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2. MCA6 DOLS Consideration Checklist
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1. Introduction

1.1 South Staffordshire and Shropshire Healthcare NHS Foundation Trust has a duty
to provide safe and appropriate treatment for all inpatients, regardless of legal
status, balancing the management of risk against the principles of least restrictive
treatment.

1.2 Section 131 of the Mental Health Act 1983 (MHA) emphasises the freedom for
patients to be admitted without any formal restrictions. The same section also
allows for patients to remain in hospital after they have stopped being detained
under another section.

1.3 Chapter 37 of the Reference Guide to the MHA contains further guidance on
provisions relating to ‘informal’ patients.

1.4 Chapter 13 of the Mental Capacity Act 2005 (MCA) Code of Practice provides
guidance on the limitations of use of restrictions imposed under the MCA and
information on the relationship between the MCA and MHA.

2. Purpose

3.1 This procedure provides guidance on the admission of patients to Trust inpatient facilities who
are not detained under the MHA 1983.

2.2 This guidance should be read in conjunction with the Trust’s policies and guidance on
Assessment for Compulsory Admission under the MHA; Mental Capacity Act; Deprivation of
Liberty Safeguards and Locked Door and with the information found at 1.3 above.

2.3 The guiding principles as shown at Section 1 of the Mental Capacity Act 2005 (MCA):

   2.3.1 Assumption of capacity
   2.3.2 Assistance to make decisions
   2.3.3 Right to make unwise decisions
   2.3.4 Best interests
   2.3.5 Least restriction

   and Chapter 1 of the MHA Code of Practice:

   2.3.6 Purpose
   2.3.7 Least restriction
   2.3.8 Respect
   2.3.9 Participation
   2.3.10 Effectiveness, efficiency and equity.

   must be considered when making decisions about any course of action:

3. Scope

3.1 This guidance relates to all qualified staff working in inpatient areas of the Trust, those in the
community involved in the process of referring and admitting patients to hospital inpatient care,
and to staff in the Mental Health Legislation Department.
3.2 This guidance also informs staff from other agencies involved in the admission of patients to Trust inpatient facilities.

4. Definitions

4.1 MCA – Mental Capacity Act 2005
4.2 MHA Mental Health Act 1983
4.3 DOLS – Deprivation of Liberty Safeguards (MCA as amended by MHA 2007)

4.4 Patients who are not detained under the MHA fall into two categories, voluntary patients (have capacity to consent and willingly accept admission to hospital and the treatment offered); and informal patients (do not have capacity to consent but do not attempt to leave and do not refuse treatment), (HL v UK (45508/99)).

4.5 These patients may be broken into further groups:

4.5.1 have capacity and accept admission to hospital and treatment offered; voluntary patients

4.5.2 have capacity but refuse treatment; treatment can only be given under the MHA if criteria for detention met

4.5.3 lack capacity but do not attempt to leave and do not refuse treatment care may be provided under the MCA provided this does not amount to a deprivation of liberty

4.5.4 lack capacity but do not attempt to leave and do not refuse treatment but significant restrictions on liberty amount to deprivation DOLS application required

4.5.5 lack capacity and refuse treatment consider use of MHA if criteria for detention met

5. Duties and Responsibilities

5.1 The Chief Executive is responsible for ensuring that responsibility for management of the legal and appropriate admission and care of inpatients is delegated to an appropriate executive lead and assuring this policy is implemented within the Trust.

5.2 The Chief Operating Officer is responsible for ensuring the effective delivery of the Trust policy and procedures for the admission and care inpatients.

5.3 The Mental Health Legislation Manager is responsible for:
   • The development, monitoring and review of this policy and practice standards
   • The provision of appropriate mandatory training and education to support the policy standards.
   • Advising the Mental Health Legislation Committee that monitors the use of the Act and reports to the Quality Effectiveness and Risk Committee, of any issues relating to the implementation of the policy.
5.4 **Mental Health Act Administrators** are responsible for
- Provide guidance and support to any staff member with queries regarding the Act

5.5 **Service Directors, Clinical Directors and Service Managers** are responsible for:
- Implementation and monitoring of this policy in their areas of responsibility
- Ensuring that systems and processes are in place and monitored to meet the requirements outlined in this policy

5.6 **Team leaders, departmental heads, ward and unit managers** are responsible for:
- Ensuring that all appropriate employees in posts in the Trust clinical services attend appropriate training.
- Implementation of the processes that are documented within this policy.

5.7 **Trust employees working in roles to provide healthcare in direct clinical contact with patients referred to and admitted to inpatient care (Qualified Practitioners, including Approved Clinicians)** are responsible for:
- Ensuring awareness of the content of this policy
- Carry out admission and assessment procedures in line with the standards detailed within this policy
- Maintaining their individual competence in the practice of the Act and attending training as required by their roles

6. **MCA/MHA/DOLS**

6.1 The MCA may be used to treat people for mental disorder when they cannot consent to the treatment because they lack capacity and where the treatment is in their best interests.

6.2 Where the care and treatment of a person who lacks capacity amounts to a deprivation of their liberty (see Appendix 1), that deprivation must be authorized to be lawful, either under the Deprivation of Liberty Safeguards (DOLS), contained in the Mental Capacity Act (MCA), or the Mental Health Act 1983 (MHA).

6.3 Form MCA6 at Appendix 2 should be completed where there is any concern where restrictions placed on an informal patient may amount to a deprivation of liberty.

6.4 The case of *GJ v The Foundation Trust (2009) EWHC 2972 (Fam)* gives important guidance on the relationship between the MHA and the MCA.

6.5 The judge in this case concluded: ...the MHA 1983 has primacy in the sense that the relevant decision makers under both the MHA 1983 and the MCA should approach the questions that they have to answer relating to the application of MHA 1983 on the basis of an assumption that an alternative solution is not available the MCA. He made it clear that the eligibility test is a legal one and it is not lawful for anyone making these decisions to “pick and choose between the two statutory regimes as they think fit”. Everyone making decisions must “recognise the primacy of the MHA 1983 and take all practical steps to ensure that that primacy is recognised and given effect to”.

6.6 However in the case of *AM v (1) South London & Maudsley NHS Foundation Trust and (2) The Secretary of State for Health [2013] UKUT 0365 (AAC)* the judge considered that “i) in the circumstances defined therein the DOLS were intended to and do provide an alternative basis to that provided by the MHA to authorise the deprivation of the liberty of an incapacitated person for a range of purposes including his or her assessment or treatment for mental or physical disorders in hospital, and so ii) a decision maker under the MHA has to consider
whether that alternative is available and, if it is, whether it should be used when he or she applies the “necessity test” set by the MHA.

6.7 The use of the MHA must be considered in every case of deprivation of liberty in a hospital before moving on to DOLS. The correct approach to whether an application could be made under the MHA is whether the decision maker thinks the criteria in sections 2 or 3 are met or whether assessment under section 5 of the MCA is a viable alternative.

6.8 Decision makers must focus on the reason the patient should be deprived of their liberty by asking a series of specific questions:

6.8.1 What care and treatment should be provided for:
   (i) physical disorders or illnesses that are unconnected to and unlikely to affect their mental disorders, and;
   (ii) mental disorders, and
   (ii) physical disorders or illnesses that are connected to them and/or which are likely to directly affect their mental disorders.

6.8.2 If the need for the package of physical treatment did not exist, would the patient be deprived of liberty in a hospital.

6.9 Where it is considered that a person might need to be detained for treatment for mental disorder, an assessment under the MHA should take place.

6.10 If the person is detained under the MHA, the Act does not apply to treatment for the person’s mental disorder which can be given without consent under the MHA.

6.11 The Act will continue to apply to detained persons for treatment and welfare decisions that fall outside the remit of the MHA.

6.12 Where the implementation of DOLS procedures are indicated are necessary, please see the Trust Policy on Deprivation of Liberty Safeguards for further guidance.

7. Procedure

7.1 On admission all informal patients should be given an information leaflet (Appendix 3) and informed of their rights as an informal patient. They should also be advised of the Trust’s Locked Door Policy (where applicable), in addition to an induction to the ward to which they are being admitted (as per local admission procedure).

7.2 Patients who become ‘informal’ following removal of a section should also be provided with the information at 7.1 above.

7.3 A record of the date and time this information is provided must be made on the patient record.

7.4 This will be done using Form MCA2 as per the Trust MCA Policy.
7.5 By testing capacity and emphasising their rights to refuse treatment and leave hospital, any concerns that the patient’s consent is implied and not informed, will be addressed.

7.6 All informal patients will also be assessed for capacity to consent to treatment at the point of first administration of medication using Form MCA2 (see 7.4 above).

7.7 The issue of the patient’s capacity must be regularly reviewed at the Multi-Disciplinary Team (MDT) meeting. The outcome should be recorded on the individual’s MDT record.

7.8 Informal admissions that exceed three months should be highlighted and capacity to consent to being an inpatient and to receive treatment should be assessed using the Trust’s MCA2 Form as an additional safeguard to the patient’s care and liberty.

7.9 All steps must be taken (where appropriate) to ensure that the patient retains contact with the family, friends, carers and others interested in their welfare

7.10 If in an exceptional case there are good clinical reasons why contact with family / carers is not in the patient’s best interests it should be ensured that this is properly documented and explained to the people it affects. Steps must be taken by the MDT to engage the involvement of a local advocacy service (or Independent Mental Capacity Advocate if applicable). If the patient regains capacity all the safeguards that are offered to the voluntary patient apply.

7.11 If there is a dispute or disagreement about whether the admission/treatment/ care plan is in the patient’s best interests, or if circumstances change to this effect, then the appropriateness of the following options should be considered in a multidisciplinary forum:-

   • Complete Form MCA2
   • Request a second medical opinion
   • Discharge
   • Consider the use of the Mental Health Act
   • Consider the use of Deprivation of Liberty Safeguards

7.12 Further advice can be sought from the Trust’s Mental Health Legislation Department.

8 **Locked doors**

8.1 Some locations within the Trust have locked doors.

8.2 It is important that patients are made aware that any security measures in place are there to protect them and all patients.

8.3 Informal patients who have a legal right to leave the ward will be informed of the arrangements in each specific area of the Trust and how they can exit the ward.

8.4 A notice will be displayed on the exit door from the ward in areas where doors are locked in line with the Trust Locked Door Policy and information will be supplied to every patient on admission detailing the patient’s rights and the process to be followed to exit the ward.
8.5 If a voluntary patient (informal patient who has capacity) wishes to leave the ward they are able to do so unless there is appropriate lawful authority to detain them.

8.6 If an informal patient, without capacity is on the ward, they may remain in their best interests (assuming that both a capacity and best interests’ assessment has been completed) as long as their remaining on the ward does not amount to a deprivation of liberty.

8.7 If such a patient is either seeking to leave the ward or expressing a persistent desire to do so, consideration should be given as to whether it is appropriate to obtain some other authority to detain the patient, such as the MHA or DOLS.

9. **Leave for Informal Patients**

9.1 Informal patients (and their relatives) who request leave from the ward or access to the hospital grounds should normally have this facilitated. Normal risk assessments for leave will apply and this may include provision of staff as an escort for the patient’s safety. Where leave is denied, the possibility of this amounting to a deprivation of liberty should be considered.

9.2 On occasions where a risk assessment deems that walks and/or access to hospital grounds is appropriate but cannot be facilitated due to lack of staff, this should be monitored to ensure access is not frequently denied. If this is the case, deprivation may be occurring but DOLS may not be authorised as the best interests clause would not be satisfied.

10. **Process for Monitoring Compliance and Effectiveness**

10.1 This policy will be reviewed every 3 years or earlier in light of new legislation, guidance or other significant change in circumstances.

Compliance with this policy will be monitored through the mechanisms detailed in the table below. Where compliance is deemed to be insufficient and the assurance provided is limited then remedial actions will be drawn together through an action plan. This progress against the action plan will be monitored at the specified committee/group. The results of the audits will be escalated to the appropriate committee/group where appropriate.

Where the policy has not been followed and implemented appropriately actions are to be taken.

<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitoring method</th>
<th>Individual or department responsible for the monitoring</th>
<th>Frequency of the monitoring activity</th>
<th>Group/committee/forum which will receive the findings/monitoring report</th>
<th>Committee/individual responsible for ensuring that the actions are completed</th>
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<tr>
<td>Tools/processes authorised for use within the organisation including compliance with statutory requirements</td>
<td>Exception report</td>
<td>MH Legislation Manager</td>
<td>Ongoing</td>
<td>MH Legislation Committee</td>
<td>MH Legislation Committee</td>
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MH Legislation Committee

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MH Legislation Committee

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11 References

- Mental Capacity Act 2005
- Mental Capacity Act 2005 Code of Practice
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- Mental Health Act 1983
- Mental Health Act Code of Practice
- Reference Guide to the Mental Health Act 1983

- AM v (1) South London & Maudsley NHS Foundation Trust and (2) The Secretary of State for Health [2013] UKUT 0365 (AAC)
- GJ v The Foundation Trust (2009) EWHC 2972 (Fam)
- HL v UK (45508/99)
### Deprivation or restriction of liberty?

**Deprivation**
- Force, threats or medication used to take resisting patient to hospital
- Subterfuge used to ensure patient’s cooperation in being taken to hospital
- Admission opposed by relatives or carers or request by relatives for discharge to their care denied
- Force or locked door used to prevent patient from leaving to go to a home which is realistically available where patient is making purposeful attempts to leave and cannot be pursued to desist
- Assessment concludes that patient would make a purposeful attempt to leave hospital to go to a home realistically available if had the physical capacity to do so
- Medication primarily used to prevent patient from making an attempt to leave
- Force consistently used to overcome patient’s resistance to care/treatment if not an inevitable response to patient’s disorder
- Threats to dissuade patient from making an attempt to leave
- Access to relatives/carers denied/ severely restricted
- Access to community denied/severely restricted

**Restriction**
- Force which is not required to overcome patient’s resistance to removal from home being used to assist with conveyance to hospital
- Care provided in a secure environment (locked ward/keypads) Design of door handles difficult for confused patient to use design
- Staff bringing patient who has wandered back to hospital using restraint if necessary
- Patient’s disorder requiring restrictions on movements within hospital and/or contact with others
- Lack of capacity to decide whether to remain in hospital
- Dissuading confused patient from leaving using restraint if necessary
- Restraint to prevent purposeful attempt to leave if to prevent immediate harm to patient
- Restrain used to provide care/treatment or prevent harm to patient if inevitable response to patient’s disorder
- Refusal to allow physically frail patient with propensity to wander and exposure to harm/vulnerability to leave without escort
- Temporary refusal to let patient leave for health and safety reasons due to unavailability of escort
- Short-term use of common-law powers to restrain patient from causing harm to others/property
- to medication in an emergency
- Reasonable limitations on visiting
- Preventing contact with person deemed a risk to patient

*Although none of these restrictions alone would constitute a deprivation of a patient’s liberty, the cumulative effect of a number of these could have such an effect.*
MCA6 – Deprivation of Liberty Consideration Checklist

Checklist for assessing whether restraint or restrictions an informal patient is subjected to may amount to a deprivation of liberty

Details of the Patient

<table>
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<tr>
<th>First Name</th>
<th>Surname</th>
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<tr>
<td>NHS Number</td>
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Note that if the answer to any of the questions and statements below is ‘False’, then you must ensure that the person is referred for an assessment under either the Mental Health Act 1983 (MHA) (if they objecting to care and treatment for their mental disorder or are a risk to others) or the Deprivation of Liberty Safeguards (DOLS) (if they are complaint with care and treatment).

1. The patient is settled on the ward and not objecting to any part of their care and treatment.
   - True
   - False

2. If the patient became unsettled today and wanted to leave (not for an outing but to go home or somewhere else permanently) we would allow them to go.
   * Restraint may be used for a short period only under the MCA if it is proportionate, in the patient's best interests, least restrictive, and not a frequent occurrence.
   - True
   - False

3. If the patient’s family wanted to discharge the person against medical advice, we would not stop them or use compulsory powers under the MHA or DOLS to keep the patient on the ward.
   - True
   - False

4. If the patient wanted to have leave off the ward or the patient’s family wanted to take them off the ward for a walk/trip, we would allow them to go.
   * Normal risk assessments for leave will apply and may include staff escort for patient’s safety.
   - True
   - False

5. The patient will not be medicated to suppress objection, sedated to make their behaviour more manageable, or given any medication covertly to avoid objection to care and treatment.
   - True
   - False

6. The patient will not be subjected to unnecessary supervision and control and have more decisions made for them than required.
   - True
   - False

7. The patient’s family and carers will be involved as far as possible and we will not be placing any restrictions on their contact with the patient during normal visiting hours.
   - True
   - False
This checklist is only intended to provide guidance and a framework to assist in assessing whether a patient is being deprived of their liberty. Where there are any doubts concerning issues restriction/restraint and deprivation, further medical and/or legal advice should be sought.

Checklist completed by

<table>
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<tr>
<th>Signed</th>
<th>Name</th>
<th>Designation</th>
<th>Organisation</th>
<th>Ward/Hospital</th>
<th>Phone Number</th>
<th>Date</th>
</tr>
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8. The patient will not need to be restrained or restricted to prevent harm or risk to others.

| Yes | No |

9. The issue of restrictions and deprivation for this patient will be discussed at this patient’s regular reviews.

| True | False |

10. If the patient’s circumstances change or the answer to any of the above questions is ‘False’, authorisation to deprive the patient of their liberty will be sought under either the MHA (patient objecting to care or treatment for their mental disorder, or risk to others) or DOLS (patient compliant with care and treatment).

| True | False |

If you have answered ‘False’ to any of the above questions, confirm which one of the following actions has been taken:

<table>
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<tr>
<th>MHA Assessment requested</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Urgent authorisation for DOLS completed</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Standard request for DOLS authorisation submitted</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Write below details.
Your rights as an informal/voluntary patient

Patient Information Leaflet
You have been admitted to hospital as an ‘informal’ or ‘voluntary’ patient because you have accepted, or are too poorly to accept, that you need to be in hospital so your mental health needs can be assessed fully and you can be offered the treatment the health professionals consider you need.

The words informal or voluntary patient mean that you are not detained under the Mental Health Act 1983 (MHA) and because of your informal status, you have certain rights (and also certain responsibilities) during your stay in hospital.

**What can I expect on admission?**

Staff will provide you with a ‘Welcome Pack’ giving useful information on what you can expect whilst you are in hospital. This will explain most of the things you will need to know about the ward such as visiting times and meal times. If there is anything you are unsure or concerned about, please speak with a member of staff.

You and your carers or relatives will be encouraged to be as involved as much as possible in all aspects of your care and a care-plan will be devised setting out the care package you will receive whilst you are in hospital and who will provide this. If you have a care coordinator in the community, they will be part of the care planning process and visit you on the ward.

**Can I leave the ward?**

As an informal/voluntary patient, you are not subject to any restrictions and have the right to leave the ward at any time. We do however ask that you speak to ward staff should you wish to leave the ward area for any period, go on day leave or overnight leave, or discharge yourself.

You may find that the ward you have been admitted to is locked for some or all of the time. If this is the case, ward staff will advise you how you may exit the ward.

Please be aware that staff have a duty of care towards you, and the Nurse-in-Charge is expected to know where you are at all times so that they may comply with Health and Safety and Fire Regulations. Staff are also required to assess you before you leave the ward. If they have concerns about you leaving the ward, they must arrange a further assessment. The outcome of this assessment will be discussed with you (and your carer where appropriate) and may result in you not being allowed to leave the ward.

**What treatment will I be offered?**

Staff on the ward will speak with you about the treatment they think you need and will involve you in the care and treatment plan that is developed for you as an individual. This may include taking medication and therapeutic individual or group work. As an informal patient, your consent is required before you can be given any treatment and you should ensure that you understand what is being offered and why before accepting any treatment. In certain circumstances, if you are too poorly to understand the treatment proposed, staff may say that you ‘lack capacity’ to consent to the treatment and may consider providing this to you in your best interests under the Mental Capacity Act 2005.

Having ‘capacity’ means being able to make your own decision about something. Staff are trained in issues of mental capacity and have information they will be happy to share with you and/or your family. Please ask questions about anything proposed in your care and treatment plan that concerns you. As an informal patient you can refuse the treatment that is being offered to you and you can not be given any treatment against your will, except in an emergency. Your right not to be treated is
protected by the *Human Rights Act* (1998) and common law. If you do refuse treatment for your mental disorder, staff may consider the use of the Mental Health Act 1983 to provide this if necessary.

**Can I discharge myself?**

You have the right to discharge yourself from hospital at any time however we strongly recommend that you speak to staff on the ward before making the decision to leave. This is to ensure that you have any necessary treatment you may require and to enable staff to arrange any follow-up care you may need.

Please remember that staff have a duty of care towards you and are required to assess you before agreeing with your discharge. If they have concerns about the possible harm that may occur to yourself or others if you do discharge yourself, they may consider the use of section 5 of the Mental Health Act 1983. A registered mental health or learning disabilities nurse may invoke section 5(4) to prevent you leaving. This means that you must stay on the ward for up to 6 hours in order for a doctor to further consider whether you should be remain in hospital for further assessment. A doctor may detain you for up to 72 hours in order for a full Mental Health Act assessment to take place where two doctors and an Approved Mental Health Professional will consider whether you need to remain in hospital for a further period of assessment and/or treatment. The outcome of this assessment will be discussed with you (and your relatives/carer where appropriate) and may result in you not being allowed to leave the ward. If these powers are used to prevent you from leaving the ward, further information about your rights and responsibilities will be given to you.

If you wish to take your own discharge against the advice of ward staff, but they do not consider the use of section 5 to be appropriate, you may be asked to sign a ‘Discharged against Medical Advice’ form before you leave.

In some circumstances staff may consider you lack capacity to decide to remain in hospital to receive care and treatment which amounts to a deprivation of your liberty but is deemed to be in your best interests and that the provisions of the Mental Health Act 1983 do not apply. In this case, they may consider using the Deprivation of Liberty Safeguards provisions of the Mental Capacity Act 2005. If this is the case, further information regarding the process will be provided to you and your relatives/carer.

**Other support**

**An Advocate**

An advocate is someone who can act on your behalf to support you in making decisions whilst you are an informal/voluntary patient. If you would like to speak to an advocate, please ask staff on your ward for details of the local advocacy service or to contact them on your behalf.

**Patient Advice and Liaison Service (PALS)**

The Patient Advice and Liaison Service provide information and confidential support to help sort out any problems you or your family/carers may have with care provided by the Trust quickly. PALS also ensure that your views and suggestions are used to shape the way the Trust is run. PALS can be contacted by ringing 01785 221469 or you may ask a member of staff to contact the PALS department on your behalf.