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2

Mental Health Legislation

Julie Chalmers

Introduction

This chapter will give an overview of mental health legislation as it applies to England and Wales, discuss some key concepts, and highlight the principles underpinning the law. Clinical staff need to have a working knowledge of all three elements to play their part in protecting and upholding the rights of individuals who are admitted to the inpatient unit.

People with psychiatric disorders can number among the most vulnerable in society and often experience a marked imbalance of power in their interactions with health care staff. Research has confirmed that perceived coercion is commonly experienced by people with mental disorders irrespective of whether mental health legislation has been used or not (1, p. 108).

Getting the approach right from the first point of contact and throughout the admission by applying the law through the lens of the principles underpinning the legislation may help reduce the sense of disempowerment and increase the likelihood of better outcomes (2).

Human rights

Human rights are basic rights and freedoms that protect everybody simply by virtue of being human. The British Institute of Human Rights has summarized the important rights with the easy to remember acronym FREDA: fairness, respect, equality, dignity, and autonomy (3). Everyone working on the ward has a part to play in upholding human rights, not just those in senior positions or those with statutory roles. As Eleanor Roosevelt, the first chair of the United Nations Commission on Human Rights, said: 'Where, after all, do universal human rights begin? In small places, close to home … so close and so small that they cannot be seen on any map of the world' (4).

There are several international statements and declarations outlining human rights in general or referring to the rights of those with disabilities which the UK government has agreed to be bound by but has yet to enact the relevant legislation to give the statement or declaration effect in domestic law. One exception is the European Convention on Human Rights (ECHR) as this does have legal effect. The Human Rights Act 1998 which came into force in 2000 enshrines the ECHR in English law so that it is now unlawful for a public body, such as the National Health Service, to act in a way incompatible with the Convention (Box 2.1).

Box 2.1 Further information about human rights

- MIND—Human Rights Act 1998: http://www.mind.org.uk/information-support/legal-rights/human-rights-act-1998/about-the-human-rights-act/#.WFfBwVOLR0w (5).
- More detailed work on human rights specifically written for psychiatrists by Brendan Kelly provides a good outline of non-binding declarations (6).
- Review of Articles 3 and 8 by Curtice (7–9).

Coming into hospital: an introduction

It is important that clinicians identify the appropriate legal framework governing admission to ensure the correct processes are followed and safeguards put in place. An adult admitted to an inpatient mental health unit will come into hospital under one of three legal frameworks:

1. Those with capacity, who have sufficient information and are free from the undue influence of others, can give their informed consent to admission.
2. The Mental Capacity Act 2005 (MCA) including, where necessary and relevant, consideration of the use of provisions to authorize a deprivation of liberty using the Deprivation of Liberty Safeguards (DoLS).
3. The Mental Health Act 1983 (MHA) including recall from a community treatment order (CTO).

The term informal admission simply refers to the group of patients who are not subject to detention under the MHA. Until very recently, informal patients were in the majority, although this may not have always been the case in some inner-city wards. In 2014/2015 overall, formal admissions are now just possibly exceeding informal ones (10, p. 9). This may be because of increased awareness of the need to protect Article 5 ('Right to liberty and security', ECHR) rights since the Supreme Court judgment (see 'The importance of Article 5') or reflect the severe degree of illness of the patients needing to access a reducing number of inpatient beds (11).

These legal categories are not mutually exclusive and the legal status of a patient may change over time and on occasions the legal regimes may need to run in parallel when there is a physical condition requiring treatment that is separate from the mental disorder.

The MHA does not cover treatment of a physical problem unrelated to the mental disorder so consent must be sought specifically. Depending on whether the person has capacity then the common law of consent or, if lacking capacity, the MCA will come into play for the treatment of the physical disorder.

Capacity

In deciding which framework is appropriate, it is necessary to identify if there is any evidence to rebut the presumption that a person has the capacity to make the decision in question. Capacity is a complex construct which refers to a set of functional abilities that a person needs in order to make a specific decision. UK law places considerable weight on self-determination and an adult who has capacity can refuse an intervention, however unwise that refusal might be, and this refusal must be respected and cannot be overruled even it would result in death. The exception is that when detained under the MHA, a person's decision to refuse assessment or treatment for a mental disorder can be overridden even if they have capacity. This, however, would be a very substantial step and the reasons for doing so would need to be justified. It should not be assumed that because a person suffers from a mental disorder, even one of a nature or degree requiring hospital admission, their capacity to make a particular decision for themselves will necessarily be impaired.

Capacity is time and decision specific and therefore clinicians should always remember that the standard documentation used by some hospitals to document capacity at the point of admission or when seeking consent to treatment is not fixed in stone and capacity must be regularly reassessed. The legal test of capacity is found in the MCA and will be considered later.

The importance of Article 5

Before considering the process of admission to the inpatient unit in more detail, it is essential that practitioners understand the obligations that are placed on them arising from the ECHR. The convention was drafted in the aftermath of the Second World War when millions had suffered arbitrary detention and had no recourse to appeal. The era in which it was written has shaped the language used, particularly in Article 5(1)e where people with mental disorder are referred to as 'persons of unsound mind'.

Article 5 states in part:

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
   e. the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.
4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.[1]

[1] Contains public sector information licensed under the Open Government Licence v3.0 (http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/).

Box 2.2 Pointers to a deprivation of liberty

- A request by carers for discharge is refused.
- Restraint.
- Sedation.
- Staff exercise complete and effective control over the care and movement of the person.
- Contact with family and friends is restricted by staff.
- The person loses autonomy because they are under continuous supervision and control.
- A decision has been taken that the person will not be allowed to live elsewhere or released into the care of others without permission.
- Unable to maintain social contacts without restrictions.

Deprivation of liberty

Article 5 of the ECHR requires that any deprivation of liberty must be authorized by a procedure prescribed by law. In order to fulfil this legal requirement, clinicians need to be able to identify when a deprivation of liberty is potentially occurring. What constitutes a deprivation of liberty is a much broader concept than one of simple physical confinement and often includes restrictions of Article 8 rights ('Right to private and family life'). The DoLS Code of Practice at paragraph 2.5 identifies some possible pointers that a deprivation of liberty may be occurring (12) (Box 2.2).

These factors are still important but must now be read in the light of a decision of the Supreme Court in what is commonly referred to as the *Cheshire West* case although other parties were involved (13). Lady Hale identified the two questions, which she referred to as the 'acid test', and if the answer to both parts is yes then this would identify if a deprivation of liberty was occurring when the person lacked capacity to consent to the arrangements for their care or treatment (Box 2.3).

It is clear from European court judgments that the first element is not limited to those who are under continuous physical supervision (such as close observation) but is to be interpreted more broadly than that (14). Additionally, the person may not be asking to go or showing by their actions that they want to but the key issue is about how staff would react if the person did try to leave or if relatives/friends asked to remove them.

The Supreme Court also identified factors that are no longer relevant to whether someone is deprived of their liberty. Their Lordships highlighted that whether a person objects or not to their care plan is irrelevant in determining whether there is a deprivation of liberty. As Lady Hale commented, 'a gilded cage is still a gilded cage' (15). This means that if a person is subject both to continuous supervision and control and is not free to leave they are deprived of their liberty irrespective of whether they are objecting or not. Given that patients on an inpatient unit are subject to a degree of continuous supervision

Box 2.3 The 'acid test' to identify if a deprivation of liberty is occurring

Part 1: is the person subject to continuous supervision and control?
And
Part 2: is the person free to leave?

Box 2.4 Deprivation of liberty resources

- *Mental Capacity Act 2005: Deprivation of Liberty Safeguards—Code of Practice to supplement the Mental Capacity Act 2005 Code of Practice* (http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf) (12).
- The Law Society. *Deprivation of Liberty: A Practical Guide* (9 April 2015) (http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/).
  - This document was commissioned by the Department of Health and is written from a legal, not clinical, perspective.
- Deprivation of Liberty Safeguards—six modules designed for doctors wanting to be authorized to undertake a specific function under DoLS (https://www.e-lfh.org.uk/programmes/deprivation-of-liberty-safeguards/). Useful introduction to deprivation of liberty including discussion of case law and also a helpful module on capacity assessment.

and many would not be free to leave then a number of inpatients will require protection of their Article 5 rights. This will most usually be by use of the MHA although there are currently very limited circumstances in the adult psychiatric setting where DoLS (the safeguards) could legally be used and these will be discussed later.

If a person lacks capacity and there is *no* deprivation of liberty, then a person can be treated for their mental disorder under mental capacity legislation without a need to invoke a legal procedure to protect their Article 5 rights. However, should they object to treatment then consideration of the use of the MHA would be required rather than to continue to rely on the MCA. Considerable attention needs to be given to whether someone is objecting or not as signs may be very subtle (16) (Box 2.4).

Legal frameworks: admission

Consent

A person can consent to be admitted to a psychiatric hospital if they have:

1. the capacity to make the decision and
2. sufficient information on which to base their decision, including the foreseeable consequences of not being admitted and
3. are free from undue duress or influence.

Most people will have a notion of what being on a general hospital ward for treatment of a physical illness involves through personal or family experience or even through numerous reality and fictional TV programmes. The 'rules of engagement' are broadly understood. This is not necessarily the case when considering admission to a psychiatric hospital. Practitioners do not always describe institutional restrictions of being on a psychiatric ward due to either simple omission or a reluctance to give the full facts in case these will sound unappealing and will negatively influence the decision to be admitted. However, it is not respectful of autonomy to fail to provide the necessary information in a balanced way. It has been suggested that there is key information a person must have to decide whether to come into a psychiatric hospital (17, 18) (Boxes 2.5 and 2.6). A person, who has capacity and is fully informed of the restrictions and limitations of the ward environment and makes the decision free from undue pressure, can consent to a care plan that amounts to a deprivation of liberty. Great care must be taken in how these discussions are framed as one study found that high levels of coercion were perceived by 48% of voluntarily admitted patients and a high score was associated with a poor therapeutic relationship which could negatively impact further experience of services and on the outcome (19).

Box 2.5 Key information to decide whether to come into a psychiatric hospital

1. That the person will be admitted to a mental health hospital for care and treatment for a mental disorder.
2. That the doors to the ward will be locked.
3. That staff at the hospital will be entitled to carry out property and personal searches.
4. That the person will be expected to remain on the ward at least until being seen by a doctor, and most likely for at least the first 24 hours of their admission.
5. That the person will be required to inform the nursing staff whenever they want to leave the ward, providing information about where they are going and a time of return.
6. That the nursing staff may refuse to agree to the person leaving the ward (including use of the MHA) if the nursing staff believe that the person may be at risk (from themselves, or from other people) or may pose a risk to others if they leave the ward.
7. That if the person leaves the ward without informing the staff, or fails to return at the agreed time, the staff will call the police who will make attempts to find them.
8. That the person's description will be recorded by staff for the purpose of point 7.
9. In addition, it is important to include the likely consequences of the person not being admitted. This will of course vary with each individual and their personal circumstances.
10. That they will not be able to smoke (include vaping) but they will be offered nicotine replacement.

The Mental Capacity Act 2005

The MCA is the legal framework for decision-making on behalf of those who are aged over 16 and lack the capacity to do so for themselves. The statute begins by laying out the principles underpinning the operation of this statute. These are summarized as follows:

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

Box 2.6 Consent resources

- General Medical Council: 'Consent: patients and doctors making decisions together', 2008 (http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp).
- General Medical Council: ten questions about consent—with useful links to various guidance including link to important legal developments (http://www.gmc-uk.org/guidance/29457.asp).

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.[2]

The MCA does not confer any specific powers, unlike the MHA, but instead provides protection from legal liability in connection with any acts carried out on behalf of an incapacitated person if done in their best interests (Section 5, MCA). Section 6 of the MCA defines the limits of Section 5 and allows restraint to prevent harm to the persons, but not others, and does not authorize a deprivation of liberty.

The documentation of such decisions leading to acting in the absence of consent needs to outline the evidence that the person lacks capacity to make the specific decision, and what steps have been taken to help them regain capacity or to participate in decision-making, best interests decision-making including reference to their known wishes or preferences, and consideration of the least restrictive option. Care plans should not only be developed with the patient in so far that this is possible but also refer to these important aspects of the MCA if seeking to rely on the legal protection conferred by Sections 5 and 6 of the MCA.

When approaching a capacity assessment, the first three principles underpinning the MCA must be at the forefront of the clinician's mind, namely the presumption in favour of capacity, the need to support decision-making, and that unwise decisions do not necessarily indicate a lack of capacity. Of course, an extremely unwise decision or one that is out of character should prompt more careful scrutiny by the assessor to identify if there is any evidence of impairment of decision-making capacity arising directly because of mental disorder. It is not up to the patient to 'prove' they have capacity, it is up to the assessor to find evidence to overturn this starting position.

The test of capacity is contained in Sections 2 and 3 of the MCA and comprises two arms, sometimes referred to as the 'diagnostic test' and the 'functional test'. Section 2 of the MCA states:

(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
(2) It does not matter whether the impairment or disturbance is permanent or temporary.

Common conditions encountered in an inpatient setting such as schizophrenia, affective disorder, and, in older adult wards, organic conditions such as dementia will fulfil the diagnostic test. It is important to be aware that personality disorder and autistic spectrum disorder are also considered to be conditions that could potentially give rise to an impairment or disturbance of mind or brain.

[2] Contains public sector information licensed under the Open Government Licence v3.0 (http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/).

The second arm is the 'functional' test which states that a person is unable to make a decision for himself if he is unable:

- to understand the information relevant to the decision
- to retain that information
- to use or weigh that information as part of the process of making the decision, or
- to communicate his decision (whether by talking, using sign language or any other means).

It is not sufficient that there is an impairment or disturbance of mind or brain and some evidence of functional impairment. It is essential that the assessor be satisfied that the inability to make a decision is *because* of the impairment of the mind or brain and for this direct link to be clearly documented.

What are best interests?

The MCA does not define best interests and the MCA Code of Practice states at Section 5.5:

> The term 'best interests' is not actually defined in the Act. This is because so many different types of decisions and actions are covered by the Act, and so many different people and circumstances are affected by it.

Rather than define best interests, the Act outlines a process by which the decision maker acting on behalf of the person without capacity can come to a conclusion as to what is in the person's best interests. The MCA in Section 4 outlines a checklist of people to be consulted including the person's past wishes (if known) and their current preferences. This checklist is unweighted so no one point of view takes precedence over the other. It is up to the decision maker to identify what is objectively the best option taking a broad view of interests, not just medical interests. However, recent case law has placed increasingly more weight on the person's preferences both past and current and it is essential that such views be identified wherever possible and given due consideration (20).

Planning in advance

The MCA contains mechanisms to allow a person, who is over 18, to plan for future incapacity while capacity is retained. These are:

- advance decisions to refuse treatment
- Lasting Power of Attorney (LPA)
- property and affairs
- welfare.

Advance decisions to refuse treatment

A valid and applicable advance decision will be legally binding and with the exception of refusal of life-sustaining treatment need not be in writing. A person can refuse treatment for either a mental or physical disorder but not for basic care. A well-known example of an advance decision to refuse treatment is the refusal of blood and blood products by Jehovah's Witnesses who carry cards to this effect. Advance decisions to refuse treatment are a way of protecting autonomy when capacity to make a specific decision is lost, although if detained under the MHA some decisions about treatment for mental health may be overridden. Clinicians working in inpatient units need to establish whether any such instruments exist and bring these to the attention of senior clinicians, indeed this should be a routine part of the admission procedure. Decisions concerning

Box 2.7 Validity and applicability of an advance decision to refuse treatment

Validity

- Capacity at the time of making an advance decision.
- Must have had sufficient information to make decision.
- Must understand the consequences of not receiving treatment—especially if refusing life-sustaining treatment.
- Freedom from duress.
- No suggestion that advance decision has been revoked.
- Evidence that this has remained fixed view.

Applicability

- Not applicable if person has capacity to make a decision at the time the decision needs to be made.
- Not applicable if the treatments proposed are not specified.
- If circumstances specified in the advance decision are absent.
- If reasonable grounds for believing current circumstances were not anticipated and, if they were, they would have affected the decision.

physical care may be particularly relevant in the care of older adults who have made advance decisions to refuse treatment prior to losing capacity. Establishing if an advance decision to refuse treatment is valid and applicable can be challenging and legal advice may need to be sought in complex cases (Box 2.7).

Advance statements

Advance statements are not legal instruments but can be a useful tool as part of the recovery model/crisis planning. They may also inform best interest decision-making by describing important values or preferences. An advance statement cannot compel a doctor to provide a specific treatment and resource considerations will also apply. In the spirit of empowerment and involvement, such statements should be followed whenever possible.

Lasting Power of Attorney

For the first time in English law, a third party, who is legally authorized to do so, may give or refuse consent on behalf of an adult who lacks the capacity to decide for themselves at the material time. One or more attorneys may be appointed when the person has capacity. There are two types of LPA, namely 'property and affairs' and 'health and welfare'.

The scope of authority may be defined and the attorney(s) must always act in the person's best interests. As with an advance decision to refuse treatment, attorneys can be appointed to make decisions about mental health treatment although they may be overridden in certain circumstances. They cannot, however, agree to a deprivation of liberty, which will need to be authorized by using the appropriate legal mechanism. The Court of Protection may appoint a deputy or deputies who, if granted authority to do so, will be able to act in a way similar to the holder of an LPA. The relationship between the MCA and mechanisms for planning in advance will be further considered under the section on treatment under the MHA.

Deprivation of Liberty Safeguards

The DoLS were introduced following the case of *HL* v *UK*, often referred to as the 'Bournewood' case when this was going through the domestic courts. This case concerned an autistic man who lacked capacity to decide if he should be admitted to a hospital, in this instance, a psychiatric hospital. This case preceded the enactment of the MCA and he was admitted without use of any formal powers under common law on the grounds that this was in his best interests. His carers wished for him to be discharged home but this was refused and so they challenged this in the domestic courts and then in the European Court of Human Rights. The European Court of Human Rights identified that the legal framework at the time failed to provide adequate protection to individuals who lacked capacity and who were deprived of their liberty and that the State was in breach of their obligation to protect against unlawful deprivations of liberty as required to under Article 5.

DoLS were introduced in April 2009 as an amendment to the MCA. The Law Commission published proposals in 2017 for a new scheme to replace DoLS to protect Article 5 rights and a new bill, Mental Capacity (Amendment) Bill 2018, is currently being debated in parliament therefore the current safeguards will not be discussed in any further detail. The principles and reasons for the need for Article 5 protection remain, however, although the processes for doing this are likely to change.

The Mental Health Act 1983

The purpose of the MHA is for 'the reception, care and treatment of mentally disordered patients' (Section 1(1)) and the MHA provides authority to deprive someone of their liberty on the grounds of their mental health and to treat in the absence of consent provided certain criteria are fulfilled. These are substantial powers that impact individual rights and freedoms albeit with a legitimate aim of maintaining health and/or safety. The principles underpinning the MHA and a description of how they might be applied are contained in chapter 1 of the MHA Code of Practice and should be essential reading for all inpatient staff (Box 2.8). The Code was revised in consultation with expert opinion, practitioners, and most importantly involvement of users by experience and carers and was published in 2014. Although not part of the primary legislation (unlike the MCA), the Code must be followed by mental health professionals unless there are 'cogent reasons' for deviating from it (21, 22).

Formal admission under the Mental Health Act

Formal admissions to the acute inpatient unit will occur most commonly under Section 2 for assessment, which can also include treatment, and can last up to 28 days and is not renewable, or for treatment under Section 3, which can last up to 6 months in the first instance although, if certain criteria are met, this period can be extended.

Both sections require two medical recommendations, one of which must be made by a specially approved doctor, referred to as being Section 12 (2) MHA approved. Application for admission is

Box 2.8 The principles underpinning the Mental Health Act

- Least restrictive option and maximizing independence.
- Empowerment and involvement.
- Respect and dignity.
- Purpose and effectiveness.
- Efficiency and equity.

made by an Approved Mental Health Professional (AMHP) who comes from one of four qualifying professions (nursing, social work, psychology, occupational therapy) and who has had an extensive training to undertake the role. The Act also allows for an application to be made by a nearest relative but in practice this almost never occurs.

Very rarely, a patient will be admitted under Section 4, a short-term section lasting 72 hours, used on the basis of urgent necessity requiring just one medical recommendation to support the application by an AMHP or relative. Section 4 can, with a second medical recommendation made within the 72-hour period, be converted into a Section 2.

The criteria for detention are that the patient suffers from a mental disorder, defined as 'any disorder or disability of mind' that warrants detention in hospital on the grounds of:

- health and/or
- safety and/or
- with a view to the protection of other people.

For Section 3 there is an additional criterion that 'appropriate treatment be available'.

It is the right of every detained patient, other than those on short-term sections (Section 4, Section 5(4), and Section5(2)) that, as soon as practicable following admission, they must be given information both orally and in writing about how the Act applies to them. Chapter 4 of the Code of Practice (4.13–4.14) outlines the information which must be supplied.

The 2007 amendments to the MHA introduced the statutory right to advocacy for patients detained on other than the short-term sections. Section 6.3 of the Code of Practice describes the purpose of Independent Mental Health Advocates (IMHAs) as follows: 'IMHA services provide an additional safeguard to patients who are subject to the Act. IMHAs are specialist advocates who are trained specifically to work within the framework of the Act and enable patients to participate in decision making, for example, by encouraging patients to express their views and supporting them to communicate their views'. Both the provision of information and the involvement, if wanted by the patient, of an IMHA are concrete ways of bringing the principles of empowerment and involvement to life. Unfortunately, there is evidence from Care Quality Commission (CQC) inspections that this is not always followed in a minority of patients (10, p. 6).

Recall of a patient subject to a community treatment order

Inpatient staff must be aware of the differences between admission under Section 2 or Section 3 of the MHA and recall of a CTO as certain reviews and decisions must be made within the 72-hour duration of the recall.

Under the civil provisions of the Act, a patient can only be placed on a CTO having been on a Section 3 and if certain criteria are fulfilled. Once on a CTO, the underlying Section 3 goes into hibernation. The criteria for making a CTO are similar to those for detention under Section 3 (mental disorder/nature and degree/necessity criteria/appropriate treatment) but in this instance the patient no longer requires detention in hospital for treatment but could be managed in the community if the Responsible Clinician (RC) had authority to recall the patient in order that treatment could be administered. The RC is a specially approved clinician in overall charge of the patient, most usually, but not always, a consultant psychiatrist. The Code of Practice states at paragraph 29.45: 'The recall power is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before the situation becomes critical and leads to the patient or other people being harmed.'

The power of recall is different from admission under the MHA in the following ways. The RC alone recalls the patient unlike detention under Sections 2 or 3 and the purpose of recall is to 'give medical treatment', not to detain in hospital. A person could be recalled, given treatment in either an outpatient setting or the ward, and then immediately return to the community. Most importantly, recall allows detention in hospital for up to 72 hours only. During this period, a decision needs to be made by the RC and an Approved Mental Health Professional as to whether further inpatient treatment is necessary or whether the patient can return to the community. If further inpatient treatment is necessary, then the CTO is revoked and the underlying Section 3 comes into play. There is also the option for the patient to consent to admission and then the CTO remains in place. Staff need to be particularly alert to the 72-hour period if the patient gets admitted over the weekend or a bank holiday and steps taken to ensure the duty consultant is informed of the recall. This is not a situation that can wait until the usual inpatient consultant is available.

Holding powers

There are two short-term holding powers. Section 5(4) can be used by a nurse from a 'prescribed class' (lasting 6 hours) when it is not possible to secure the attendance of a doctor. Section 5(2) can be used by the RC or their nominated deputy who must be a registered medical practitioner (so this excludes Foundation Year 1 doctors) lasting up to 72 hours. The purpose of Section 5(2) is to authorize the detention of the patient so that consideration can be given to making an assessment about whether an application for detention should be made. It could be argued that with careful consideration at the point of admission, the need to use such powers should diminish as the appropriate legal framework would have been identified at the point of admission. The CQC has reported that 28% of patients admitted informally were then detained under the MHA (23). Providing clear information about the nature of a stay on an inpatient ward would avoid patients agreeing to informal admission only to change their minds when they experience the reality of the ward environment. Clinicians must not write in an informal patient's notes that they should be detained on a Section 5(2) should they wish to leave. In that one sentence the second limb of the acid test described earlier is met as the patient is not free to go. As it is very likely that they will also be subject to continuous supervision and control, they are deprived of their liberty and their Article 5 rights must be protected.

Sections 135/136

Some wards may have associated areas designated as a 'place of safety' and will receive patients detained on a Section 136 (police powers to remove a person thought to be suffering from a mental disorder and in immediate need of care or control) or brought under a Section 135(1) warrant to be assessed in a place of safety. In January 2017, the duration of detention under Section 136 was reduced from