DOCTORS’ AND APPROVED CLINICIANS’ HOLDING POWER
(SECTION 5(2) MENTAL HEALTH ACT 1983)
JANUARY 2016

This policy supersedes the previous policies for Implementation of the MHA 1983 and the Code of Practice 2007 on Inpatient wards (Jan 2009) and for Assessing Patients on Wards for Admission under the MHA 1983 (March 2004)
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1. Trust values

Camden and Islington NHS Foundation Trust developed its set of six values with more than 500 service users and members of staff.

Our values are important to us. They are our promise to patients as well as to each other that we will behave in a certain way, no matter what our job title is or how under pressure we feel.

Our commitment to our values makes us who we are. It gives our service users confidence that they will be treated in the most compassionate way possible as they go through their journey to recovery. It also gives us pride in the knowledge we are providing the best care.

Our values show that we are welcoming, respectful and kind. Professional in our approach. Positive in our outlook. Working as a team, we are your partner in care and improvement.

These values are part of a wider campaign, Changing Lives which is helping to drive up the standards of care across the Trust.

In simple terms our values assure our service users that:

- They will receive a warm welcome throughout the journey to recovery;
- They, their dignity and their privacy will always be respected;
- Their care will be founded on compassion and kindness;
- They will receive high quality, safe care from a highly trained team of professionals;
- We work together as a team to ensure they feel involved and offer solutions and choices – ‘no decision about you, without you’;
- We are positive so they can feel hopeful and begin their journey of recovery knowing we will do our very best.

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2. Policy and governance

A policy is an organizational statement of rules and standards which govern performance and actions required to be followed by those in employment by the Trust. A policy provides a framework for the Trust to work within and should specify actions which are required. A policy may include detailed procedures which supply standardized methods of performing clinical or non-clinical tasks by providing a series of actions to be conducted in a certain order to achieve a safe and effective outcome in a consistent method by all concerned.

Policies should take account of existing good quality evidence. The Whittington Health Library provides a library service to the Foundation Trust and can assist with literature searches and finding evidence to inform policy and practice. For more information please contact:
Good governance lies at the heart of all successful organizations. Good governance helps protect the Trust, its staff and service users from poor decisions and exposure to risks. All Trust policies must be compliant with the relevant statutory legislation, e.g.: the Mental Health Act 1983 (which was amended in 2007) and national expectations, e.g.: the NHS Litigation Authority Risk Management Standards 2012-13.

A policy which has not been scrutinized and approved by the appropriate Trust committee but is being used by staff could lead to poor practice being delivered which could potentially harm service users and have consequences for staff. It is therefore essential that in either developing or revising a policy, managers ensure that the proper governance procedures have been followed. By following the correct governance procedures, we all help to reduce risk and assure safe and effective care is delivered to service users.

### 3. Policy statement

This policy sets out the standards and procedures for all health and social care professionals employed by, or acting on behalf of Camden and Islington NHS Foundation Trust who may apply section 5(2).

This policy reflects the requirements of the Mental Health Act 2008 as well as the 2015 Code of Practice to the Mental Health Act.

### 4. Executive summary

Section 5(2) can be used where the doctor or approved clinician in charge of the treatment of a hospital in-patient (or their nominated deputy) concludes that an application for detention under the MHA 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.

The period of detention starts at the moment the doctor’s or approved clinician’s report is furnished to the hospital managers (e.g. when it is handed to an officer who is authorised by the managers to receive it, or when it is put in the hospital’s internal mail system).

If a patient subject to section 5(4) is assessed and detained by a doctor under section 5(2), their liability to detention under section 5(2) will expire seventy-two hours after their liability to detention under section 5(4) began.

A hospital in-patient means any person who is receiving in-patient treatment in a hospital, except a patient who is already liable to be detained under section 2, 3 or 4 of the Act, or who is a supervised community treatment patient. It includes patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005. It does not matter whether or not the patient was originally admitted for treatment primarily for a mental disorder.

The power cannot be used for an out-patient attending a hospital’s accident and emergency department, or any other out-patient. Patients should not be admitted informally with the sole intention of then using the holding power.

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.

Although the holding power lasts for a maximum of 72 hours, it should not be used to continue to detain patients after:
• The doctor or approved clinician decides that, in fact, no assessment for a possible application needs to be carried out; or
• A decision is taken not to make an application for the patient’s detention.
Patients should be informed immediately that they are no longer detained under the holding power and are free to leave the hospital, unless the patient is to be detained under some other authority, such as an authorisation under the Deprivation of Liberty Safeguards in the Mental Capacity Act 2005.

5. Duties and responsibilities

The Chief Executive has ultimate responsibility for ensuring that mechanisms are in place for the overall implementation, monitoring and revision of policy.

The Director of Nursing and People is the executive director responsible for this policy, but will delegate authority for the operational implementation and ongoing management of the policy to the Mental Health Law Manager.

The Mental Health Law Manager is responsible for reviewing this policy every three years.

The Associate Director, Governance and Quality Assurance, via the Clinical and Corporate Policy Manager, is responsible for ensuring:

• Dissemination and implementation of the policy
• Identification of any resource implications to enable compliance
• Training and monitoring systems are in place
• Regular review of the policy takes place.

Associate Divisional Directors are responsible for implementation of the policy within their own spheres of management and must ensure that:

• All new and existing staff have access to and are informed of the policy
• Ensure that local written procedures support and comply with the policy
• Ensure the policy is reviewed regularly
• Staff training needs are identified and met to enable implementation of the policy.

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 with the Code of Practice of their professional body.

All Trust staff are responsible for ensuring that they:

• Are familiar with the content of the relevant policy and follow its requirements
• Work within, and do not exceed, their own sphere of competence.

6. Definitions

Care Quality Commission: The regulator established by the Health and Social Care Act 2008 of all providers of regulated health and social care. This includes care provided under the Mental Health Act 1983.

Mental Health Act (MHA): The term used within this policy to refer the Mental Health Act 1983 which is the legislation that deals with the care and treatment of people who are mentally disordered.

Code of Practice: The Code required within the MHA which defines good practice for exercising powers and functions under the MHA, and is something which all persons exercising functions under the MHA should have regard to.
Approved Clinician (AC): a person approved by the Secretary of State to act as an approved clinician for the purposes of the MHA. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

Responsible Clinician (RC): The Approved Clinician who has overall responsibility for the care and treatment of a patient subject to the MHA. Certain decisions (such as renewing a patient’s detention or placing a patient on a community treatment order) can only be taken by the responsible clinician.

Approved Mental Health Professional (AMHP): A role defined within the Act which includes the responsibility for making applications for detention under Part II of the MHA.

Mental Capacity Act 2005: Act of Parliament that governs decision-making on behalf of people, aged 16 years and over, who lack capacity, both where they lose capacity at some point in their lives, for example as a result of dementia or brain injury, and where the incapacitating condition has been present since birth.

Independent Mental Health Advocates (IMHA) provide an additional safeguard for patients who are subject to the Act. They support patients to exercise their rights and ensure they can participate in the decisions that are made about their care and treatment. They do not replace any other advocacy or support services and work in conjunction with other services. They help qualifying patients to obtain relevant information and to understand their position including their rights and aspects of their treatment.

7. Criteria for Detention

7.1 The statutory criteria for Section 5(2) are as follows:
- the patient is already a hospital in-patient receiving treatment on an informal basis or is subject to detention under section 5(4), and
- the patient has been examined by the doctor in charge of their care (or that doctor’s deputy nominated under section 5(3)) or approved clinician, and
- the examining doctor or approved clinician is satisfied there may be grounds for the patient’s detention under section 2 or 3, and
- a full mental health act assessment by an AMHP and two suitably qualified doctors cannot be completed before the patient exercises their right to leave the unit, and
- the patient cannot be persuaded to stay in hospital before an assessment for detention under the Act is completed.

7.2 When carrying out any Mental Health Act assessment any actions taken under this policy must take into consideration the guiding principles governing the use of the Act as outlined in chapter one of the Code:
- Least Restrictive option and Maximising Independence
- Empowerment and Involvement
- Respect and Dignity
- Purpose and Effectiveness
- Efficiency and Equity

7.3 All decisions must be lawful and informed by good professional practice. This includes compliance with the Human Rights Act, 1998.

7.4 Section 5(2) must not be used as a threat. Staff must regard the use of this section as the first step in a patient’s assessment for further detention under section 2 or 3 of the Act.

7.5 Completion of Form H1 (Appendix 2) is required to give authority to detention under section 5(2). Form H1 should only be completed after the doctor in charge of the patient’s care, his nominated deputy or AC has examined the patient, and has decided it is immediately necessary for the patient to be detained.

7.6 Part 2 of the Form H1 must be completed on behalf of the Hospital Managers as soon as the form is received.
8. **Duration of Liability for Detention**

8.1 The patient may be held on the ward for up to seventy-two hours, during which time he/she must be assessed for detention under section 2 or 3 of the Act. The assessment must be completed, and the patient released from detention, or further detained if appropriate, before seventy-two hours elapse.

8.2 The period of detention commences at the moment form H1 has been furnished to the Hospital Managers or the person authorised to receive it on their behalf, and becomes effective when it is either provided to the person authorised to receive it, or when it is committed to the internal mail system. If the patient has left hospital before the completion of form H1, he cannot be subsequently detained and returned to the hospital.

8.3 If a patient subject to section 5(4) is assessed and detained by a doctor under section 5(2), their liability to detention under section 5(2) will expire seventy-two hours after their liability to detention under section 5(4) began. Any time previously detained under section 5(4) should be taken into account and counted as part of the 72-hour detention period of the section 5(2).

8.4 There is no authority under the Act for a patient’s liability to detention under this section to be renewed or extended. At the end of seventy-two hours, the patient will:
- be discharged home if appropriate, or
- remain in hospital informally or voluntarily, or
- be detained in hospital under the Act (section 2 or 3).

8.5 As noted above, Section 5(2) is not renewable, however, circumstances could arise where a change in the patient’s situation could lead to a second use of this provision being contemplated soon after its first use. It should be noted that it is considered exceptionally bad practice to use section 5(2) more than once on the same patient within a short time scale. An Approved Mental Health Professional (AMHP) must be involved in this process as early as possible.

8.6 Section 5(2) should not be allowed to lapse unless exceptional circumstances apply, in which case advice should be sought and the circumstances and the advice noted in the patient’s records.

9. **Treatment**

9.1 **There is no authority for the compulsory treatment of patients liable to detention under this section of the MHA.** Treatment can only be given with the patient’s consent or under the Mental Capacity Act 2005. Please refer to the Trust MCA Policy for further guidance.

10. **Transfers**

10.1 **It is not possible for patients detained under section 5 to be transferred to another hospital under section 19** (because they are not detained by virtue of an application made under part 2 of the Act).

10.2 A patient who is subject to section 5(2) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the MCA, including that it is in the person’s best interests and any restrictions on the person’s liberty are permitted by the MCA.

10.3 If, following transfer, the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(2) to provide authority to detain the patient in that hospital.

10.4 In all cases, if the conditions are met, an emergency application for detention under section 4 of the Act could be made to the sending hospital. The patient could then be transferred to the receiving hospital under section 19. Alternatively, an emergency application under section 4 could be submitted to the managers of the receiving hospital.
11. Leave

11.1 The use of Section 17 is not permitted for patients detained under this section as the powers to grant leave of absence only apply to patients detained by virtue of an application.

12. Absent without Leave

12.1 If a patient is liable to detention under section 5(2), they may be returned from a period of absence without leave (AWOL) within the duration of the original liability to detention.

12.2 If a patient liable to detention under section 5(2) is returned from a period of AWOL, the Act makes no provision for an extension of that section. Staff must complete their assessment of the patient’s mental health and detain them under a further section of the Act if appropriate, within the time remaining of the original liability to detention.

13. Responsibility of Assessing Doctor

13.1 The doctor or AC in charge of the patient’s care or their nominated deputy must examine the patient and if, in the view of the doctor or AC at that time, the criteria for detention appears satisfied, complete statutory Form H1, and hand it immediately to a member of the Trust’s staff authorised to receive detention papers on behalf of the Hospital Managers. An entry must be made in the patient’s case notes to record the reasons for their detention.

13.2 Nursing staff must ask a doctor or AC to assess a patient for detention under section 5(2), where the patient is already detained under section 5(4)\(^1\). The use of section 5(4) should be viewed as evidence of a psychiatric emergency, and a doctor or AC should attend a patient subject to that section as quickly as possible. If the doctor or AC fails to attend a patient detained under section 5(4) within the first three hours of their liability to detention, the RC or Duty Consultant should be contacted and should support the management of such an emergency.

13.3 Once a patient is detained under section 5(2), the doctor or AC in charge of their care, must ensure that a plan for the patient’s future care is put in place as soon as possible.

13.4 A patient detained under section 5(2) must be treated as informal or voluntary and the section rescinded as soon as it is decided further detention under the Act is not appropriate. Accordingly, the RC must complete a section 23 form to rescind the section, and inform the patient they are no longer detained. Exceptionally, if the RC authorises the patient’s release from detention, but is unable to attend the patient on the ward in order to complete the rescinding form, a note must be made in the patient’s case notes to that effect, as well as highlighting the time the section ended.

14. The Nominated Deputy

14.1 If the doctor or AC in charge of the patient’s care is unable to attend and assess a patient for detention under section 5(2), the doctor or AC who has been nominated to deputise for them under section 5(3) must attend and assess the patient.

14.2 At any time, there can be only one nominated deputy. According to Trust policy the nominated deputy would then be:

- During working hours the doctor who is the immediate deputy of the doctor in charge of the patient’s care, involved in the day to day care of the patient in question. This would be the SPR, Staff Grade Doctor or SHO in order of seniority based on their availability.
  Or if, and only if, the said doctor is not available:
- The rostered duty doctor who is on call at the time the patient needs to be assessed.

14.3 Only a doctor or AC on the staff of the same hospital may be a nominated deputy (although the deputy does not have to be a member of the same profession as the person nominating them).

\(^1\) A patient may be detained under section 5(4) for up to six hours.
14.4 If the nominated deputy examines the patient, and is satisfied the criteria for detention appear to be satisfied, they should complete statutory Form H1, and hand it immediately to a member of the trust's staff authorised to receive detention papers on behalf of the Hospital Managers. An entry must be made in the patient's case notes to record the reasons for their detention.

14.5 The role of nominated deputy is specific to the use of section 5 and should not be confused with other occasions when for example cover arrangements for a RC’s annual leave are agreed, and another doctor, usually another consultant, will act as the temporary RC.

14.6 It is unlawful for one nominated deputy to nominate another.

15. Doctors and Approved Clinicians Working in Psychiatric Liaison Services in General Hospitals

15.1 The use of section 5(2) is extended to general hospitals. A patient could be receiving treatment as an inpatient in a general hospital for a physical condition and still be detained under section 5(2). In a general hospital, where the patient is receiving treatment other than for a mental disorder, it is likely that the physician in charge of the patient’s care will be the only person with the authority to detain them under section 5(2).

15.2 Doctors and ACs employed by the Trust working in psychiatric liaison services in a general hospital associated with this Trust may not detain a patient in that hospital under section 5(2), unless there is a Service Level Agreement (SLA) that allows care and treatment for mental disorder to be given under the direction of a consultant psychiatrist (or other approved clinician) from the Trust.

16. Nurse in Charge of the Ward where the Patient is Detained

16.1 Required Documentation: The nurse in charge of the ward where the patient is detained (or the Bleep Holder if out of hours) must ensure that:
   - Part 2 of the Form H1 is completed by a member of staff authorised to receive papers on behalf of the Hospital Managers as soon as possible, or be committed to the hospital’s internal mail system addressed to the Mental Health Act Office.
   - An initial check is made for errors in Forms H1 that can be amended by the person(s) who completed the form(s). The Mental Health Act Officer is ultimately responsible for making sure errors are amended if possible, which may need legal advice.
   - Completed Trust and statutory documentation is forwarded to the Mental Health Act Office as soon as possible (and not later than the next working day).

16.2 Patient’s Rights: The nurse in charge must ensure that patients detained under this section are informed immediately (unless their mental state is such that it will be inappropriate to provide this information, in which case detail should be recorded in the records), of their rights under section 132 of the MHA 1983.

16.3 Nursing staff must follow the procedures set out in the Information for Patients, Nearest Relatives, Carers and Others under Section 132 MHA 1983 Policy and attempts duly recorded on EPR.

16.4 Co-ordination of assessment: Depriving a patient of his or her liberty is a serious matter. It is therefore imperative for the arrangements to assess the patient to be made as soon as possible. The assessment must be completed before the 72 hours expires. The nurse in charge of the ward where the patient is detained must ensure:
   - An AMHP is contacted immediately to ensure arrangements for considering the detention of the patient can be made as soon as possible.
   - The RC is informed at the earliest opportunity of the patient’s detention.
   - That the completion and outcome of the assessment is recorded on in the patient’s notes by the AMHP.
16.5 **Assessments not completed within 72 Hours**: If the patient’s assessment is not completed within seventy-two hours, there is no authority under the Act for the duration of the section to be extended. The nurse in charge of the ward where the patient is detained (or Bleep Holder if out of hours) should decide whether it is necessary for the patient to remain in hospital, either in the interests of the patient’s own health and safety, or for the protection of others.

16.6 If continued in-patient treatment is believed to be necessary, the nurse will assess the patient having regard to the patient’s needs and the risk that the patient might pose to others, and should invite them to remain in hospital informally.

16.7 If the patient has capacity and consents to in-patient treatment, the patient should continue to be treated on the ward. If the patient lacks capacity to consent to treatment and is compliant with remaining on the ward, continued intervention may only be authorised under the Deprivation of Liberty Safeguards.

16.8 If a patient who has capacity elects to leave the unit, having been invited to remain informally, the nurse who assessed the patient must:

- Inform the manager responsible for the site immediately;
- The manager responsible for the site, or Nurse Manager On Call, must nominate a suitable member of staff to supervise the patient’s leaving. This includes making any follow-up arrangements that are necessary in the interests of the patient’s own health and safety, or for the protection of others. Ideally this should be co-ordinated by the Bleep Holder for the site. Duties may include ensuring adequate transport is organised and any follow up appointments are made.
- A suitable member of staff should inform the patient, if it is the view of the nurse who assessed the patient that it will be contrary to medical advice to leave the hospital.
- If in-patient treatment is no longer necessary, the patient must be allowed to exercise their right to leave the unit. There is no power to prevent someone who has capacity from leaving whilst attempts to complete the suggested arrangements are made.

17. **Training**

17.1 Specialist training on the exercise of doctors’ and Approved Clinicians’ holding powers under Section 5(2) MHA is available to all clinical staff from the Learning and Development Department.

17.2 Local Mental Health Act Officers provide local training sessions on request covering the requirements of Section 5(2) of the Mental Health Act.

17.3 Training on the exercise of doctors’ and Approved Clinicians’ holding powers under Section 5(2) MHA is delivered by the Mental Health Law Hub. For further details of mental health law training, refer to the mental health law training brochure.

17.4 For training requirements please refer to the Trust’s Mandatory Training Policy and Learning and Development Guide.

17.5 For further details of available training, contact the Learning and Development Department.

18. **Dissemination and implementation arrangements**

18.1 The Associate Director, Governance and Quality Assurance, via the Clinical and Corporate Policy Manager, will disseminate and implement the policy.

18.2 For clarification or support in the implementation of the policy, contact Dominique Merlande, Mental Health Law Manager.

19. **Monitoring and audit arrangements**

19.1 The following aspects of this policy will be monitored and audited:

- how quickly patients are assessed for detention and discharged from the holding power;
- the proportion of cases in which applications for detention are, in fact, made following use of section 5.

19.2 The Mental Health Law Manager will be responsible for carrying out the audits.

19.3 The audits will be undertaken every 3 years. They will be undertaken more frequently when concerns have been raised via internal or external assurance sources e.g. mental health law related incident, legal claim, complaint, CQC MHA monitoring report.

19.4 The results will be reported to the Mental Health Law Monitoring Group, which reports to the Mental Health Law Committee.

19.5 Actions from the audit will be implemented by Associate Divisional Directors and monitored by the Mental Health Law Committee.

19.6 Learning from the audit will be shared in the Mental Health Law Committee.

<table>
<thead>
<tr>
<th>Elements to be monitored</th>
<th>Lead</th>
<th>How Trust will monitor compliance</th>
<th>Frequency</th>
<th>Reporting</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>How quickly patients are assessed for detention and discharged from the holding power</td>
<td>Mental Health Law Manager</td>
<td>Audit</td>
<td>Every 2 years</td>
<td>MHL Monitoring Group MHL Committee</td>
<td>Required actions will be identified and completed in a specified timeframe</td>
<td>Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
<tr>
<td>Proportion of cases in which applications for detention are, in fact, made following use of section 5(2)</td>
<td>Mental Health Law Manager</td>
<td>KP90 returns</td>
<td>Every 2 years</td>
<td>MHL Monitoring Group MHL Committee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Review of the policy

20.1 The review date will be two years from the date of ratification. If the review date is earlier or later than two years, a justification for this will be provided.
21. References

- Mental Health Act 1983
- Code of Practice to the Mental Health Act 1983
- Mental Capacity Act 2005

22. Associated documents

- Trust’s Information for Patients, Nearest Relatives, Carers and Others Policy
- Trust’s Nurses’ Holding Power under section 5(4) MHA 1983 Policy
- Trust’s Mental Capacity Act Policy
- Trust’s Mandatory Training Policy
- Trust’s Learning and Development Guide
### Appendix 1

**Equality Impact Assessment Tool**

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td><strong>Does the policy/guidance affect one group less or more favourably than another on the basis of:</strong></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
<td>The policy provides for information to be given in other languages where necessary.</td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td>The policy provides for alternative media to be used to give information where necessary.</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td><strong>Is there any evidence that some groups are affected differently?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td><strong>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</strong></td>
<td>N/a</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td><strong>Is the impact of the policy/guidance likely to be negative?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td><strong>If so can the impact be avoided?</strong></td>
<td>N/a</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td><strong>What alternatives are there to achieving the policy/guidance without the impact?</strong></td>
<td>N/a</td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td><strong>Can we reduce the impact by taking different action?</strong></td>
<td>N/a</td>
</tr>
</tbody>
</table>
Appendix 2
Section 5(2) Form H1

THIS FORM IS ACCESSIBLE FROM THE INTRANET