MENTAL HEALTH ACT SECTION 5(2)

DOCTORS’ (AND OTHER APPROVED CLINICIANS’)

HOLDING POWER POLICY

<table>
<thead>
<tr>
<th>Version:</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Mental Health Legal Strategies Lead</td>
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</tbody>
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MHA Section 5(2) Drs Holding Powers Policy

V4

- 2 -

December 2013
<table>
<thead>
<tr>
<th>Section</th>
<th>Summary of Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doc</td>
<td>Document Control</td>
<td>2</td>
</tr>
<tr>
<td>Cont</td>
<td>Contents</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Purpose and Scope</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Duties and Responsibilities</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Explanations of Terms Used</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Using the Power in the Trust</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Using the Power in a General Hospital</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Obtaining a Mental Health Act Assessment</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>Transferring Patients Between Hospitals</td>
<td>7</td>
</tr>
<tr>
<td>9</td>
<td>Treatment</td>
<td>7</td>
</tr>
<tr>
<td>10</td>
<td>Training Requirements</td>
<td>8</td>
</tr>
<tr>
<td>11</td>
<td>Equality Impact Assessment</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>Monitoring Compliance and Effectiveness</td>
<td>8</td>
</tr>
<tr>
<td>13</td>
<td>Counter Fraud</td>
<td>9</td>
</tr>
<tr>
<td>14</td>
<td>Relevant Care Quality Commission (CQC) Registration Standards</td>
<td>9</td>
</tr>
<tr>
<td>15</td>
<td>References, Acknowledgements and Associated Documents</td>
<td>10</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

1.1 This power can only be used to detain patients who have already been informally admitted to a hospital, or have become informal while on the ward. It can be used whether or not the patient has capacity to consent to their admission to hospital, but cannot be used with outpatients, with those attending the hospital in other capacities, e.g. as visitors, or with patients who are already liable to be detained under the Mental Health Act 1983 or subject of a Supervised Community Treatment Order.

1.2 The power to detain lasts a maximum of 72 hours and is not renewable although its use can be considered again once the patient has reverted to informal status. It can only be used when the doctor or approved clinician (AC) in charge of treatment, or their nominated deputy, believe the patient meets the criteria for detention under Part II of the Act. Whether or not to use this power is frequently a difficult decision for doctors or ACs, but good practice will always depend on the professionals involved in implementing the holding power correctly understanding the power and its purpose.

2. PURPOSE AND SCOPE

2.1 To inform doctors and other Approved Clinicians what action to take when an informal patient is trying to leave the ward and it is believed 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.

2.2 The patient may be held for up to 72 hours.

2.3 All doctors and other Approved Clinicians caring for patients on the wards should be familiar with the procedures detailed in this document.

3. DUTIES AND RESPONSIBILITIES

3.1 The Trust Board has a duty to care for patients looked after by the Trust,

3.2 The Director of Governance and Corporate Development is responsible for this policy covering the appropriate use of section 5(2) within the Trust, but will delegate authority for the operational implementation and ongoing management of this policy to the Mental Health Legal Strategies Lead.

3.3 The Mental Health Legal Strategies Lead is the author of this policy, who will review this policy at least every two years.
3.4 Each **registered healthcare professional** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body.

3.5 **All doctors** caring for patients on the wards, and all non-doctor approved clinicians should be familiar with the procedures detailed in the document and other related policies.

3.6 **Ward managers** are responsible for ensuring all nursing staff are conversant with this policy and related policies.

4. **EXPLANATIONS OF TERMS USED**

   MHA – Mental Health Act 1983 as amended by the Mental Health Act 2007.

   AC – Approved Clinician. This could be a suitably qualified psychologist, nurse, social worker or occupational therapist.

5. **USING THE POWER IN THE TRUST**

5.1 The power should only be used after the patient’s doctor or approved clinician (AC); or their nominated deputy in charge of the treatment of a hospital in-patient, personally examines the patient and concludes that an application for detention under the Act should be made, and when it is unsafe to wait for a full assessment to admit under Part II of the Act.

5.2 There should only be one nominated deputy for any patient at any time. This can be by title rather than name; for example, the on-call doctor. No instruction should be left for the doctor or AC to use s.5(2), nor should forms be completed for use in the doctor’s or AC’s absence.

5.3 If the patient is already detained under s.5(4) the request from a nurse to assess for detention under s.5(2) should be treated as an emergency and be responded to quickly.

5.4 The doctor or AC invoking the power should complete Form H1, the power to detain operating from the time the form is completed and signed.

5.5 Patients who try to leave while Form H1 is being completed can be prevented from doing so under common law.

5.6 There is no power to return absconding patients subject to s.5(2) once the 72 hour period has elapsed.

5.7 The doctor or AC must be fully aware of the diverse needs of the
patient when considering detention and must take them into account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand.

6. USING THE POWER IN A GENERAL HOSPITAL

6.1 Any doctor in charge of a patient’s care may detain a patient under s.5(2), using Form H1. This includes a doctor in a non-psychiatric hospital.

6.2 The non-psychiatric doctor should try to discuss the use of the power, prior to using it, with a senior psychiatrist. If this is not practicable then a senior psychiatrist should be contacted as soon as the power is used. The senior psychiatrist should see the patient as soon as possible to determine whether the patient should be further detained.

6.3 If the patient is already receiving treatment for a mental disorder, as well as their physical disorder, then the consultant psychiatrist is the doctor in charge of treatment.

6.4 The full Mental Health Act assessment should be initiated as below.

6.5 A s.5(2) cannot be used in an A & E department.

6.6 The doctor or AC must be fully aware of the diverse needs of the patient when considering detention and must take them into account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand.

7. OBTAINING A MENTAL HEALTH ACT ASSESSMENT

7.1 Once s.5(2) has been invoked the doctor or AC completing Form H1 should initiate a Mental Health Act assessment of the patient by ensuring an Approved Mental Health Professional (AMHP) is informed.

7.2 A hospital doctor providing a medical recommendation to detain under either s.2 or s.3 should be available to discuss the patient with the doctor providing the second medical recommendation and the AMHP (or nearest relative if the nearest relative is the applicant).

7.3 The patient should be told both orally and in writing of their detained status and rights, including their right to refuse treatment. The oral and written information given to the patient must be in a format and language they can understand.

7.4 Should the patient’s doctor, AC, or nominated deputy after consultation with the patient’s doctor or AC, decide that no
assessment need be carried out then the authority to detain under s.5(2) will cease immediately. A note should be made by the doctor or AC on the patient’s EPR of the time the s.5(2) ended.

7.5 If an AMHP has been informed of the need for a Mental Health Act assessment, the doctor or AC should ensure he/she is immediately told of the patient’s reversion to informal status as it is the responsibility of the AMHP to coordinate the assessment process.

7.6 The authority to detain the patient under s.5(2) ends once the assessment has been completed and a decision made not to detain the patient under s.2 or s.3. A note should be made by the doctor or AC on the patient’s EPR of the time the s.5(2) ended.

7.7 The patient should be informed that he or she is no longer detained under s.5(2).

7.8 The s.5(2) should not be allowed to run for the full 72 hours if a decision has been made not to proceed with a full Mental Health Act assessment.

7.9 The Mental Health Act administrators should be informed as soon as the patient reverts to informal status.

8. TRANSFERRING PATIENTS BETWEEN HOSPITALS

8.1 Patients subject to s.5(2) on a hospital site in the Trust may not be removed to another hospital site in the Trust. For example, a s.5(2) detained patient on Rydon or Pyrland wards could be transferred to Holford ward, but a patient detained on s.5(2) on Rowan ward could not be transferred to Holford ward as it is on a different hospital site.

8.2 Patients subject to s.5(2) in a general hospital cannot be transferred, under a provision of the Mental Health Act 1983, to a psychiatric hospital. They should be assessed in situ.

8.3 Patients detained on s.5(2) and lacking capacity can be transferred to another hospital site, but the s.5(2) lapses once they leave the hospital site to which the s.5(2) applies. On reaching the new hospital site, consideration should be given to imposing a fresh s.5(2) should they try to leave the hospital.

9. TREATMENT

9.1 Patients detained under s.5(2) are in the same position in regard to treatment as voluntary patients. No treatment, except when given in an emergency, can be administered without consent. To obtain the patient’s consent, the use of professional interpreter may be required.
9.2 Emergency treatment can only be given within the principles of common law and the Mental Capacity Act. That is to say, only if the patient lacks capacity and treatment is immediately necessary to save life, prevent a serious deterioration in the patient’s health, alleviate serious suffering or prevent the patient from behaving violently and being a danger to themselves or others. Treatment should be the least restrictive and the minimum necessary.

10. TRAINING REQUIREMENTS

10.1 The Trust will work towards all staff being appropriately trained in line with the organisation’s Staff Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

11. EQUALITY IMPACT ASSESSMENT

11.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

12. MONITORING COMPLIANCE AND EFFECTIVENESS

12.1 Monitoring arrangements for compliance and effectiveness

The Trust will monitor adherence to the Trust’s policy. Overall monitoring will be by the Regulation Governance Group. The Mental Health Legislation Group is a sub-group of the Regulation Governance Group and is accountable to the Regulation Governance Group.

12.2 Responsibilities for conducting the monitoring

The Mental Health Legislation Group will monitor policy document compliance and effectiveness where they relate to the use of section 5(2) and feedback to the Regulation Governance Group.

12.3 Methodology to be used for monitoring

Discussions of the following will be recorded within the MHL Group minutes

- internal audits
- complaints monitoring
- incident reporting and monitoring
12.4 Frequency of monitoring

- annual reports on the general use of S5(2) in the Trust to the Mental Health Legislation Group, by the Mental Health Legal Strategies Lead

12.5 Process for reviewing results and ensuring improvements in performance occur.

Information received will be discussed at the MHL Group which will identify good practice, any shortfalls, action points and lessons learnt. Any change in policy will be presented to the Regulation Governance Group which will be responsible for ensuring improvements, where necessary, are implemented.

13. COUNTER FRAUD

13.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

14. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

The standards and outcomes which inform this procedural document are as follows:

<table>
<thead>
<tr>
<th>Section</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and involvement</td>
<td>2 Consent to care and treatment</td>
</tr>
<tr>
<td>Personalised care, treatment and support</td>
<td>4 Care and welfare of people who use services</td>
</tr>
<tr>
<td>Safeguarding and safety</td>
<td>7 Safeguarding people who use services from abuse</td>
</tr>
<tr>
<td>Quality and management</td>
<td>19 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the MHA 1983</td>
</tr>
<tr>
<td></td>
<td>20 Notification of other incidents</td>
</tr>
<tr>
<td></td>
<td>21 Records</td>
</tr>
<tr>
<td></td>
<td>28 Notifications – notice of changes</td>
</tr>
</tbody>
</table>
15. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

15.1 References
MHA ’83 Code of Practice – Chapter 12 – The Stationery Office 2008

15.2 Cross reference to other procedural documents
Consent and Capacity to Consent to Treatment Policy
Detained Patients AWOL Policy
Development & Management of Procedural Documents
Learning Development and Mandatory Training Policy
Record Keeping and Records Management Policy
Risk Management Policy and Procedure
Section 5(4) Nurses’ Holding Power Policy
Staff Training Matrix (Training Needs Analysis)
Training Prospectus
Untoward Event Reporting Policy and procedure
All current policies and procedures are accessible to all staff on the Trust intranet (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet (on the home page, click on Information, then Local Guidance).