus statement on high-dose antipsychotic medication

(recommendations that may be of particular interest to Mental Health Act Commissioners are in bold type)

1. **The Consensus Working Group recommends the following definition for high dose:**
   - **a total daily dose of a single antipsychotic which exceeds the upper limit stated in the *British National Formulary* (*BNF*; published by the British Medical Association & Royal Pharmaceutical Society of Great Britain); or**
   - **a total daily dose of two or more antipsychotics which exceeds the *BNF* maximum using the percentage method**.

2. **Current evidence does not justify the routine use of high-dose antipsychotic medication in general adult mental health services, either with a single agent or combined antipsychotics**.

3. **If high doses are to be used in an individual case, this should only be after evidence-based strategies have failed, and as a carefully monitored therapeutic trial**.

4. **The decision to prescribe high dose (of either an individual agent or through combination) should be taken explicitly and should involve an individual risk–benefit assessment by a fully trained psychiatrist. This should be undertaken in consultation with the wider clinical team and the patient and a patient advocate, if available, and if the patient wishes their presence**.

5. Supplementary prescribers should not make the decision to proceed to the use of high dose.

6. **The decision to prescribe high dose should be documented in the case notes, including the risks and benefits of the strategy, the aims, and when and how the outcome will be assessed**.

7. Dose escalation should be in relatively small increments and allow adequate time for response, and this includes prescribing once the high-dose threshold has been passed.

8. **Careful watch should be kept on the dosage in terms of total percentage arising from drug combinations, and the use of PRN (as required) medication. Local systems should be developed to alert the responsible psychiatrist/clinical team to patients currently being administered or at risk of receiving high doses**.

9. The use of PRN medication should be kept under regular review, with training of the clinical team and psychiatric trainees in the use of PRN and alternative ways of dealing with acute patient agitation. Staff administering PRN should be aware of its potential to raise the total daily dose of antipsychotic above the high-dose threshold.

10. The possible contraindications to high dose, for the drug(s) in the patient concerned should be considered before prescribing a high dose.

11. Consider possible drug interactions when prescribing high-dose antipsychotic medication.

12. **Before prescribing high-dose antipsychotics carry out an ECG to establish a baseline, and exclude cardiac contraindications, including long QT syndromes. An**

ECG should be repeated after a few days and then every 1–3 months in the early stages of high-dose treatment. The ECG should be repeated as clinically indicated.

13. Services should be structured, managed and resourced to preclude or minimise the perceived need for high dose (see chapters on Responsibilities for prescribing, administering and dispensing and Service implications).

14. **Each service should establish the audit of antipsychotic doses as a matter of routine practice**.

Aggression with psychosis and rapid tranquillisation

15. Therapeutic strategies, such as de-escalation techniques and rapid tranquillisation using benzodiazepines and/or antipsychotic drugs within recommended dosage range, are recommended (see National Collaborating Centre for Nursing and Supportive Care, 2005 and Royal College of Psychiatrists College Research Unit, 1998).

16. In cases of acute violence and emergency tranquillisation the dose of antipsychotic used may be minimised by:
    - constantly reviewing the use of alternative/adjunctive strategies (de-escalation and aggression management techniques, benzodiazepines)
    - providing (or transferring the patient to) a suitable environment, with adequate numbers of appropriately skilled staff
    - allowing sufficient time for clinical response between dosage increments.

17. **If high-dose antipsychotic treatment has been used, it is particularly important that the routine monitoring of a sedated patient is carried out, with particular attention to regular checks of pulse, blood pressure, respiration, temperature and hydration. ECGs should be carried out frequently during dose escalation, if and when possible**.

18. During acute violence or emergency tranquillisation avoid parenteral antipsychotics if possible, but if used, ECG monitoring or regular ECGs should be performed.

Treatment-resistant psychosis

19. A fully trained psychiatrist should carefully and regularly assess patients whose illnesses have proved unresponsive to conventional doses of antipsychotics (for example, treatment-resistant schizophrenia).

20. The possible contribution to poor response of non-adherence to prescribed medication should be considered, including consideration of plasma drug assay.

21. **Local protocols, based on national guidelines, should be developed for the clinical management of cases of treatment resistance and of imminent violence and aggression**.

22. **Before resorting to a high dose of antipsychotic medication, evidence-based strategies for treatment resistance should be exhausted, including use of clozapine**.

23. The use of high dose should be treated as a limited therapeutic trial in treatment-resistant schizophrenia, and the dose reduced back to conventional levels after a 3-month period unless the clinical benefits outweigh the risks.

STOP

Annex B

Consent to Treatment Summary Form

(Certificate of consent to treatment T2 or Certificate of second opinion T3)

ONLY MEDICATION AUTHORISED ON THIS FORM CAN BE PRESCRIBED OR ADMINISTERED. THIS INCLUDES PRN. THE ONLY EXCEPTION IS IF A AN RC AUTHORISES TREATMENT UNDER s62.

Patient Details

Name:

Date of Birth:

Mental Health Act Section:

The patient above is authorised to receive only the medication listed below

(This list must include all when required (PRN) medication)

Number Of Meds	Medication (Please state if Clozapine excluded or included)	Route of admin	Regular or PRN	BNF Category & Drug number	Within BNF Limits Yes or No

If accumulative antipsychotic dose above 100%. Please state agreed % above BNF max	**……%**

Certificate of Authorisation Attached (Please mark X)

Approved Clinician: Dr……

Certificate of consent to treatment - T2 …… ☐

Certificate of second opinion - T3…… ☐

Checked Against Original Certificate of Authorisation By:

Print Name……Sign……..Date:…….

Raymond Gray, Principal Pharmacist Mental Health, Solent NHS Trust. June 2011

Guidance on use of ECT in relation to the MCA and the MHA

Legal status of patient	Capacity to consent to ECT	Consents to ECT	Action by ECT department
Informal inpatient	Yes	Yes	Give ECT with consent
Informal inpatient	Yes	No	Do not give ECT
Informal inpatient	No	Positive about treatment or not objecting	ECT may be given in Best Interests under MCA if:- - a Best Interests meeting should be held if practicable within the time frame. Clear documentation would be needed to establish they lack capacity and that it is in their best interest, including a clear statement why it is less restrictive and better option for patient than use of MHA. The starting point should be their wishes and views and their carers views should also be considered. Furthermore, if they are unbefriended consideration should be given to a referral for an IMCA. At this meeting the use of ECT, their attitude to it, the impact of it on them, the fact they are in an institution and the impact it has on them should be considered as they are all significant factors pointing towards a deprivation of liberty. - each case would need to be considered on the wider facts including the contact they have with the outside world, the contact they have with family, any activities they engage in, and anything that could be considered an objection to the treatment plan. - if it is concluded there is no deprivation of liberty and a patient is to be given ECT under s5 of the MCA then a second doctor, who is an AC in the Trust, should be asked, if practicable within the time frame, to give a second opinion on: 1) their capacity, 2) if ECT is medically necessary (art 3) and in their best interest (art 8), 3) if an IMCA has not been involved is one needed, and 4) if, considered in the context of their wider care, are they are deprived of their

			liberty and therefore if the MHA applies.
Informal inpatient	No	Actively refusing,; advance decision refusing; deputy/attorney refusing	If a person who lacks capacity in anyway objects to ECT this would be a very strong pointer towards a deprivation of liberty occurring (it is difficult to think of cases where it would not be a deprivation of liberty) and therefore an assessment under the MHA would be needed (not the Deprivation of Liberty Safeguards).
Sections 2 or 3	Yes	Yes	Give ECT if form T4 in place
Sections 2 or 3	Yes	No	ECT cannot be given unless it is an emergency (s 62)
Sections 2 or 3	No	No advance decision, and no deputy or attorney refusing	Give ECT if form T6 in place
Sections 2 or 3	No	Advance decision refusing; deputy/attorney refusing	ECT can only be given if it is an emergency (s 62).
CTO	Yes	Yes	Give ECT but CTO11 needs to be in place within a month
CTO	Yes	No	Cannot give ECT.
CTO	No	No advance decision, and no deputy/attorney refusing	ECT can be given but only if the person is not objecting or is objecting but force does not need to be used to give the ECT. A CTO11 needs to be in place within a month or in an emergency (s 64G).
CTO	No	Advance decision, or deputy/attorney refusing	ECT may only be given in an emergency (s 64G).
Informal community patient	Yes	Yes	Give ECT with consent

Informal community patient	Yes	No	Do not give ECT
Informal community patient	No	Positive about treatment or not objecting	ECT may be given in Best Interests under MCA if:- - a Best Interests meeting should be held if practicable within the time frame. Clear documentation would be needed to establish they lack capacity and that it is in their best interest, including a clear statement why it is less restrictive and better option for patient than use of MHA. The starting point should be their wishes and views and their carers views should also be considered. Furthermore, if they are unbefriended consideration should be given to a referral for an IMCA. - each case would need to be considered on the wider facts including the contact they have with the outside world, the contact they have with family, any activities they engage in, and anything that could be considered an objection to the treatment plan. - if the plan is to give ECT under s5 of the MCA then a second doctor, who is an AC in the Trust, should be asked to give a second opinion on: 1) their capacity, 2) if ECT is medically necessary (art 3) and in their best interest (art 8), 3) if an IMCA has not been involved is one needed, and 4) if in agreement with the best interest assessment and stated reasons why this is less restrictive and a better option for the person than detention under the MHA.
Informal community patient	No	Actively refusing; advance decision; deputy/attorney refusing	- Use of MHA and admission would need to be considered. - Patients for whom this situation may occur should be encouraged to make an advance statement of wishes or an advance decision to refuse treatment, at a time when they have capacity.

Additional notes:

1) Emergencies for patients detained under s2 or s3:
Where ECT is **immediately necessary** to either save the patient's life or prevent serious deterioration in their condition ECT may be given even if the patient has capacity and refuses, has made an advance decision, or their deputy or attorney has refused consent.

2) Maintenance ECT:
The above principles apply to both acute treatment with ECT and maintenance ECT. However, we would recommend that any patient, who lacks capacity, for whom maintenance ECT is planned, should have a second opinion from another AC within the Trust if not subject to a SOAD via the MHA.

3) Outpatients who lack capacity:
If a person is not objecting or positive about ECT and has no advance decision to refuse it is hard to argue that they would need to be detained to receive ECT for the following reasons:

- if detained they would need to receive care in an institution with all its restrictions rather than being at home and only attending hospital for their treatment, and
- they would be being denied a treatment that would be available to informal inpatients who lack capacity.

4) CTO in patients who lack capacity:
In terms of the use of CTO, in order to meet the criteria it would have to be shown that the power of recall was necessary. If a person is not objecting in any way and may even be positive about treatment it should be asked if this can really be shown? Furthermore, in order to go on a CTO a person would first need to be detained on a s3. The use of CTO to give ECT to a person who lacks capacity when there is no other need for the CTO would place this group of patients under a restrictive statutory framework that others in the same situation are not placed under: those not on a s3 receiving ECT. At the same time it is difficult to see how, in the absence of other reasons, it could be justified to use a s3 to put a person on CTO, so ECT could be given in the community. Legal advise could always be sought.

Covert medication under The Mental Health Act 1983

Solent NHS Trust

RC Responsible for decision: Name and role of others consulted:
Medication to be given covertly SOAD DATE:
Patients level of understanding that they would be receiving medication and its purpose
What are the risks of giving the medication non-covertly both in terms of risks associated with administering it and likelihood of the person not receiving treatment.
What is the risk to the patient or others if they don't receive treatment and the benefits if they do.
Considering this why is covert administration of medication a proportionate response?
Arrangements for review (at least 1 month, 3 months, six months, and then yearly)
If the case goes to a tribunal then it may be ruled that it is necessary for the medication to be disclosed in the interests of justice. Considering this why is it still justified?

Appendix 7: Equality Impact Report

It is essential that the relevant groups of stakeholders are consulted in the development of policies and that the impact assessment is carried out as part of the document development with stakeholders. Every time a document is reviewed it is essential that the Impact Assessment is also reviewed.

Document Managers will be asked to discuss the Impact Assessment at the Document Steering Group meeting.

Step 1 – Scoping; identify the policies aims	**Answer**
1. What are the main aims and objectives of the document?	To ensure that Solent NHS Trust are able to discharge their duties as set out in the Mental Health Act 1983 and its code of practice.
2. Who will be affected by it?	Detained patients, informal patients under 18 and visitors to the ward
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	The Mental health Act Scrutiny Committee over sees the administration of the Mental Health Act and reports to the Board. The Committee receives audits and statistical reporting form the Mental Health Act Lead, and the services. This policy sets out the key monitoring and reporting of the Act and how this will occur. The Code of Practice sets out a number of policies that organisations that manage detained patients should have in place. This policy sets out how these requirements are met.
4. What information do you already have on the equality impact of this document?	Nationally those from minority ethnic groups are disproportionately detained under the Mental Health Act. Local data is difficult to identify but the data that can be identified indicates a similar pattern. This policy will establish transparency and accountability in discharge of the Mental health Act and therefore be a safeguard against discrimination.
5. Are there demographic changes or trends locally to be considered?	As in 4
6. What other information do you need?	none

Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully against any group?		x	The document ensures an objective standard is used in decision making that underpins decisions made under the Mental Health Act.
2. Can any group benefit or be excluded?		x	All groups should have respect shown for their specific needs. This is a guiding principle of the policy.
3. Can any group be denied fair & equal access to or treatment as a result of this document?		x	As above
4. Can this actively promote good relations with and	x		Respect for diverse needs and

between different groups?			participation are guiding principles of the policy.
5. Have you carried out any consultation internally/externally with relevant individual groups?	x		All relevant staff have been consulted
6. Have you used a variety of different methods of consultation/involvement	x		A number of different groups have been contacted.
Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	x		MCA taken into account in the policy.

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	Low
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	**Ensure policy is followed in decision making**
3. Are there likely to be different outcomes with any modifications? Explain these?	

Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	**A number of audits, risk events, complaints and statistical information will be reported to the Mental Health Act Scrutiny Committee that will monitor the discharge of the Act.**
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	MHA Administration team. This will be reported to the MHA scrutiny committee.

Step 5 - Publishing the Results	**Answer**
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	Be kept with the policy

****Retain a copy and also include as an appendix to the document****