MENTAL HEALTH LAW

SUPPLEMENTARY POLICY

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| --- | --- |
| Version number | 1.3 |
| Consultation Groups | n/a |
| Approved by (Sponsor Group) | Mental Health Law Monitoring Group |
| Ratified by: | Quality Committee |
| Date ratified: | 23rd February 2022 |
| Name of originator/author: | Associate Director of Mental Health Law |
| Executive Director lead : | Chief Medical Officer |
| Implementation Date : | February 2022 |
| Last Review Date | November 2021 |
| Next Review date: | February 2025 |

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| --- | --- |
| Services | Applicable |
| Trustwide | Yes |
| Mental Health and LD | Yes |
| Community Health Services | Yes |

**Version Control Summary**

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| **Version** | **Date** | **Author** | **Status** | **Comment** |
| 1.0 | 20th Jan 2016 | Guy Davis - Associate Director of Mental Health Law | Final | Sets out legal and MHA code of practice requirements not covered in other policies |
| 1.1 | 17th Oct 2018  7th Jul 2019  11th Sept 2019 | Guy Davis - Associate Director of Mental Health Law | Draft | Examples of when information might be given to patients added to Para 2.6.  Examples of when information should be given to Nearest Relatives added to 2.7.  Amended appendix 1 scrutiny checklist.  Changed title from ‘MHA Monitoring’  Added paras on leave and discharge |
| 1.2 | 3rd Sept 2020 | Guy Davis - Associate Director of Mental Health Law | Final | Changed title from ‘Mental Health Act’ to ‘Mental Health Law’  Amended scheme of delegation and medical scrutiny procedure as ratified by MHL Monitoring Group 3rd August 2020 |
| 1.3 | Nov 2021 | Guy Davis - Associate Director of Mental Health Law | Draft | Added references to electronic submission of MHA documents and disposal of paper copies.  Added legal position re serving of nearest relative discharge orders |

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**Executive Summary**

This document directs the practice of Trust staff in relation to various aspects of mental health law that are not already covered in other Trust policies – Giving Information, Emergency Detention, Holding Powers, Receipt & Scrutiny of section papers, renewals of detention, extensions of Community Treatment Orders, Welfare of Children in Hospital, Leave and Discharge, Deprivation of Liberty Safeguards.

**1.0 Introduction**

1.1 The policy should be read in accordance with the Mental Health Act 1983 ('the Act’), the Mental Health Act Code of Practice 2015 (‘the Code’; notably its guiding principles which should always be considered when making any decision under the Act); associated legislation, case-law and relevant Trust policies and guidance.

**2.0 Purpose**

2.1 The purpose of the policy is to set out the Trust’s position, roles and responsibilities in respect to those aspects of mental health law that are not already covered by other Trust policies.

**3.0 Duties and Responsibilities**

3.1 Various duties and responsibilities are set out in the main body of the policy and there are some which are specifically set out in the Trust’s Mental Health Law Scheme of Delegation in appendix 2.

**4.0 Duty to give information to detained patients, community patients and Nearest Relatives (sections 132, 132A and 133, Code of Practice 4.1 - 4.48)**

4.1 It is a legal requirement under section 132 (detained patients) and 132A (Community Treatment Order patients) that the Trust takes such steps as are practicable to ensure that patients understand which provision of the Act they are subject to, the effect of that provision, what rights of appeal are available and how to access an Independent Mental Health Advocate (IMHA).

4.2 The Trust's Mental Health Act Scheme of Delegation allows for Band 4 (or equivalent) and all Mental Health Law staff to undertake this duty.

4.3 As soon as practicable after commencement of detention or Community Treatment Order (CTO), patients should be given a copy of the relevant information/rights leaflet which can be found on the intranet. At the same time, a verbal explanation should also be given, allowing the patient to ask questions and clarify anything that they do not understand. Assistive technologies, interpretive and advocacy services should be used where appropriate.

4.4 A record of the steps taken to enable the patient to understand their position should be made on the electronic patient record (i.e. in RiO there is a ‘section 132 and 132A rights’ form), indicating whether or not the patient fully understood the information given to them.

4.5 A record should also be made as to when the procedure will be repeated, and if the patient did not fully understand the information, what practicable steps will be taken to help the patient to understand it.

4.6 The Code at 4.29 states that a fresh explanation of the patient’s rights should be considered in certain situations such as:

* 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, or such a request is refused;
* the rules in the Act about their treatment change (e.g. because three months have passed since they were first given medication, or because they have regained capacity to consent to treatment);
* any significant change in treatment is being considered;
* there is to be a care programme approach review (or its equivalent);
* renewal of detention, or extension of CTO is being considered;
* a decision is taken to renew detention or to extend CTO;
* a decision is taken to recall a community patient or revoke a CTO; or
* a decision is taken to recall a conditionally discharged patient to hospital.

4.7 It is a legal requirement under sections 132 and 132A, that unless the patient otherwise requests, the Nearest Relative must be given a copy of any written information that was given to the patient. The patient's views should be made known to the Mental Health Law office, so that unless the patient has requested otherwise, relevant information will be sent from that office to the Nearest Relative.

4.8 Unless either the patient or Nearest Relative has requested otherwise, the clinical team or Mental Health Law office must, where practicable, inform the Nearest Relative that the patient is to be discharged from detention or a CTO. Where practicable, this should be done at least seven days prior to the date of discharge.

**5.0 Emergency Admission (section 4, Code of Practice Chapter 15)**

5.1 Section 4 allows for an application for detention to be made in cases of urgency, where the applicant can rely on just one medical recommendation rather than two, which would be required for sections 2 or 3.

5.2 The Trust will monitor the use of section 4 as a means of potentially identifying increases in its usage and to address any factors that might be contributing to such increases.

**6.0 Holding Powers (section 5(2) & (4), Code of Practice Chapter 18)**

6.1 In situations where an informal in-patient is suffering from a mental disorder to such a degree that they need to be immediately restrained from leaving hospital, section 5(4) allows a Registered Mental Health or Learning Disability nurse to order the detention of a patient for up to 6 hours, until a doctor can attend to consider whether or not further detention under the Act is required. This should be recorded on statutory Form H2.

6.2 In situations where the doctor or Approved Clinician in charge, or their nominated deputy (see 'Responsible Clinician and Nominated Deputy' policy) is of the opinion that an application for detention under sections 2 or 3 ought to be made, and due to the circumstances at the time it is not practicable to complete an assessment for detention under sections 2 or 3 (i.e. the patient has been administered rapid tranquillisation), section 5(2) allows that practitioner to complete and furnish Form H1 which has the effect of giving the hospital the authority to detain the patient for up to 72 hours, for the purpose of enabling assessments for detention under sections 2 or 3 to take place.

6.3 Having taken into account the circumstances of the case, it should be clearly indicated and explained on Form H1 as to why informal care and treatment is no longer appropriate i.e. refusal of necessary treatment, refusal of necessary stay in hospital, lack of capacity to consent to an informal stay in hospital (if that stay means the patient is deprived of their liberty).

6.4 Arrangements for assessments to consider an application under sections 2 or 3 should be put in place as soon as practicable after the H1 form is furnished. There must be no undue delay; i.e. waiting for the Consultant Psychiatrist to come on duty.

6.5 The authority to detain under section 5(2) will end if a decision is made to not make an application for the patient's detention, or the doctor or approved clinician in charge decides that no assessments need to be carried out. As such it should rarely be the case, if at all, that the 72-hour period will be allowed to lapse. The date and time that authority to detain under section 5(2) came to an end should be recorded in the patient’s progress notes and the Mental Health Law office advised accordingly.

6.6 Neither of the powers in section 5 can be applied to someone who is an in-patient on a Community Treatment Order; in cases where practitioners would be minded to use such powers, consideration must be given to recalling the patient under section 17E.

6.7 All documents pertaining to holding powers must be sent electronically to the Mental Health Law office as soon as is practicable.

**7.0 Receiving, scrutinising and rectifying applications for detention (sections 6 and 15, Code of Practice chapter 35)**

7.1 The Trust's Scheme of Delegation (see appendix 2) sets out who is authorised to receive applications for detention on behalf of the Trust. Those practitioners should check that the necessary procedures under the MHA have been carried out, by scrutinising the statutory documents that comprise the application for detention (a checklist to assist is provided in appendix 1). Where practicable, this should initially be done in the presence of the applicant (if this is an Approved Mental Health Professional (AMHP), they should also provide the Trust with a copy of their outline report). Important as those checks are, the process should never prevent, delay or otherwise interfere with, the admission or the care and treatment needs of the patient.

7.2 All detention documents must be sent electronically to the Mental Health Law office as soon as is practicable. Upon receipt, the MHL office will confirm with the clinical team that the relevant paper copies can be disposed of safely.

7.3 The Mental Health Law office will then carry out further scrutiny of the documents and arrange for any necessary rectifications to be made. In examining the medical grounds for detention on the recommendations, consideration should be given as to whether or not there is sufficient reasoning regarding the statutory criteria, to support the conclusions stated on the form.

7.4 In all cases where there is doubt about the authority to detain, the Mental Health Law office should escalate the matter to their line manager who may in turn seek advice from the Associate Director of Mental Health Law or Lead Nurse in Mental Health Law, to enable a final decision to be made.

**8.0 Renewal of authority to detain and extension of Community Treatment Orders (sections 20 and 20A, Code of Practice chapter 32)**

8.1 Responsible Clinicians should ensure that the on-going need for compulsory powers (detention or Community Treatment Order) is routinely reviewed and documented, especially where the authority is about to expire, so that compulsory powers are not in place unnecessarily.

8.2 If compulsory powers are to continue beyond the expiry of the original authority, the Responsible Clinician should carry out a face to face

examination of the patient within the statutory two-month period prior to

expiry.

8.3 If the Responsible Clinician submits a report renewing detention or extending a Community Treatment Order, this will potentially trigger a review by a Hospital Managers panel (see 'Hospital Managers Power of Discharge' policy and associated guidance).

8.4 Prior to potential renewal of detention, the Responsible Clinician must consult at least one person who has been professionally concerned with the patient's medical treatment (treatment is defined in section 145), and a professional not from the same profession as the Responsible Clinician (i.e. registered nurse, occupational therapist, social worker, psychologist, doctor) concerned with the patient's medical treatment, who must agree by indicating in Part 2 of Form H5, that the conditions for renewal as set out in section 20(4), are met.

8.5 Prior to potential extension of a Community Treatment Order, the Responsible Clinician must obtain the written agreement of an AMHP (by way of Part 2 of Form CTO7), that the conditions for extension as set out in section 20A(6), are met. The Responsible Clinician must also consult with at least one person who has been professionally concerned with the patient's medical treatment (should not be the AMHP described above and must not be someone from the same profession as the Responsible Clinician, i.e. a registered nurse, occupational therapist, social worker, psychologist, doctor etc - see 32.13 of Code of Practice).

**9.0 Welfare of certain children in hospital (section 116, Code of Practice 37.12)**

9.1 For any child admitted to a hospital (for any reason) in the Trust who:

* Is in the care of a Local Authority by virtue of a Care Order under the Children Act 1989; or
* Is subject to the Guardianship of a local social services authority under section 7 of the Mental Health Act; or
* Has a local social services authority acting as their Nearest Relative,

the clinician in overall charge of the patient's care shall take steps to alert the relevant authority described above, of the patient's admission to hospital, so that visits by that authority can be made to the patient. The steps taken should be recorded in the electronic patient record system.

**10.0 Leave of absence (section 17)**

10.1 Only the Responsible Clinician may authorise leave of absence under s.17 in situations where the patient is going to exit the grounds of the hospital where they are liable to be detained (some patients may have been ordered by the court or Ministry of Justice to be detained in a particular unit, in which case the RC must authorise under s.17, if the patient is to leave the immediate unit).

10.2 S.17 allows for conditions to be attached to the authorisation such as the patient remaining in the custody of a member(s) of staff or someone else, leave for certain periods of time or for specific events.

10.3 If leave is going to be granted for a period of more than seven days, the RC is required to consider the need for the use of a CTO.

10.4 All of the above should be recorded on the relevant Trust form (do not send to Mental Health Law office).

10.5 If a patient who is on leave contacts the hospital to ask for permission to extend their leave or explain that they will be late in returning, the matter should be referred immediately to the RC (the covering or on-call consultant psychiatrist if the usual RC is not available – see Responsible Clinician and Nominated Deputy policy).

10.6 If s.17 leave is cancelled or expired, the form must be struck through and if applicable, uploaded onto the electronic patient record system.

**11.0 Discharge from detention or Community Treatment Order by Responsible Clinician (section 23)**

11.1 If the Responsible Clinician decides that compulsory powers are no longer required, they should order discharge in writing (this is the point at which discharge takes effect) by completing the Trust’s section 23 discharge form which must be sent electronically to the Mental Health Law office, a copy having being given to the patient where practicable. See also para 4.8 above re informing Nearest Relative.

**12.0 Discharge from detention or CTO by Nearest Relative (sections 23 & 25)**

12.1 A patient's nearest relative has the power to give notice of order to discharge whilst the patient is detained under sections 2, 3 or 4, or subject to a Part II CTO under section 17A.

* 1. Section 25 sets out the restrictions of this power as follows:

1. The nearest relative must give not less than 72 hours notice before the order takes effect and this is explained in the letter they are sent as per 4.7 above. The notice will be deemed to be served and the 72 hour period begins when:

* The notice is physically handed to someone and if not that person, someone authorised (see appendix 2) takes receipt of it (see appendix 2); or
* The notice is sent by post and received at the hospital (inc. i.e. in the ‘post-room’)
* Having been sent by e-mail, after midnight (00:01) on the following business day (business days being Monday to Friday and not bank holidays)

b) Once received, the discharge notice must be handed/sent to the Responsible Clinician immediately; i.e. it must not be put in the internal mail or simply left somewhere in the clinical area. The Responsible Clinician should then consider whether or not, if the patient were to be released from compulsory powers, s/he would be likely to act in a manner dangerous to other people or himself/herself. This is the only time that the word 'dangerous' appears in the Act and so it implies that there is a much higher threshold for continuing detention or use of CTO, than the criteria which are set out for commencing and continuing those powers.

c) If the Responsible Clinician is of the opinion that the ‘dangerousness’ threshold is not met, the order for discharge can take effect once the 72 hour period is reached and the patient must be released if they are still in hospital.

d) If the Responsible Clinician is of the opinion that the ‘dangerousness’ threshold is met, statutory form M2 must be completed by that clinician and furnished to a member of staff prior to the ending of the 72 hour period. The form should be forwarded immediately to the Mental Health Law office via electronic means. The nearest relative cannot then make any further order for discharge within 6 calendar months, irrespective of any breaks in compulsory powers or change of identity of nearest relative.

**Appendix 1**

**ELFT MHA Scrutiny Aide-Memoire**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patients Name:** |  | | | | |
| **Section and Start Date:** |  | | | | |
| **Ward:** |  | | | | |
| **Patient objects to rights information being given to nearest relative** | Y/N | | | | |
| **Y** | **N** | **N/A** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **If ‘no’ on any of these, the application should not be accepted** | | |  | |  | |  | |
| Correct forms used for relevant section. | | |  | |  | |  | |
| Application and both medical recommendations signed. | | |  | |  | |  | |
| To the best of your knowledge (no further checks required), forms are completed by someone qualified to do so. | | |  | |  | |  | |
| Patient admitted to hospital stated on application. | | |  | |  | |  | |
| Patient admitted to hospital within 14 days of second medical examination (For section 4; within 24 hrs of medical examination). | | |  | |  | |  | |
| Both section 3 medical recommendations indicate potential admission to same hospital that application is made out to (if neither do, do not accept. If one does, accept and Mental Health Law office will arrange rectification). | | |  | |  | |  | |
| Medical recommendations made out on or before application date. | | |  | |  | |  | |
| Application made within 14 days of AMHP seeing patient (s.4 - 24 hours). | | |  | |  | |  | |
| To the best of your knowledge (no further checks required), there is no conflict of interest between the assessors, the patient or their nearest relative. | | |  | |  | |  | |
| **If ‘no’ on any of these, accept and they may be rectified if necessary** | | |  | |  | |  | |
| Patients name and address is same on all forms. | | |  | |  | |  | |
| Hospital name and address is generally correct. | | |  | |  | |  | |
| If two medical examinations were conducted separately, there was no more than 5 clear days between them e.g. [date of 1st examination] [□ □ □ □ □ days] + [date of 2nd examination] = OK. | | |  | |  | |  | |
| At least one doctor is s.12 approved (not required for s.4). | | |  | |  | |  | |
| If neither doctor had previous acquaintance with patient, AMHP has stated reasons for this. | | |  | |  | |  | |
| AMHP has indicated outcome of requirement to inform/consult with Nearest Relative. | | |  | |  | |  | |
| Copy of AMHP report with section papers. | | |  | |  | |  | |
| If patient was transferred in from external provider, Part 1 of Form H4 states correct receiving hospital and is signed. | | |  | |  | |  | |
|  | **Med Rec 1** | | | | **Med Rec 2** | | | |
| Is there evidence of or to suspect, a mental disorder of a nature and**/**or degree which warrants patient’s detention? (Has doctor described patient’s symptoms and behaviour and explained how those symptoms and behaviour led them to their opinion?) | Y | | N | | Y | | N | |
| Is there explanation as to why it was in interests of patient’s health or safety or for protection of others, for patient to be detained? (Has doctor described patient’s behaviour and explained risk associated with that behaviour?) | Y | | N | | Y | | N | |
| Is there explanation of why patient needed to be admitted to hospital and why informal admission was not appropriate (or, where applicable, authorisation under Deprivation of Liberty Safeguards is not appropriate)? | Y | | N | | Y | | N | |

**Appendix 2**

**MENTAL HEALTH LAW SCHEME OF DELEGATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **FUNCTION** | **PRIMARY/SECONDARY LEGISLATION REFERENCE (or other as indicated)** | **CODE OF PRACTICE REFERENCE (or other as indicated)** | **AUTHORISED PERSON(S)** |
| **1** | Hospital Managers authority to detain and exercise compulsory powers in the community | MHA sections 6(2), 17A, 35, 36, 40, 45B, 135 and 136 | Chapter 37 | The Trust as exercised by its staff |
| **2** | Receipt and scrutiny of statutory documents | MHA sections 11 and 15  Regulations 3 and 4 | Chapter 35 | All Mental Health Law staff and any clinical staff at Band 4 or above (or equivalent) who have completed in-house ‘Receipt & Scrutiny’ training |
| **3** |  |  |  |  |
| **4** | Arrangements for rectification of applications and recommendations | MHA section 15 | Chapter 35 | Mental Health Law staff |
| **5** | Receipt of Nearest Relative orders for discharge under section 23 | MHA section 25  Regulation 25 | Chapter 32 | All Mental Health Law staff and any clinical staff at Band 4 or above (or equivalent) who have completed ‘Overview of MHA’ training. |
| **6** | Restrictions on discharge by nearest relative | MHA section 25 | Chapter 32 | Responsible Clinician report to be furnished to clinical staff at Band 4 or above (or equivalent) or Mental Health Law staff |
| **7** | Request for social circumstances report from social services following receipt of an application for detention made by the Nearest Relative. | MHA section 14 | Chapter 37 | Mental Health Law staff |
| **8** | Deciding if, when and where a Hospital Managers Review should take place | N/A | Chapter 38 | Mental Health Law staff |
| **9** | Hospital Managers power to discharge from compulsory powers | MHA Section 23(2)(a) | Chapter 38 | Non-executive directors and appointed Associate Hospital Managers |
| **10** | Duty of Hospital Managers to give information to patients subject to compulsory powers | MHA sections 20(3), 20A(5) and 132 | Chapter 4 | All Mental Health Law staff and any clinical staff at Band 4 or above (or equivalent) who have completed ‘Overview of MHA’ training. |
| **11** | Duty of Hospital Managers to give information to a patient’s nearest relative | MHA sections 25(2), 132(4) and133 | Chapter 4 | All Mental Health Law staff and any clinical staff at Band 4 or above (or equivalent) who have completed ‘Overview of MHA’ training. |
| **12** | Medical practitioner/approved clinician ‘nominated deputy’ power under section 5(2) | MHA section 5(3) | Chapter 18 | Duty doctor as per duty doctor rota or as otherwise set out in writing. |
| **13** | Return of patients who are absent without leave (AWOL) | MHA section 18 | Chapter 28 | Any member of staff of the Trust or any other person authorised in writing by the Hospital Managers[[1]](#footnote-1) |
| **14** | Transfer of authority to detain/exercise compulsory powers in the community | MHA sections 19 and 19A  Regulations 7, 8, 9 and 10 | Chapter 37 | Mental Health Law staff and staff at Band 5 or above (or equivalent) |
| **15** | Conveyance to Hospital on recall, transfer or other reasons | MHA sections 17C or 19  Regulations 11 and 12 | Chapter 17 | Any member of staff of the Trust or any person authorised in writing by the Hospital Managers (see AWOL above) |
| **16** | Record of detained patients moving within United Kingdom to England and Wales | MHA Part VI  Regulations 15 and 16 | N/A | Mental Health Law staff |
| **17** | Record of Renewal/Extension of compulsory powers | MHA sections 20, 20A and 21B  Regulation 13 | N/A | Mental Health Law staff |
| **18** | Evidence of admission arrangements | MHA sections 35(4), 36(3), 37(4), 38(4), 44(2) and 45A(5) | N/A | Evidence from the assigned Approved Clinician or another person authorised by that Approved Clinician. |
| **19** | Duty to refer cases to First Tier Tribunal (Mental Health), or requesting references to be made by the Secretary of State | MHA sections 67, 68 and 71 | Chapters 12 and 37 | Mental Health Law staff |
| **20** | Sending reports to First Tier Tribunal (Mental Health) | Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 | Chapter 12 | Mental Health Law staff |
| **21** | Completion of Statement of Information for First Tier Tribunal (Mental Health) | Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008.  First Tier Tribunal (Mental Health) Practice Direction 2013 | Chapter 12 | Mental Health Law staff |
| **22** | Completion of Responsible Clinician Report for First Tier Tribunal (Mental Health) | Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008.  First Tier Tribunal (Mental Health) Practice Direction 2013 | Chapter 12 | Responsible Clinician or other clinician delegated by the Responsible Clinician |
| **23** | Completion of Social Circumstances Report for First Tier Tribunal (Mental Health) | Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008.  First Tier Tribunal (Mental Health) Practice Direction 2013 | Chapter 12 | Care Co-ordinator, Social Worker or other practitioner delegated by the care co-ordinator or relevant Team Manager |
| **24** | Completion of Nursing Report for First Tier Tribunal (Mental Health) | Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008.  First Tier Tribunal (Mental Health) Practice Direction 2013 | Chapter 12 | Registered Nurse (Mental Health or Learning Disability) as delegated by Team Manager |
| **25** | Withholding Correspondence of Patients | MHA Section 134 | Chapters 4 and 37 | Staff at Band 6 or above (or equivalent) |
| **26** | Hospital Managers duty to give information to victims regarding unrestricted Part III patients | Domestic Violence, Crime and Victims Act 2004 | Chapter 37 | Responsible Clinician |
| **27** | Hospital Managers duty to ensure that in-patients under the age of eighteen (detained and informal) are accommodated in a suitable environment. | MHA Section 131A | Chapter 19 | Senior clinician with knowledge and experience of cases involving patients under the age of eighteen who suffer with a mental disorder |
| **28** | Duty on the NHS body to instruct an independent mental capacity advocate if serious medical treatment is prescribed and P who lacks capacity has no other person to consult | MCA Section 37 |  | Consultant in charge of relevant care or treatment |
| **29** | Duty on the NHS body to instruct an independent mental capacity advocate if it is proposed to move P to a hospital or care home for a period likely to exceed 28 days and P who lacks capacity has no other person to consult | MCA Section 38 |  | Consultant in charge of relevant care or treatment |
| **30** | Duty on the managing authority to alert the supervisory body for the purposes of appointing an independent mental capacity advocate when P is subject to SchA1 safeguards and there is no person to consult regarding best interests | MCA Section 39A-D |  | Ward manager |
| **31** | Duty on the managing authority to request a standard authorisation to deprive P of his liberty if P meets qualifying requirements | MCA Schedule A1 para 24) |  | Clinician with knowledge and experience of deprivation of liberty safeguards |
| **32** | Duty on the managing authority to request a fresh standard authorisation if there is one in force but there has been a change of the place of detention or circumstances | MCA Schedule A1 paras 25-30 |  | Clinician with knowledge and experience of deprivation of liberty safeguards |
| **33** | Duty on the managing authority to keep written records of requests for standard authorisation to the supervisory body | MCA Schedule A1 para 32 |  | Lead Nurse in Mental Health Law |
| **34** | Duty on the managing authority to give P information about the effects of an authorisation | MCA Schedule A1 para 59 |  | Registered Nurse (Mental Health or Learning Disability) as delegated by Team Manager |
| **35** | Duty on the managing authority to give itself an urgent authorisation in relevant cases and make a request for extension of duration | MCA Schedule A1 paras 76 & 84 |  | Clinician with knowledge and experience of deprivation of liberty safeguards |
| **36** | Duty on the managing authority to keep written records of urgent authorisations and provide a copy to the supervisory body and P or any S39A IMCA | MCA Schedule A1 para 82 |  | Lead Nurse in Mental Health Law |
| **37** | Duty on the managing authority to give RPRinformation about the effects of an authorisation | MCA Schedule A1 para 83 |  | Registered Nurse (Mental Health or Learning Disability) as delegated by Team Manager |
| **38** | Duty on the managing authority to give notice to the supervisory body that they are satisfied that P has ceased to meet the eligibility requirement or one or more of the qualifying requirements for P’s existing standard authorisation are reviewable | MCA Schedule A1 paras 91(3) & 103(2) |  | Clinician with knowledge and experience of deprivation of liberty safeguards |
| **39** | Ensuring that required mental health law policies and procedures are in place, reviewed and updated. |  |  | Associate Director of Mental Health Law |

1. For written authorisation purposes, the Scheme of Delegation directs that this function can be exercised by a Service Director, the patient’s Responsible Clinician or anyone delegated by a Service Director or the Responsible Clinician. [↑](#footnote-ref-1)