Policy:

NPCS 014 Duty to Give Information Under Section 132, 132A & 133 Mental Health Act 1983

Executive Director Lead	Executive Medical Director
Policy Owner	Head of Mental Health Legislation
Policy Author	Head of Mental Health Legislation

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Summary of policy

A policy to describe the duties in respect of the legal duty to provide information to detained patients and their Nearest Relatives as required by and defined within the Mental health Act 1983

Target audience	Staff involved in the administration of the Mental Health Act and in providing care and treatment under the Mental Health Act 1983

Keywords	Rights; Mental Health Act

Storage & Version Control

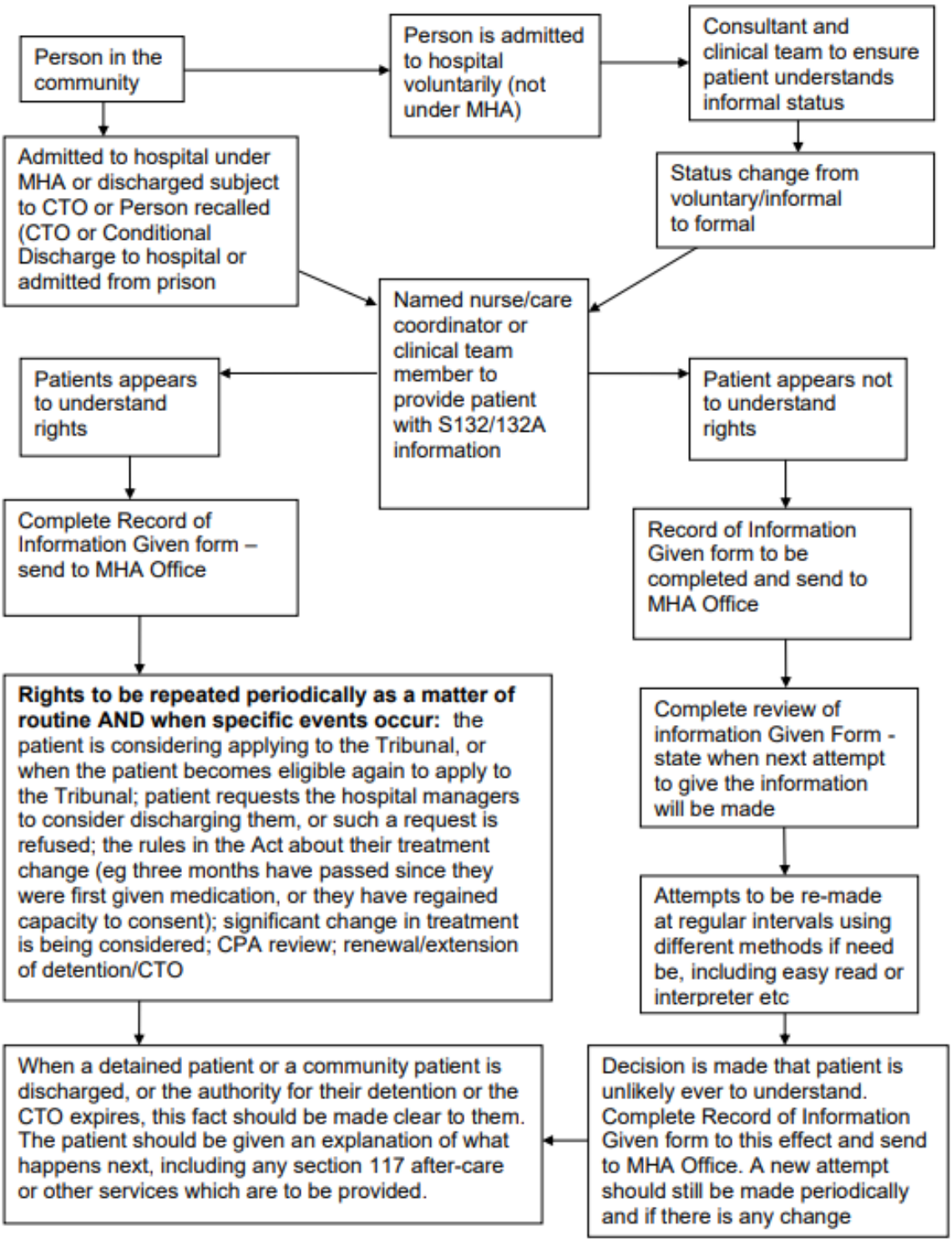
Version 5 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V4 March 2019). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
1.0	Approval and issue		
2.0	Review on amendment of MHA	2008	Early review undertaken to update the policy to in order to comply with new regulatory requirements.
3.0	Review	05/2016	Revision of MHA Code of Practice
4.0	Review for renewal	03/2019	Full review completed as per schedule; job titles updated; detail added to flow chart in respect of triggers for fresh explanation of rights
5.0	Review for renewal	07/2022	Responsible Executive updated Corrections to legislation date Update to governance structure New/updated contact details

Contents

Flowchart
INFORMING PATIENTS OF THEIR RIGHTS UNDER SECTION 132& 132A MENTAL HEALTH ACT 1983



1 Introduction

Patients have a legal right under the Mental Health Act 1983 to be informed of their legal situation and rights. Patients must be kept as fully informed about and involved in their treatment and care plan as is practicable. There is a legal duty to inform a patient of the reasons for his/her detention under Article 5(2) Human Rights Act 1998.

Effective communication is essential in ensuring appropriate care and respect for patients' rights. The Act requires hospital managers to take steps to ensure that patients who are detained are subject to community treatment order understand important information about how the Act applies to them.

All patients whether they are detained under the Mental Health Act (MHA) 1983 or not must be informed of their legal rights whilst being cared for by the service.

With regard to patients who are already detained, the MHA 1983 requires hospital Managers (ie the Trust) to take steps to ensure that patients who are detained in hospital under the MHA 1983 or who are on Community Treatment Order (CTO) understand important information about how the MHA 1983 applies to them. This must be done as soon as practicable after the start of the patient's detention or CTO and must also be provided to a patient subject to CTO, who is subject to recall to hospital.

It must also be remembered that explaining the rights to the patient is not a one-off event but needs to be on-going throughout the detention as a person's level of understanding can fluctuate. There needs to be a repetition of rights at significant times, as described in the flow-chart

2 Scope

This policy applies to all those who are involved in the care and treatment of those subject to detention in hospital or to a Community Treatment Order under the Mental Health Act 1983.

Those who are in hospital but not subject to detention under the Mental Health Act must still be given information about their legal rights; this is not covered by this policy.

It does not cover the responsibility for the provision of information to those subject to Guardianship (s7 or s37 of the Act) as this is the responsibility of the Local Authority

3 Purpose

The purpose of this policy is to ensure that those detained in hospital under the Mental Health Act or are subject to compulsion in the community are given information in accordance with Section 132 & Section 132A Mental Health Act 1983 (amended 2007) and that information is given in a way in which the patient is able to understand, taking into account language, gender, religion, age, cultural background and any disability which may inhibit the patient's understanding.

4 Definitions

The Act

Refers to the Mental Health Act 1983 as amended by the Mental Health Act 2007

Hospital Managers

This does not mean the management team of the hospital but the people or body whose hospital it is i.e. the NHS Foundation Trust as a body.

Patient

The Mental Health Act 1983 refers to those detained in hospital or who are subject to a Community Treatment Order as patients. As this policy is concerned with rights and information under the Mental Health Act it uses the same terminology.

Community Treatment Order (CTO)

Community Treatment Order is the name given to the overall legal system for managing patient care and treatment in the community with the power to recall the patients to hospital if necessary.

Approved Clinician (AC)

A person approved under the Mental Health Act to act as a Responsible Clinician

Responsible Clinician (RC)

The Approved Clinician in charge of the treatment for a patient who is detained under the Mental Health Act .

Care Co-ordinator

The Care Co-ordinator is the identified member of staff responsible for the overall coordination of a person's care under the Care Programme Approach (CPA).

Nearest Relative (NR)

The Nearest Relative is defined under section 26 MHA 1983. The nearest relative as defined under the Act is not necessarily the same person as the patient would regard as their next of kin. The person identified as the nearest relative has various functions and rights under the Act

Mental Health Tribunal (MHT)

Detained patients, those subject to CTO and (in certain circumstances) the nearest relative have a right to apply to the MHT. The MHT has the power to decide whether patients should continue to be detained under the Act, continue to be subject to CTO, continue under guardianship or continue to be subject to conditional discharge following detention under s37/41.

Second Opinion Appointed Doctor (SOAD).

Second Opinion Appointed Doctor, who is appointed through the Care Quality Commission, provides a safeguard for detained patients in the event that, in the absence of the patient's consent to treatment through refusal or lack of capacity, the Responsible Clinician wishes to impose treatment for the patient's mental disorder.

Code of Practice

The Code of Practice gives statutory guidance to registered practitioners, approved clinicians, managers and staff of hospitals and mental health act professionals on how they should proceed when undertaking duties under the Act. Reference in this Policy to the Code of Practice refers to the Code of Practice Revised2015. Chapter 4 of the Code of Practice give further guidance on information for patients, nearest relative, carers and others.

Care Quality Commission (CQC)

The Care Quality Commissions role is to keep the use of the MHA under review and may investigate certain types of complaints. The CQC also provides Second Opinion Appointed Doctors when necessary.

5 Detail of the policy

This policy is concerned with statutory duties under the Mental Health Act

6 Duties

Although it is the responsibility of the Hospital Managers to ensure that patients detained in hospital or those subject to community treatment orders are provided with information regarding their rights under the Act, in practice this will be delegated to staff caring for the detained patient or those on community treatment orders.

Hospital Managers should ensure that sufficient training/guidance is given to those staff delegated with this duty to enable them to meet the legal requirements.

The Executive Medical Director has delegated responsibility for ensuring that clinical practice is carried out in accordance with Mental Health Act legislation.

Clinical Directors are responsible for ensuring that practise within their service areas is carried out in accordance with MHA legislation.

Ward/Team Managers are responsible for ensuring that staff members are aware of the policies that apply to their areas of practice and for monitoring such practices. Ward/Team Managers are also responsible for ensuring that staff who give patients an explanation of their rights under the mental health act have the knowledge and understanding to do so.

All staff implementing the provisions of the Mental Health Act must be aware of their duties and responsibilities under the Act.

7 Procedure

7.1 Communication of Information

All possible steps must be taken to ensure that all patients who are detained in hospital or who are on CTO are given and understand specific information relating to their detention as soon as practicable after the start of their detention or CTO and at regular intervals throughout their period of detention. The information should be given in a manner appropriate to the needs of the individual.

The Hospital Managers must ensure that:

- The correct information is given to the patient.
- The information is given at a suitable time and in a suitable manner including the use of interpreters/translators/BSL interpreters/easy read documents.
- A nominated person is identified in relation to each detained patient and that they receive sufficient training /guidance to enable them to meet the legal requirements.
- A record is kept of the information given, including when and by whom it was given.
- A regular check is made to ensure that information has been properly given to each detained patient or CTO patient and understood by them.
- The information is given both orally and in writing.
- The written information is also given to the nearest relative where appropriate.

Most of the Hospital Managers' responsibilities under the MHA 1983 may be delegated to officers of the Trust. The duty of giving information to detained patients is normally discharged by the senior nurse on duty who may also be the patient's named nurse.

However, the giving of information relating to the consent to treatment provisions will more appropriately be undertaken by the patient's Responsible/Approved Clinician.

For those discharged on to CTO the information should be given by a senior nurse on the ward, which could be the patient's named nurse, prior to discharge onto the CTO and again by the care coordinator once the CTO is implemented in the community. However, as with those detained in hospital, the giving of information relating to the consent to treatment provisions will more appropriately be undertaken by the patient's RC.

Where an interpreter is needed, every effort should be made to identify who is appropriate, given the patient's gender, religion, age, language, dialect and cultural background.

Only in exceptional circumstances should the patent's relative and friends be used as interpreters.

The person providing the information should be as helpful as possible and try to explain any points that the patient appears not to understand. This requires the staff member to have a full understanding of the rights involved; it is not a matter simply of reading out the content of the leaflet.

Independent Mental Health Advocates (IMHAs) can play a role in helping patients to understand the question and information being presented to them and in helping them present their views

7.3 What information should be given?

Information should be given both orally and in writing. The Department of Health produce leaflets relating to the legal rights of a detained patient. These can be found on the MHA page of the Trust's Intranet in English and many foreign languages.

7.3.1 Patients must be informed of:

- The provisions of the section of the Act under which they are detained or CTO and the effect of those provisions.
- The rights (if any) of their nearest relative to discharge them and what can happen if their RC does not agree with that decision.
- The rights to apply to the First Tier Mental Health Tribunal and how to go about this. Patients must be informed that they can access legal advice, that free legal aid for representation at the Tribunal is available and be supported in contacting a legal representative should they wish to do so.
- For CTO patients, the effect of the community treatment order, including the conditions which they are required to keep to and the circumstances in which their RC may recall them.
- The help is available to them from an Independent Mental Health Advocate (IMHA) and how to obtain that help

This information should include:

- The reason for their detention or CTO (the full facts should be given rather than broad reasons)
- The maximum length of the current period of detention or CTO
- That their detention or CTO may be ended at any time and by whom
- That they will not automatically be discharged from section when the current period of detention or CTO ends
- That the detention or CTO may be renewed/extended.

It is particularly important that patients on CTO who may not have daily contact with people who could help them make an application to the tribunal are informed and supported in this process.

7.3.2 Information on the following must be given where relevant:

- The powers of the Hospital Managers, RC and nearest relative in relation to discharge
- The right to access an Independent Mental Health Advocate (IMHA)
- Information in respect of Consent to Treatment
- In particular the circumstance (if any) in which they can be treated without their consent.
- The role of the SOAD and the circumstances in which they may be involved.
- Their right to refuse ECT, other than in urgent circumstances
- The existence of the Code of Practice
- The role of the Care Quality Commission
- The powers of the Hospital Managers in relation to patients' correspondence
- The patient should also be informed of their rights to apply to the Hospital Managers for a review of their detention and the process to do this.

A copy of the detention or CTO documents should be made available to the patient; unless it is thought that the information disclosed would adversely affect the health or well-being of the patient or others. It may be necessary to remove any personal information in respect of others,

7.3.3 Information about consent to treatment

Patients must be told about:

- The circumstances(if any) in which thy can be treated without their consent
- The circumstance in which they have a right to refuse treatment
- The role of the Second Opinion Appointed Doctors (SOADs) and the circumstances in which they may be involved
- (Where relevant) the rules on electro-convulsive therapy (ECT) and medication administered as part of ECT

7.3.4 Information about recall to hospital whilst on CTO

A patient who is to be recalled to hospital should, wherever possible, be given an oral explanation for the recall before the recall takes place. This should be given by the RC but if that is not possible then the care coordinator should give the reasons for the recall.

7.4 Information about recall whilst subject to a conditional discharge

It is the Secretary of State's responsibility to give an explanation for the recall, however the patient should also receive a full explanation for of the reason with in 72hours of admission.

This should be both oral and written.

7.5 Information about the CQC

Patients must be informed about the role of the CQC, their right to make a complaint to the CQC and support to do this should be available if required

7.6 Information about withholding correspondence

Detained patients must be told that their letters for posting may be withheld if the person to whom it is addressed requests the hospital managers to do so.

7.7 Information on voting rights

Changes in the law introduced in the Representation of the People Act 2000 reflect the widened voting rights of detained patients. There are still voting restrictions on patients who are detained under Part 3 of the MHA (patients concerned in criminal proceedings or under sentence).

The Trust staff will give information about voting rights to patients and assist them in the exercise of this right when possible (e.g. through Section 17 leave or guidance on postal votes).

7.8 When Should Information Given?

All information should be given as soon as practicable after the implementation of the detention or CTO (or admission if the patient has been transferred under section 19 MHA) and whenever the section under which the patient is detained is changed, including renewal of detention or extension of CTO. Practicability encompasses having regard to the patient's current mental state of mind and ability to understand the information.

A review of the information given and the patients understanding of the information should be undertaken on a regular basis as appropriate to the individual.

CTO patients who are recalled to hospital or their CTO is revoked must also be given the relevant information.

The information must be given both orally and in writing. Those giving the information should ensure all relevant information is conveyed in a way that the patient understands. Particular care should be taken in providing information orally (and using an interpreter when necessary) for those for whom English is not their first language or the written information is otherwise inaccessible

If a patient is too unwell to be given such information or to understand or retain the information, further attempts must be made at a later time. Details of these further attempts should be recorded in the notes and on the appropriate forms.

Every effort should be made to establish how much the patient does understand about the information given and, if appropriate, staff should offer alternative independent support if needed.

Some patients may have difficulties relating to their capacity to understand or their ability to retain the information given to them. Whilst these patients are detained under the Mental Health Act 1983, the Mental Capacity Act Code of Practice (2007) advocates good practice in relation to detained patients who lack capacity or have fluctuating capacity. In these situations staff need to comply with the principles of the Mental Capacity Act 2005 and its Code of Practice and take all reasonable steps to provide information in a suitable format eg large print, easy read or pictorially in order to facilitate understanding if at all possible.

If the patient is still unable to understand, the reasons for the lack of understanding should be recorded along with the most appropriate way to deal with the difficulty.

If the patient is unlikely ever to understand, attempts should still be made at regular intervals and each attempt should be recorded in the notes and on the appropriate forms.

The explanation of a patient's rights is not a one off event and a fresh explanation should be considered when:

- The rules about their treatment change i.e because three months have passed since they were first given medication or because they have regained capacity to consent to their treatment
- Renewal of their detention of extension of the CTO is being considered
- Following the renewal of the detention or CTO
- Any significant change to their treatment is being considered.
- The patient is considering applying to the Tribunal and when the patient becomes eligible to apply to the Tribunal
- The patient requests the hospital managers to consider discharging them or such a request is refused
- There is to be a care programme approach review

7.9 Information Given To Informal/Voluntary In-Patients

Though Sections 132 and 132A are specific to detained and CTO patients, more general information regarding rights and in particular the right to leave the ward, or to refuse

treatment, must also be given to informal patients. This must be documented in the patient's health record.

It is important that information is immediately given to patients when their status is changed from detained or CTO to informal status. This must happen whether the change in status is planned or not, for example if detention papers are found to be invalid or a section inadvertently lapses.

7.10 Information To Be Given To The Nearest Relative

The written information provided should, unless either the patient or the nearest relative objects, be copied to the nearest relative.

Particular attention should be paid to ensuring that nearest relatives understand their rights in relation to discharge.

The nearest relative should be told of the patients discharge from detention or CTO. If practicable the information should be given at least seven days in advance of the discharge.

The nearest relative should also be informed of the renewal of the patient's detention or extension of CTO and transfer from one hospital to another.

The duties to inform the nearest relative are not absolute and in almost all cases information should not be shared if the patient objects.

7.11 Record Keeping and Documentation

All staff involved in the giving of information to patient should be aware of the statutory duties and of the importance of keeping adequate records of actions taken.

It is a requirement of the Code of Practice that a record is kept of the information given, including how, when, where and by whom it was given. The record should also show the patient's wishes in relation to the giving of the relevant information to the nearest relative.

The person giving the information must ensure that whenever a patient is given an explanation of their rights under the Act the Trust's 'Record of information given under section 132 &132A MHA 1983' is completed and any supplementary information is recorded in the patient's notes.

The Review of Information Given to Detained Patients form should be completed as soon as attempts have been made to give an explanation of the rights to the patient. This will record whether the patient appeared to understand or not and when it would be appropriate to review the rights even for those who are considered to have understood.

8 Development, Consultation and Approval

This policy was developed by the Mental Health Legislation Operational Group (MHLOG) in line with the requirements of the Mental Health Act 1983 (as amended) and its Code of Practice (2015). This review has updated job titles and Executive responsibility. It has been reviewed by the MHLOG for submission to the Policy Governance Group for approval.

9 Audit, Monitoring and Review

This section should describe how the implementation and impact of the policy will be monitored and audited. It should include timescales and frequency of audits.

If the policy is required to meet a particular standard, it must say how and when compliance with the standard will be audited.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Compliance with the weekly MHA audit and monthly CTO audit	Review of audit results	MHLOG	Monthly	Quarterly to Mental Health Legislation Operational Group (MHLOG)	MHLOG	MHLOG; Mental Health Legislation Committee

Policy to be reviewed 3 yearly

10 Implementation Plan

Action / Task	Responsible Person	**Deadline**	**Progress update**
Upload new policy onto intranet and remove old version	Policy governance		
Advise staff of updated policy	SHSC Communications		
Ward/Team managers to ensure that staff are aware of policy	Matrons; General Managers; Service Managers		

11 Dissemination, Storage and Archiving (Control)

This policy replaces the previous version (v4) on SHSC Intranet and Internet. In addition, members of the Mental Health Legislation Operational Group and Ward/Team Managers will be asked to ensure all staff are made aware of this policy. The previous policy will be removed from the Trust website by the Policy Governance Team/Communications team. Ward Managers will be responsible for ensuring that it is also removed from any policy and procedure manuals. A paper version of previous policies will be archived in the Mental Health Act Administration Office

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
5	August 2022	August 2022	August 2022	

12 Training and Other Resource Implications

The Trust delivers training on the Mental Health Act and the process of giving information forms part of that training

13 Links to Other Policies, Standards (Associated Documents)

Mental Health Act 1983 (as amended)
Mental Health Act Code of Practice
All other Mental Health Act policies.
Mental Capacity Act 2005
Mental Capacity Act Code of Practice

14 Contact Details

Title	***Name***	***Phone***	***Email***
Head of Mental Health Legislation	Jamie Middleton	271 8110	jamie.middleton@shsc.nhs.uk
Mental Health Legislation Administration Manager	Mike Haywood	271 8104	mike.haywood@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. I confirm that this policy does not impact on staff, patients or the public.	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**	**N/A**	**No**
Disability	**No**	**N/A**	**No**
Gender Reassignment	**No**	**N/A**	**No**
Pregnancy and Maternity	**No**	**N/A**	**No**

Race	**Yes**	Staff to be aware of different languages and the need to provide information in the patient's language and to use interpreters to ensure rights are understood	**No**
Religion or Belief	**No**	**N/A**	**No**
Sex	**No**	**N/A**	**No**
Sexual Orientation	**No**	**N/A**	**No**
Marriage or Civil Partnership	**No**		

Impact Assessment Completed by:

Jamie S Middleton, Head of Mental Health Legislation
July 2022

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	✓
2.	Is the local Policy Champion member sighted on the development/review of the policy?	×
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	× Statutory requirements
5.	Has the policy been discussed and agreed by the local governance groups?	✓
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	✓
	Template Compliance	
7.	Has the version control/storage section been updated?	✓
8.	Is the policy title clear and unambiguous?	✓
9.	Is the policy in Arial font 12?	✓
10.	Have page numbers been inserted?	✓
11.	Has the policy been quality checked for spelling errors, links, accuracy?	✓
	Policy Content	
12.	Is the purpose of the policy clear?	✓
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	✓
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	✓
15.	Where appropriate, does the policy contain a list of definitions of terms used?	✓
16.	Does the policy include any references to other associated policies and key documents?	✓
17.	Has the EIA Form been completed (Appendix 1)?	✓
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	✓
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	✓
20.	Is there a plan to i. review ii. audit compliance with the document?	✓
21.	Is the review date identified, and is it appropriate and justifiable?	✓