

Practice Guidance Note – Mental Health Act 1983		
Section 5(2) and 5(4) Holding Powers – V04		
V04 issued Issue 1 – Nov 15 Issue 2 – Feb 16	Planned review November 2018	MHA-PGN-02 Part of NTW(C)55 – MHA Policy
Author/Designation	Sandra Ayre - Mental Health Legislation Manager	
Responsible Officer / Designation	Rajesh Nadkarni – Acting Executive Medical Director	
Section	Content	Page No:
1	Introduction	1
2	Background	1
3	Aims and Objectives	2
4	Responsibilities	2
5	Holding powers pending applications in respect of patients already in hospital - section 5(2) and (4)	2
6	Holding power of doctors and approved clinicians under section 5(2)	3
7	Nomination of deputies	4
8	Assessment for admission while a patient is detained under section 5(2)	5
9	Ending section 5(2)	5
10	Holding power of nurses under section 5(4)	5
11	Assessment before invoking section 5(4)	6
12	Action once section 5(4) is used	7
13	Recording the end of detention of Section 5(4) and 5(2)	7
14	Monitoring use	7
15	Information	8
16	Medical treatment of patients	8
17	Transfer to other hospitals	8
18	Impact on Equality and Diversity	8
19	Training and Support	9
20	Implementation	9
21	Review and Monitoring	9

Appendix – listed separately to practice guidance note				
Document No:	Description	Issue	Date Issued	Review date
Appendix 1	Section 5 - Monitoring form	1	Nov 15	Nov 18
Hyperlinked to Patient Information Centre				
Leaflets	A4	V03	Dec 14	Dec 17
	A5	V03	Dec 14	Dec 17
	Easy to Read	V03	Dec 14	Dec 17
	A4	V03	Dec 14	Dec 17
	A5	V03	Dec 14	Dec 17
	Easy to Read	V03	Dec 14	Dec 17

1. Introduction

1.1 This practice guidance note deals with the use of holding powers available to doctors and approved clinicians under section 5(2) of the Mental Health Act 1983 (MHA) and to certain nurses under section 5(4) of the MHA within Northumberland, Tyne and Wear NHS Foundation Trust (the Trust). It should be read in conjunction with the Mental Health Act Code of Practice and the Reference Guide to the Mental Health Act.

1.2 **Definition of Terms** – for the purposes of this practice guidance note the following terms will be used;

- Mental Health Act 1883 (MHA) – Mental Health Act 1983 as amended by the Mental Health Act 2007.
- Responsible Clinician (RC) - is the approved clinician who will have overall responsibility for the patient's case
- Approved Clinician (AC) - A mental health professional approved by the Secretary of State (or the Welsh Ministers) to act as an approved clinician for the purposes of the Act.
- Nurse of the prescribed class - A nurse registered in the register of qualified nurses and midwives maintained by the Nursing and Midwifery Council, registered in sub-part 1 and 2 of the register and whose entry includes the nurse's field of practice is mental health or learning disability nursing.
- Hospital in-patient (section 5(2) context) 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 subject to a Community Treatment Order (CTO). 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 patient could be receiving treatment in a hospital for a physical condition.
- Hospital in-patient (section 5(4) context) means an in-patient who is already receiving treatment for mental disorder.

2. Background

2.1 The Code of Practice for the Mental Health Act 1983 (2015) and the Reference guide to the Mental Health Act 1983 (2015) describes the use of holding powers in detail. This practice guidance summarises this information and puts it into an operational context.

3. Aims and Objectives

3.1 This practice guidance note aims to set out the principals and procedures necessary to meet its responsibilities to service users, staff and the MHA. In doing that it aims to:

- Ensure that service users and those around them are protected with the use of holding powers when this is appropriate
- Ensure that service users understand what is happening to them when holding powers are used
- Ensure that holding powers are ended at the earliest opportunity
- Ensure the use of holding powers is monitored by the hospital managers

4. Responsibilities

4.1 Doctors and Approved Clinicians (AC) in charge of the treatment of a hospital in-patient (or their nominated deputy) and Nurses of the prescribed class will have regard to the details in this practice guidance note and highlight any issues with the operation of this document to their line manager for. Details of specific duties are given within the guidance of this document.

4.2 **Training and development** – will ensure that the use of holding powers is incorporated into the Trusts rolling programme of MHA training and will be augmented by inclusion in clinical supervision (where the need is identified) and included in junior doctors induction training.

4.3 **Mental Health Act Steering Group** – will ensure this practice guidance note is monitored, reviewed and updated as necessary.

4.4 **Registered Nurse on the ward** – will complete the monitoring form referred to in paragraph 14.1.

5. Holding powers pending applications in respect of patients already in hospital - section 5(2) and (4)

5.1 In certain circumstances, hospital in-patients may be detained temporarily in the hospital pending the making of an application, as described below. For this purpose 'Hospital' includes the premises/ grounds of the hospital.

5.2 This does not apply to patients who are already detained on the basis of an application under the Act, nor to patients subject to a Community Treatment Order (CTO), who are in hospital informally or recalled to hospital; But does include patients who are in hospital by virtue of a Deprivation of Liberty authorisation under the Mental Capacity Act 2005.

- 5.3 Detention under section 5(2) or 5(4) cannot be renewed, but that does not prevent it being used again on a future occasion if necessary.
- 5.4 The power cannot be used for an out-patient attending a hospital's accident and emergency department, or any other out-patient or day hospital. Patients should not be admitted informally with the sole intention of then using the holding power.
- 5.5 The patient is detained under the holding power by the managers of that hospital and as such can be detained in any part of the hospital that is managed by hospital managers of the ward where the patient is an in-patient. There is no authority to detain the patient in a part of the hospital that is managed by different hospital managers.

6. Holding power of doctors and approved clinicians under section 5(2)

- 6.1 The power 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 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.
- 6.2 The identity of the person in charge of a patient's medical treatment at any time will depend on the particular circumstances; but a professional who is treating the patient under the direction of another professional should not be considered to be in charge.
- 6.3 There may be more than one person who could reasonably be said to be in charge of a patient's treatment, for example where a patient is already receiving treatment for both a physical and a mental disorder. In a case of that kind, the psychiatrist or approved clinician in charge of the patient's treatment for the mental disorder is the preferred person to use the holding power.
- 6.4 The period of detention starts at the moment the doctor's or approved clinician's report is furnished (using Form H1) 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).
- 6.5 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.
- 6.6 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.

- 6.7 Doctors and approved clinicians should use the power only after having personally examined the patient.
- 6.8 Sometimes a report under section 5(2) may be made in relation to a patient who is not at the time under the care of a psychiatrist or an approved clinician. In such cases, the doctor invoking the power should make immediate contact with a psychiatrist or an approved clinician to obtain confirmation of their opinion that the patient needs to be detained. If possible, the doctor should seek such advice before using the power.

7. Nomination of deputies

- 7.1 Section 5(3) allows the doctor or approved clinician in charge of an in-patient's treatment to nominate a deputy to exercise the holding power in their absence. The deputy will then act on their own responsibility.
- 7.2 Only a doctor or approved clinician 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). Only one deputy may be authorised at any time for any patient, and it is unlawful for a nominated deputy to nominate another.
- 7.3 Doctors should not be nominated as a deputy unless they are competent to perform the role. If nominated deputies are not approved clinicians (or doctors approved under section 12 of the Act), they should wherever possible seek advice from the person for whom they are deputising, or from someone else who is an approved clinician or section 12 approved doctor, before using section 5(2).
- 7.4 Nominated deputies should report the use of section 5(2) to the person for whom they are deputising as soon as practicable.
- 7.5 It is permissible for deputies to be nominated by title, rather than by name – for example, the junior doctor on call for particular wards – provided that there is only one nominated deputy for any patient at any time and it can be determined with certainty who that nominated deputy is. This must be communicated to the ward staff so they know who the nominated deputy for a particular patient is at any given time.
- 7.6 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 to use section 5(2), nor may they complete a section 5(2) report in advance to be used in their absence. The deputy must use their own professional judgement.

8. Assessment for admission while a patient is detained under section 5(2)

8.1 Arrangements for an assessment to consider an application under section 2 or section 3 of the Act should be put in place as soon as the section 5(2) report is furnished to the hospital managers. Local Social Services Authorities should be informed at this time so an AMHP can be identified.

9. Ending section 5(2)

9.1 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

9.2 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.

10. Holding power of nurses under section 5(4)

10.1 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)

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

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

10.4 The patient may be detained from the moment the nurse makes the necessary record - using Form H2. The record must then be sent to the hospital managers.

10.5 The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else.

10.6 The Trust will ensure that suitably qualified, experienced and competent nurses are available to all wards where there is a possibility of section 5(4) being invoked, particularly acute psychiatric admission wards and wards where there are patients who are acutely unwell or who require intensive nursing care. Where nurses may have to apply the power to patients from outside their specialist field, the Trust will provide suitable training in the use of the power in such situations.

11. Assessment before invoking section 5(4)

11.1 Before using the power, nurses should assess 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 the matter 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.

11.2 In consideration of their decision nurses should consider:

- The patient's expressed intentions;
- The likelihood of the patient harming themselves or others;
- The likelihood of the patient behaving violently;
- Any evidence of disordered thinking;
- The patient's current behaviour and, in particular, any changes in their usual behaviour;
- The patient's recent communication with family and friends;
- Whether the date is one of special significance for the patient (e.g. the anniversary of a bereavement);
- Any recent disturbances on the ward;
- Any relevant involvement of other patients;
- Any history of unpredictability or impulsiveness;
- Any formal risk assessments which have been undertaken (specifically looking at previous behaviour); and
- Any other relevant information from other members of the multi-disciplinary team

11.3 Nurses should be particularly alert to cases where patients suddenly decide to leave or become determined to do so urgently.

11.3 Nurses should make as full an assessment as possible in the circumstances before using the power, but sometimes it may be necessary to invoke the power on the basis of only a brief assessment.

12 Action once section 5(4) is used

- 12.1 The reasons for invoking the power should be entered in the patient's notes. 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.
- 12.2 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.
- 12.3 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).
- 12.4 If no doctor or approved clinician able to make a report under section 5(2) has attended within six hours, the patient is no longer detained and may leave if not prepared to stay voluntarily. This should be considered as a serious failing, reported to senior management both verbally and using incident reporting systems. The incident should be investigated locally and a report made to the Quality And Performance Effective Sub Group with a copy to the MHA Steering Group.

13. Recording the end of detention of Section 5(4) and 5(2)

- 13.1 The time at which a patient ceases to be detained under section 5(2) or 5(4) should be recorded, using the form for monitoring and recording use of holding powers under sections 5(4) and 5(2) MHA 1983 available on the patients case record on RiO. This will be sent to the MHA office once complete. The reason why the patient is no longer detained under the power should also be recorded, as well as what then happened to the patient (e.g. the patient remained in hospital voluntarily, was discharged, or was detained under a different power) in the patient's records.

14. Monitoring use

- 14.1 The use of section 5 will be monitored using the form for monitoring and recording the use of holding powers under sections (5(4) and 5(2) MHA 1983 available via the patient's case record on RiO and will include the requirements of paragraph 18.39 of the Code of Practice 2015. This will be monitored by the Mental Health Legislation Team and an exception report taken to the relevant Quality and Performance Effective Sub Group and reported at the Mental Health steering Group. Assurance for compliance will be taken at the Mental Health Legislation Committee in an annual report.

15. Information

- 15.1 The nurse in charge must ensure that patients detained under section 5 are given information about their position and their rights, as required by section 132 of the Act. This will be recorded on the form for monitoring and recording use of holding powers under sections (5(4) and 5(2) MHA 1983 and on the local [H3L form on the patients case record on RiO](#).

16. Medical treatment of patients

- 16.1 Detaining patients under section 5 does not confer any power under the Act to treat them without their consent. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act.

17. Transfer to other hospitals

- 17.1 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).
- 17.2 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.
- 17.3 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.
- 17.4 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 (see chapter 15 Code of Practice 2015). 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.

18. Impact on Equality and Diversity

- 18.1 In conjunction with the Trust's Equality and Diversity Officer this practice guidance note has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner.

19. Training and Support

- 19.1 Training - Training of staff to comply with this practice guidance note will be integrated into the MHA/MCA training programme. A stand alone session may be delivered in response to local need.
- 19.2 Support for the operation of this practice guidance note and the AC role will be sought via line management.

20. Implementation

- 20.1 This practice guidance note will be implemented at ratification and reviewed in 3 years or sooner if there are changes to national or local guidance.

21. Review and Monitoring

- 21.1 This practice guidance note will be monitored by [the Mental Health Act Steering Group](#). Any issues with the operation of this PGN will be brought to the attention of the relevant Quality And Performance Effective Sub Group for any required actions.