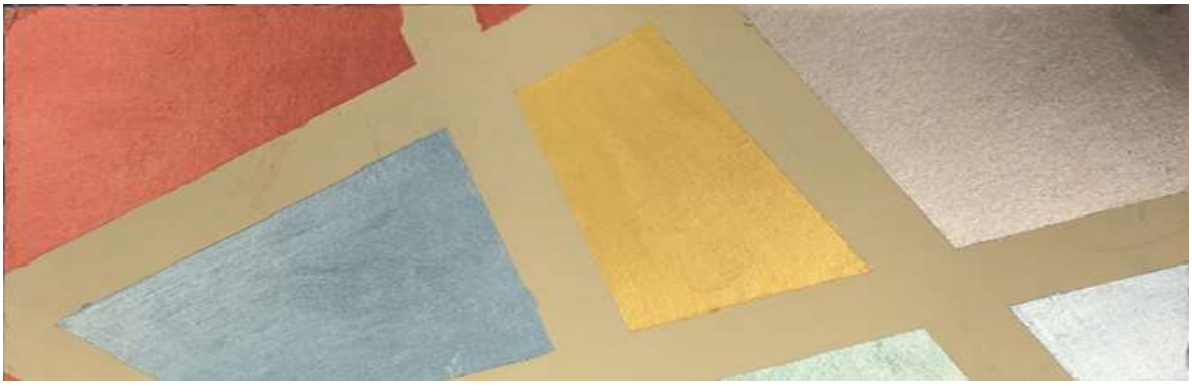
RAPID RESPONSE GUIDANCE NOTE: COVID-19 AND THE MENTAL HEALTH ACT 1983

8 April 2020



A: Introduction

1. This Rapid Response Guidance Note relating to COVID-19 and the Mental Health Act is intended to assist those involved in Mental Health Act assessments, in particular patients, nearest relatives, approved mental health professionals ('AMHPs'), and doctors. We focus on the civil admissions process, not the amendments to the criminal admissions process or to the three-month medication rule.

2. What follows is a general discussion, as opposed to legal advice on the facts of individual cases, which the team can provide. This document cannot take the place of legal advice.

B: What are the potential changes?

3. The Coronavirus Act 2020 Schedule 8 permits important changes to be made to the Mental Health Act 1983. At the time of writing, these changes have NOT yet happened. Indeed, it is hoped they will not be needed. But the pressures caused by the coronavirus are such that, if necessary, the changes can be implemented if patient safety is at considerable risk.

4. We understand that the Department of Health and Social Care will be publishing guidance in this area which will no doubt provide further detail.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

5. If the changes are implemented, we do not know whether they will take place nationally or, like the Care Act changes, be left to individual areas. Nor do we know whether there is an intention to implement only some of the changes (for instance those relating to admission, but not treatment).

6. We have produced this guidance to ensure that everyone can plan ahead in case any of the changes are made. This reduces the risk of crisis-made decisions and enables authorities to produce draft protocols, policies etc to assist staff if the time comes.

7. The main changes to civil admissions would be:

   (a) Admission under sections 2 and 3 could be made with one section 12-approved medical recommendation if the AMHP considers that getting a second medical recommendation is "impractical or would involve undesirable delay".

   (b) Some of the short-term maximum periods of detention would increase:

   - The place of safety period could increase from 24 to 36 hours (with a possible 12 hours extension if a doctor confirms that patient's condition is such that it would not be practicable to complete the assessment in time)
   - Holding powers could increase from 72 to 120 hours (for doctors) and from 6 to 12 hours (for nurses of a prescribed class).

8. The other changes relate to Part 3 (criminal admissions) and to SOAD certification. In brief, the Part 3 changes would be:

   - Remand to hospital for a report or treatment would no longer have a time limit of 12 weeks (s.35(7) and s.36(6))
   - Court orders and transfer directions can be by one medical practitioner instead of two
   - Relaxation of time limits for actually implementing orders.

9. The main changes to the treatment provisions would be:

   - Decision to give medicine without consent for a period of more than three months under MHA s.58 could be taken by the approved clinician in charge of treatment without a second opinion if it would be impractical or would involve undesirable delay
   - In certifying the treatment, the approved clinician could consult with only one other person if consulting two would be impractical or would involve undesirable delay
     - That person must have been professionally concerned with the patient's medical treatment, and

- must not be a nurse, a registered medical practitioner, the responsible clinician or the approved clinician in charge of the treatment in question.

B: One medical recommendation

10. At the moment, an AMHP cannot make an application to the hospital unless, amongst other things, two medical recommendations have been provided that confirm that the criteria for admission have been met. With some doctors in self-isolation and others being required to help deal with the coronavirus, there is a risk that there may not be enough doctors to go around which may impact on a person's access to mental health care.

11. Now more than ever, AMHPs have as vital a role to play in upholding people's human rights. Even if/when the changes are brought into force, the general rule will still apply, namely that two medical recommendations will be required and no changes have been made to guardianship, which still requires two. Although separate medical examinations are not encouraged by the Code, the MHA 1983 is already generous in permitting no more than five clear days to have elapsed between them. So if the first examination takes place on 1 May, the second can take place no later than 7 May. And the increases in the ss135/6 and s5 maximum periods will provide more time to involve the second doctor.

12. However, one medical recommendation can be used if the AMHP considers that getting a second recommendation

    (1) is impractical, or

    (2) would involve undesirable delay.

13. In this situation, the application for admission "must include a statement of the opinion" of the AMHP as to the reason relied upon for using only one medical recommendation. Given this represents a significant dilution in the statutory safeguards for compulsory detention, we suggest that this opinion must provide detailed reasons. The AMHP would have to clearly explain why for this particular patient at this particular time it was either impractical or would involve undesirable delay, with details of attempts made to secure the second doctor. It should also be noted that if one recommendation is used, it is only valid if provided by a section 12 approved doctor. The AMHP cannot therefore rely upon one medical recommendation of, for example, a non-section 12 approved GP.

"Impractical" or "undesirable delay"

14. Neither term is defined in the Act, but we suggest that "impractical" relates to the feasibilities of undertaking and completing the MHA assessment in the circumstances and timeframes permitted. As mentioned above, the increase in the detention periods for place of safety and holding powers make it more practical to involve the second doctor. So where the person is already

in a place of safety or an inpatient, unless GPs and psychiatrists are in incredibly short supply, it should be the exception rather than the norm for it to be impractical to obtain a second medical view on the admission criteria.

15. The concept of "undesirable delay" is not an unfamiliar one as it is already used in the MHA section 4 criteria. We suggest it focuses on what is undesirable for the patient, rather than for others. It cannot therefore be relied upon for administrative convenience and it is the impact of delay on the patient that ought to be the focus. An AMHP should not make a section 4 application with one medical recommendation merely because it is more convenient for them than waiting for a second doctor. According to the Code:

> *15.7 Section 4 should never be used for administrative convenience. So, for example, patients should not be admitted under section 4 merely because it is more convenient for the second doctor to examine the patient in, rather than outside, hospital.*
>
> *15.8 An emergency may arise where the patient's mental state or behaviour presents problems which those involved cannot reasonably be expected to manage while waiting for a second doctor. To be satisfied that an emergency has arisen, the person making the application and the doctor making the supporting recommendation should have evidence of:*
>
> *• an immediate and significant risk of mental or physical harm to the patient or to others*
>
> *• danger of serious harm to property, or*
>
> *• a need for the use of restrictive interventions on a patient (see chapter 26).*

16. It is also important to stress that "undesirable delay" for what is presently section 4 purposes relates to a maximum 72-hour period before either the patient is discharged from detention or a second medical recommendation is provided resulting in a section 2 admission. Whereas in the coronavirus context, "undesirable delay" with a single recommendation for a section 3 could lead to a period of detention for up to 6 months.

Section 4 emergency admissions

17. The main issue here is whether the AMHP could/should proceed with a section 4 admission on the basis of one medical recommendation or to proceed straight to a section 2 on the "impractical/undesirable delay" ground. Our interpretation of this is that there is nothing in the 2020 Act that precludes the use of section 4 admissions. The Coronavirus Act 2020 states:

> *"An emergency application under section 4 may not be founded on a single recommendation (but this does not limit section 4(3))."* (Sch 8, para 3(4))

MHA s4(3) states:

> *"An emergency application shall be sufficient in the first instance if founded on one of the medical recommendations required by section 2 above, given, if practicable, by a practitioner who has previous acquaintance with the patient and otherwise complying with the requirements of section 12 below so far as applicable to a single recommendation, and verifying the statement referred to in subsection (2) above."*

The statement referred to is "*that it is of urgent necessity for the patient to be admitted and detained under section 2 above, and that compliance with the provisions of this Part of this Act relating to applications under that section would involve undesirable delay*".

18. Whilst section 4's tend to be rare, their use may increase in these pandemic circumstances. Section 4 is an emergency half-way house to a section 2, where the AMHP has one medical recommendation but the urgent necessity to admit to hospital and the undesirable delay on waiting for a second doctor is such as to warrant the 72-hour period of detention. This then provides time for a second section 2 medical recommendation to be provided.

19. The key point we think is that the statutory definition of "single recommendation" refers to both section 2 and 3 admissions. Whilst a section 4 admission is founded upon one recommendation this is not the same as a "single recommendation" as defined in the 2020 Act. Moreover, it is clearly unlawful to make a section 4 application with a single section 3 recommendation. Going from section 4 to section 3 would usually require two fresh section 3 medical recommendations. Note, however, that if this comes into force, it would be possible to go from a section 4 to a section 3 with a single recommendation if the exception applied. However, AMHPs would no doubt be very reluctant to do so.

20. It will be interesting to see whether AMHPs opt for a section 4 rather than straight to a section 2 based on a single recommendation. The former would certainly be less restrictive of the person's rights, as the detention maximum remains 72 hours which provides time to get a section 12 doctor to proceed to a section 2 admission. A section 4 also has the advantage that it can proceed with the recommendation of a GP rather than section 12 approved doctor.

21. For admissions from the community, AMHPs and doctors may therefore wish to focus on sections 4 and 2 (not section 3) admissions where a second recommendation would be impractical or involve undesirable delay. Where a patient is already detained under section 2, forward planning by the hospital treating team should ensure that the two medical recommendations are secured in a timely fashion for continued detention under section 3.

22. No changes have been made to the nearest relative provisions. So AMHPs must still inform the nearest relative of a section 2 admission and consult with the nearest relative for a section 3 admission in the usual way. The increases to the place of safety and holding power periods provides more time to inform/consult. Indeed, the fact that the nearest relative is more likely to be at their home should generally make them more accessible. If the AMHP visits the nearest

relative's house, of course ensure that social distancing measures are followed.

Doctors and personal examinations

23. Only a section 12 approved doctor's medical recommendation can be relied upon if the AMHP makes the section 2 or 3 application on the basis of a single recommendation. Although it would be preferable, there is no statutory requirement for the section 12 doctor to have previous acquaintance with the patient.

24. Section 12(1) states that the doctor must have "personally examined the patient". The MHA Code of Practice states:

> *14.71 A medical examination must involve:*
>
> *• direct personal examination of the patient and their mental state, and*
>
> *• consideration of all available relevant clinical information, including that in the possession of others, professional or non-professional.*
>
> *14.72 If direct physical access to the patient is not immediately possible and it is not desirable to postpone the examination in order to negotiate access, consideration should be given to requesting that an AMHP apply for a warrant under section 135 of the Act (see paragraph 14.55 and chapter 16).*
> *…*
>
> *14.55 It is not desirable for patients to be interviewed through a closed door or window, and this should be considered only where other people are at serious risk. Where direct access to the patient is not possible, but there is no immediate risk of physical danger to the patient or to anyone else, AMHPs should consider applying for a warrant under section 135 of the Act allowing the police to enter the premises (see chapter 16).*

25. We address personal protective equipment below, but in this context doctors must of course consider the physical distancing rules. A doctor can examine by observing the person's conduct over a sufficient period of time, even if s/he refuses, for example, to answer questions or to submit to a physical examination or is otherwise hostile and unco-operative.[2] Indeed, the patient would be perfectly entitled to require the doctor to keep a distance given the physical distancing rules.

26. One issue that might arise is to what extent, if at all, can the "personal" examination be carried out on screen (ie virtually) rather than in person. This is unlikely to arise where the Mental Health Act assessment is taking place in hospital where, even if the person is displaying COVID-19 symptoms, the doctor can take precautionary steps whilst personally examining them. But the issue might

[2] R. *(on the application of M) v The Managers, Queen Mary's Hospital* [2008] EWCA Civ 1112; [2008] MHLR 306, paras 25-26 where it was said that there is no set time that must be taken for an examination to qualify under this provision; what is required is a matter for the professional judgment of the doctor.

arise where the person is at home, understandably not wanting others to enter for fear of contracting the virus. Could the doctor "personally" examine on screen?

27. Whilst the Royal College of Psychiatrists' guidance generally encourages the use of remote consultations to avoid unnecessary travel and face-to-face contact, this is not specific to MHA assessments.[3] We therefore await the government's guidance which we hope will consider this issue as opinions may vary.

C: Short-term detention powers extended

Holding powers

28. The holding powers of mental health/learning disability nurses can be increased from 6 to 12 hours. The doctors' holding powers can increase from 72 to 120 hours and, unlike at present, the doctor or approved clinician need not be the one in charge of the patient's treatment if this is impractical or would involve undesirable delay. Note that section 5 still only refers to in-patients. The nurses' power can only be used if the in-patient is receiving treatment for mental disorder. The doctors' power is available for any in-patient. And the purpose of section 5 has not changed, namely to undertake a MHA assessment.

Place of safety

29. The increase from 24 to 36 hours may not make a dramatic difference in practice as the usual challenge is to find a hospital bed. But given the possible increasing risk of hospital-acquired coronavirus infection, what we might see is a greater use of other places of safety, such as crisis assessment centres. Indeed, the meaning of "place of safety" is very broad and can include "any other suitable place" which could be a person's home if they agree for it to be used as such (s135(6)-(7)).

D: Other issues

Suitable manner

30. AMHPs must interview the patient in a suitable manner (s13(2)). Government guidance should be followed, and steps reasonably taken to see whether the person has a new/continuous cough and/or a temperature of 37.8C or above. All those involved in MHA assessments must consider the physical distancing rules and have available to them any necessary personal protective equipment ('PPE'). It is important to bear in mind that the risk of coronavirus could be passed from the assessment team to the patient or vice versa. Whilst a MHA assessment can be frightening to a person at the best of times, it may be especially so if the assessors are fully covered in PPE. So

[3] Hayden J in *BF v Surrey County Council* [2020] EWCOP 17 also held that it was lawful for purposes of DoLS for an assessment of capacity to be done in such a fashion. The MCA 2005 does not have, however, have the same statutory requirement of personal examination, so the assistance from this case may be limited.

there is much to bear in mind when working out how to undertake an assessment.

Electronic communication

31. One issue upon which further guidance is required is the extent to which medical recommendations and AMHP applications can be written and signed electronically. Simon Lindsay, Partner at Bevan Brittan suggests that a medical recommendation cannot be transmitted electronically because the Regulations do not expressly permit it. Ross Tomison of Thalamos considers that, provided all other formalities have been met under the Act, an electronic signature can be legally valid.

Section 117 after-care

32. Unlike the changes made to the Care Act 2014, the Coronavirus Act 2020 makes absolutely no changes to section 117 after-care arrangements. This is particularly important as there may be competing demands upon community-based options and services to facilitate the discharge of detained patients.

IMHAs

33. Again, the legislation makes no changes to IMHA services. We anticipate that creative ways will need to be found to ensure detained patients are able to (virtually) access advocacy services.

Section 17 leave

34. No changes have been made in this regard. But it is important to note that section 17 leave is only required from the "hospital". If the grounds form part of the "hospital" then no section 17 is required and instead a risk assessment (which need not be undertaken by the responsible clinician) can determine whether a patient can go, for example, into the grounds to smoke. The Code helpfully states:

> *27.7 What constitutes a particular hospital for the purpose of leave is a matter of fact which can be determined only in the light of the particular case. Where one building, or set of buildings, includes accommodation under the management of different bodies (eg two different NHS trusts), the accommodation used by each body should be treated as forming separate hospitals. Facilities and grounds shared by both can be regarded as part of both hospitals.*

35. Blanket policies regarding the use of section 17 leave must be avoided. When leave of absence is granted, we see no reason why the responsible clinician cannot attach a condition that the patient adheres to physical distancing rules.

Magistrates Court warrants

36. Magistrates are mostly virtual and continuing to do urgent work, which includes the issuing of MHA s.135 warrants.

CTOs

37. There is no legal requirement for an AMHP to see the patient but this is best practice. The Code at para 29.22 states that the AMHP "*should meet with the patient*" before deciding whether a CTO is appropraite. Again, physical distancing rules should be adhered to and, if the circumstances require it, there is no reason why this meeting could not be carried out remotely.

Tribunals and hospital managers hearings

38. Through changes brought about by a Pilot Practice Direction[4] in England and the Coronavirus Act in Wales, judges are (whether or not the wider changes to the MHA 1983 come into force) already likely to be sitting alone and remotely. Whilst this is necessary it does of course lose a degree of connection with the patient, results in a loss of professional insight of the other tribunal members, and presents difficulties in assessing the patient's life in hospital. In short, there is a risk of the patient being further alienated. Justice must not only be done but must be seen to be done. Face-to-face virtual hearings are therefore far better than telephone hearings. The same applies to hospital managers hearings.

Actions to mitigate impact of workforce shortages

39. NHS England has helpfully provided some guidance which suggests the following mitigating actions:

    - Additional administrative resource to support the local section 12 rota: there will be staffing changes locally and these need to be well-managed and communicated.[5]
    - NHS providers and local authorities to consider how to support each other in operating out-of-hours services.
    - If necessary, access to and support from IMHAs should be arranged virtually, with the assistance of appropriate digital technology, to ensure this critical safeguard is maintained.
    - Clear and accessible information to ensure people and their families are aware of any operational changes and how they can access support.
    - Local systems to ensure s140 agreements in relation to bed availability are in place and updated in light of COVID-19.
    - Close working with the ambulance service, and in some instances secure transport, with

[4] Pilot Practice Direction: Health, Education and Social Care Chamber of the First-Tier Tribunal (Mental Health), 19 March 2020:

[5] The Department of Health and Social Care is extending the licences of section 12 doctors and approved clinicians. Licences will be extended for 12 months, either from the next expiry date or from the date of application for licence renewal from doctors whose approvals have lapsed within the previous 12 months.

regards to conveying individuals detained under the MHA.

- Advanced planning for MHA work where possible, eg identifying all sections in need of renewal over the coming weeks to help plan resources effectively.
- Collaboration with the Criminal Justice System to facilitate assessments, transfers and remissions.
- Strong communication between the management of the section 12 rota and AMHP rota locally.
- Close liaison with the tribunal services and MHA review managers regarding tribunals and MHA review managers' hearings respectively.
- Identification of colleagues with AMHP warrants who may not be on the rota, or individuals who need refresher training to be able to be on the rota, to ensure AMHP capacity.
- Dedicated senior operational resource to co-ordinate demand for MHA work, bringing together all requests across admissions, s136 suites, community treatment order recalls, section renewals, the Criminal Justice System, tribunals, etc.

G: Useful resources

40. Useful free websites include:

- www.39essex.com/resources-and-training/mental-capacity-law – database of guidance notes (including as to capacity assessment) case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Report, to which a free subscription can be obtained by emailing marketing@39essex.com.
- www.mclap.org.uk – website set up by Alex with forums, papers and other resources with a view to enabling professionals of all hues to 'do' the MCA 2005 better.
- www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.
- www.scie.org.uk/mca-directory/ - the Social Care Institute of Excellence database of materials relating to the MCA.

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