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Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic

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This guidance concerns the impact of the coronavirus (COVID-19) pandemic on the use of the Mental Health Act (MHA) and supporting systems to safeguard the legal rights of people receiving mental health, learning disability and autism services, including specialised commissioned services. It will be regularly updated to reflect the rapidly changing context and questions/concerns as well as feedback from the sector.

This guidance has been assessed to identify potential equality impacts of the COVID-19 pandemic on people with mental health needs and learning disabilities and/or autism. It is acknowledged that people with mental health needs, learning disabilities or autism, who contract COVID-19, may require reasonable adjustments. Further, it is acknowledged that the COVID-19 pandemic has the potential to subsequently affect mental health and wellbeing. Health services must continue to have due regard to their obligation to advance equality under the Equality Act 2010, this includes recognising and factoring-in the vulnerability of different cohorts with protected characteristics; and inequalities in access, experience and outcomes in health services. The [Advancing Mental Health Equalities Toolkit](#) provides support in identifying and addressing mental health inequalities in the round. Partnership working with voluntary and community sector partners is also encouraged to facilitate wrap-around support for vulnerable people, and to maximise engagement with underrepresented groups.

1. Introduction

This guidance provides advice and support to commissioners (clinical commissioning groups [CCG] and specialised commissioning), providers (CCG commissioned and specialised commissioned), health care professionals, social workers, Approved Mental Health Professionals, local authorities, experts by experience, clinical experts, and independent chairs for Care and Education and Treatment Reviews, as well as regional NHS England and NHS Improvement colleagues, to help with the local planning already underway. The guidance will also be helpful for other individuals and partner organisations, involved in the pathways of care, for people with mental health needs, a learning disability and/or autism, including police, prisons and Immigration Removal Centres (IRCs).

The guidance has been **updated following its original publication on 30 March 2020** and is one of a [suite of resources](#) to support the mental health and learning disability and autism sectors in responding to the outbreak. These resources should be consulted in parallel; the other resources cover:

- managing capacity and demand within inpatient and community mental health and learning disability and autism services
- patient and carer/family engagement and communication
- workforce considerations

- supporting patients of all ages who are unwell with COVID-19 in mental health, learning disability, autism, dementia and specialist inpatient facilities

This document makes a number of references to the **pandemic period** and advice/guidance that is applicable during this time only. Due to the nature of the pandemic, this time period cannot currently be clearly defined, but will be reviewed regularly. It will be clearly communicated when guidance set out in this document is no longer applicable.

2. Key messages

- There are currently no enacted changes to the Mental Health Act 1983 (MHA) legislation. The MHA legal framework is a basic protection of rights. Emergency changes to the current MHA legal framework, set out in the Coronavirus Act, will only be enacted if patient safety is deemed to be at considerable risk – the overarching aim of the emergency powers is to ensure that those people in critical need of mental healthcare are able to access this throughout the pandemic period.
- While there are currently no legislative changes, the Department of Health and Social Care (DHSC) has provided advice on using the MHA Code of Practice during the COVID-19 pandemic period (see Section 5 and Annex D). This aims to offer specific advice and guidance on areas, which are posing a particular challenge as a result of the pandemic and where temporary departures from the Code of Practice may be justified in the interests of minimising risk to patients, staff, and the public.
- MHA powers must not be used to enforce treatment or isolation for any reason unrelated to the management of a person's mental health, such as detaining inpatients whose refusal to be tested/isolated is unrelated to their mental disorder. For currently detained patients, providers should not impose blanket restrictions, but the use of the MHA may offer authority for enforcing social distancing and isolation of symptomatic patients. It is vital these powers are used with regard to the principles of the MHA Code of Practice.
- While the NHS and social care are facing unprecedented challenges relating to COVID-19, wherever possible health and care services and professionals must continue to guard against overly restrictive practice.
- Decisions about the application of the Mental Capacity Act 2005 (MCA) and MHA have always involved significant nuance and complexity. During the COVID-19 outbreak, providers and Local Authorities should follow their organisational policies to ensure the safety of staff and patients and decide on the appropriate use of the relevant legal framework on a case-by-case basis, with reference to organisational ethics committees or ethics forums and support from medicolegal and expert social work colleagues as required.

- Robust and live communication across services is hugely important at a time when significant resource shortages across the sector are likely. Colleagues should take advantage of digital technologies to support communication. [NHSX guidance](#) supports mental health providers and Local Authorities in using digital and virtual channels such as MS Teams, Skype, WhatsApp and FaceTime. Section 14 of this document also provides guidance on when video assessments can support remote MHA assessments.
- Local authorities have substantial statutory responsibilities under the MHA and Care Act 2014, especially in providing access to approved mental health professionals and co-ordinating s117 discharge arrangements. This guidance considers how local authorities and mental health providers can work together to try and mitigate the effects of significant staff shortages.

3. The Mental Health Act 1983 and the emergency Coronavirus Act

- Currently, no changes have been made to the MHA legislation and all organisations and staff should continue to operate in line with existing MHA law and Code of Practice as far as possible (see section 5 and Annex D for more information on cogent reasons to depart from the code).
- The emergency [Coronavirus Act](#) was passed on 25 March 2020 and contains a number of emergency provisions which, if enacted, will amend certain aspects of the MHA regarding second opinion safeguards and detention period. However, they will only be enacted if it is deemed nationally that the mental health sector is experiencing extraordinary resource constraints that put patients' safety at significant risk.
- There is ongoing communication with local systems to rapidly identify if any areas are at high risk of such circumstances occurring. If the powers are enacted nationally, localities will still need to apply to their NHS England and NHS Improvement regional teams for support to use them when required, providing clear justification as to why they are needed and commitment to monitoring their impact. This governance process will be clearly communicated to local systems in advance of the powers being enacted.
- Even if local use is supported, the powers should only be used when individual practitioners decide they are necessary and can justify their use.
- The emergency Coronavirus Act makes no changes to the MCA.
- **Box 1** below summarises the emergency powers. Further information on the powers and process for enacting them is available in Part 2 of this guidance, however we are reminding everyone that they should **continue to work within the current legislation**.

Box 1: What does the emergency Coronavirus Act do?

- If enacted, the emergency powers relating to the Mental Health Act will allow:
 - Approved mental health professionals (AMHP) to obtain a medical recommendation from one section 12 approved doctor (who does not necessarily need to have previous acquaintance with the person being assessed) rather than two, when applying to detain a person with a mental disorder. But this would only be allowed in circumstances where the AMHP is of the view that, because of staff shortages caused by COVID-19, seeking the advice from two doctors would either be impractical or would involve undesirable delay to the application. The legislation also makes clear that the AMHP would be required to justify and record their decision in these circumstances and updated statutory application forms will support this.
- Patients may be detained for slightly longer than they would otherwise have been under normal circumstances – in two areas of the law:
 - under section 5 (emergency detention for people already in hospital, which would extend from 72 hours to a maximum of 120 hours; and nurses' holding powers which would extend from 6 to a maximum of 12 hours)
 - under sections 135 and 136 (police powers to detain a person found in need of immediate care at a 'place of safety', which would extend from 24 hours to 36 hours).
- Clinicians in charge of a patient's treatment to certify that it is appropriate for the patient to be given medication without consent (usually this must be certified by a separate doctor).
- More time for defendants and prisoners with a mental health condition to be both:
 - kept on remand in hospital
 - transferred from prison to hospital by allowing more time before a direction to transfer expires (under s47 only).

4. Operational considerations for use of the MHA

- Over the coming weeks, it is possible that local operational challenges arising from resource constraints may start to impact on the use of the MHA. It is important that steps are taken to enable mental health services to deal with potential increased staff shortages while maintaining the safeguards for patients set out in the MHA. In particular, there is a need to ensure that the MHA can continue to be used to detain and treat people in a timely way, where this is necessary.

- The emergency provisions, referenced above, are intended to help address these operational challenges in the situation that they start to pose a significant risk to patient safety, but their implementation should ultimately be seen as a last resort, with the primary aim to continue to operate in line with the current MHA legislation.
- **Box 2** below lists the areas in relation to the use of the MHA where workforce shortages can be expected to have the most significant impact, along with some suggested actions to help mitigate this:

Box 2: Possible areas impacted by workforce shortages

- MHA assessments due to inadequate access to section 12 doctors and AMHPs: this also applies to MHA assessments in prisons and immigration removal centres.
- Access to independent mental health advocacy (IMHA).
- Reduction in staff with specialist learning disabilities/autism training
- Section renewals, especially where patients may be placed out of area.
- Seclusion and long-term segregation reviews.
- Mental health tribunals, in particular the availability of tribunal members in the context of guidance about vulnerable groups.
- Availability of MHA review managers' hearings.
- Community treatment order recall to hospital and subsequent assessment.
- Social supervision and tribunal reports.
- Access to legal visits.

Suggested mitigating actions

- Additional administrative resource to support the local section 12 rota: there will be staffing changes locally and these need to be well-managed and communicated.*
- NHS providers and local authorities to consider how to support each other in operating out-of-hours services.
- If necessary, access to and support from IMHAs and legal advice should be arranged virtually, with the assistance of appropriate digital technology (such as video), to ensure these critical safeguards are maintained.
- Clear and accessible information to ensure people and their families are aware of any operational changes and how they can access support.
- Local systems to ensure s140 agreements in relation to bed availability are in place and updated in light of COVID-19.

- Advanced planning for MHA work where possible, eg identifying all sections in need of renewal over the coming weeks to help plan resources effectively.
- Collaboration with the Criminal Justice System to facilitate prison and Immigration Removal Centre (IRC) assessments, transfers and remissions.
- Strong communication between the management of the section 12 rota and AMHP rota locally.
- Where appropriate, implementation of digitally supported remote MHA assessments (see section 14 for more information).
- Close liaison with the tribunal services and MHA review managers regarding tribunals and MHA review managers' hearings respectively.
- Identification of colleagues with AMHP warrants who may not be on the rota, or individuals who need refresher training, to be able to be on the rota, to ensure AMHP capacity. This is being undertaken nationally by Social Work England and the Local Government Association.
- Dedicated senior operational resource to co-ordinate demand for MHA work, bringing together all requests across admissions, section 136 suites, community treatment order recalls, section renewals, the Criminal Justice System, tribunals, etc.
- Close working with the ambulance service and general acute providers, and in some instances secure transport.

* The DHSC has allowed for the extension of the licenses of section 12 doctors and approved clinicians. Licenses will be extended for 12 months, either from the next expiry date or from the date of application for licence renewal from doctors whose approvals have lapsed within the previous 12 months.

5. Guidance on using the Code of Practice during the COVID-19 pandemic period

- This section of the guidance (the detail of which is contained in Annex D) was developed with and approved by the DHSC.
- Registered medical practitioners (ie doctors), approved clinicians, managers and staff of providers and approved mental health professionals (AMHPs) are all required to have regard to the Code of Practice while carrying out their professional duties.
- During the ongoing COVID-19 pandemic, mental health services and practitioners may need to make certain changes to current practice in order to continue functioning in cases of reduced service capacity, and in order to comply with public health advice. In addition to adopting the recommended mitigating operational

actions set out above, this may necessitate practitioners to make temporary departures from certain requirements of the Code of Practice in the interests of minimising risk to patients, staff, and the public.

- The guidance in Annex D provides advice to mental health practitioners who may be faced with increasingly challenging circumstances over the coming weeks and months. The guidance (Annex D) sets out alternative procedures with regards to certain aspects of the Code of Practice for which NHS England and NHS Improvement and DHSC find that current circumstances may provide cogent reasons for departure. It also aims to highlight to best practice and existing flexibilities in the Code of Practice that may help support providers during the pandemic period. Note, it is for practitioners to decide whether it is appropriate to depart from the Code of Practice in any particular case. Any departure should be justified and recorded clearly, as it may later be subject to scrutiny by the courts. The aspects of the Code of Practice covered in Annex D are:
 - Section 136 assessments
 - AMHPs and responsibilities of Local Authorities
 - The role of the hospital managers’ panel
 - Mental Health Tribunal Hearings
 - Medical reviews when a patient is placed in seclusion
 - Section 17 leave and visitors
 - Access to IMHAs
 - Second Opinion Appointed Doctors service
 - Electronic forms and electronic delivery
- **The guidance only applies during the COVID-19 pandemic** and to those responsible for exercising functions under the Mental Health Act. The content of this guidance should not become the new norm beyond the pandemic and it only applies until withdrawn by the DHSC.
- Decision makers should only apply the alternative processes that constitute a departure from best practice (described in Annex D) where they think it is necessary and proportionate to do so. All decisions must be taken on a case by case basis. During the pandemic, the provisions of the Equality Act 2010, regarding non-discrimination and principles set out in the Code of Practice, continue to apply to all decisions made about patients’ care, support and treatment under the Act. These are:
 - Least restrictive option and maximising independence
 - Empowerment and involvement
 - Respect and dignity

- Purpose and effectiveness, and
- Efficiency and equity.
- **Monitoring and reporting:**
 - It is important that any departures from the Code of Practice, including the rationale, are robustly documented at a local level and in individual patient notes where appropriate.
- The Care Quality Commission (CQC) is continuing its Mental Health Act monitoring programme in order to ensure that patients' human rights and safety continue to be upheld during the pandemic. Monitoring is being carried out remotely, and information gathered from individual service providers, local authorities, inpatients and their families/ carers. Crucially, the CQC may still carry out site visits if concerns are identified using the remote process. If people believe the Mental Health Act or Code of Practice, or the alternative procedures in this guidance, are being inappropriately applied, safeguards are still in place. Any concerns can be reported in local incident management systems or raised by contacting the CQC, using safeguarding arrangements or through local whistleblowing procedures.

6. The Mental Capacity Act

- DHSC has published [emergency guidance](#) for health and social care staff in England and Wales who are caring for, or treating, a person who lacks the relevant mental capacity during the COVID-19 pandemic.
- The Mental Capacity Act (MCA) 2005 provides protections for people who lack, or may lack, the relevant mental capacity to make decisions about different aspects of their life.
- The Deprivation of Liberty Safeguards (DoLS) are an important part of this act. They provide further safeguards for those who need to be deprived of their liberty in order to receive care or treatment in a care home or hospital, but do not have the capacity to consent to those arrangements. During the outbreak, the principles of the MCA and the safeguards provided by the DoLS still apply.
- The guidance ensures that decision makers are clear about the steps they need to take during the COVID-19 pandemic period. It focuses on new scenarios and potential 'deprivations of liberty' created by the outbreak.

7. The Care Act

- The emergency Coronavirus Act and associated [statutory Guidance](#) allows councils to prioritise which needs they can meet by relaxing some statutory duties where they are unable to fulfil their Care Act obligations because of local resource and capacity pressures.

- Councils should continue to meet all Care Act duties as far as possible and they remain under a duty to meet needs where failure to do so would breach an individual's human rights under the European Convention on Human Rights (ECHR), including the right to life under Article 2; the right to freedom from inhuman and degrading treatment under Article 3; and the right to private and family life under Article 8.
- Where councils choose to operate under the easement measures, they must notify the DHSC of their decision at CareActEasements@dhsc.gov.uk.
- Once the pandemic period is over, delayed Care Act compliant assessments, including financial assessments, and reviews, should be completed in full. Where easements have been used to meet urgent needs, people should be made aware that, after the pandemic period is over, care could be reduced or removed, and they may need to make a financial contribution following a financial assessment.
- The Chief Social Workers office has produced an [ethical framework for adult social care](#) that is designed to support people making decisions in relation to social care and support during the COVID-19 temporary arrangements.
- The provision of aftercare on discharge from hospital and to reduce admission under section 117 of the MHA has not been changed.

8. Specific considerations regarding restraint, restrictive practice and the management of people who refuse to isolate

- Services are operating in unprecedented circumstances, which pose new and complex challenges for staff. It is acknowledged that the impact of COVID-19 may occasionally result in a justifiable need for restrictive practice in order to maintain both patient and staff safety. However, with this in mind, it remains important that at every opportunity providers use the least restrictive methods possible in line with the MHA and MCA Codes of practice (see Box 3). Any use of restriction must be proportionate to the risks involved and providers should refer to their ethics committees where required.

Box 3: The MHA and MCA Codes of Practice – restraint and restrictive practice

- The MHA Code of Practice expects mental health services to commit to reducing restrictive interventions, including the use of restraint, seclusion and rapid tranquilisation, but also wider practices, eg imposing blanket restrictions that restrict a person’s liberty.
- The MCA Code of Practice sets out that, when considering the use of restraint, decision-makers should take into account the need to respect an individual’s liberty and autonomy. In addition to needing to be in the best interests of the person, who lacks capacity in respect of the relevant decision, acts of restraint are only permitted if:
 - the person taking action reasonably believes that restraint is necessary to prevent harm to the person who lacks capacity, and
 - the amount or type of restraint used, and the amount of time it lasts, is a proportionate response to the likelihood and seriousness of that harm.
- Any use of restrictive practice should end at the earliest opportunity while ensuring the safety of the patient and staff; restrictive practice should not be used as a long-term solution.
- We should acknowledge that an increase in restrictive practice may result in psychological harm for patients, especially those with a history of trauma, and so it is important to consider what further support is in place for these individuals.
- Decisions to increase forms of restrictive practice resulting from the impact of COVID-19 should also be documented.
- Where it is necessary to increase restrictions, it is particularly important to make sure that inpatient environments provide sufficient meaningful activities and therapeutic interactions for people.
- It is important to continue to consider the role of safeguarding for people within mental health, learning disability and autism inpatient services, especially if restrictive practice is being used. The Local authorities responsibilities for safeguarding remain unchanged and are outlined in [Annex D of the Care Act Easements Guidance for Local Authorities](#).
- There is clear evidence that people from a black, Asian or other minority ethnic (BAME) group are more likely to be detained under the Mental Health Act, to be subject to restraint and restrictive practice, and to have worse outcomes from their care. It is therefore critical that during the COVID-19 pandemic period, services

continue to use local data and information to identify if BAME people, under their care, are being disproportionately subject to restrictive practice and their work to address these inequalities should continue in partnership with experts by experience.

Blanket restrictions

- It is possible that an increased use of blanket restrictions will be required in some cases to maintain safe care where staffing levels are significantly impacted by COVID-19. Where blanket restrictions are identified as necessary and proportionate due to COVID-19, providers should continue to adhere to their own organisational policies regarding the regular review of the restrictions and documentation as to why they are necessary. The documentation is particularly important to help us monitor the impact of the virus on mental health services. It is strongly recommended that readers revisit the CQC's [brief guide](#) on the use of 'blanket restrictions' in mental health wards.
- Section 17 leave should still be made available to individuals where this is appropriate, particularly where it is an important part of discharge planning, while giving due consideration to the requirements on social distancing and need to reduce risk of transmitting COVID-19. Please see Annex D for further details.
- The principles set out in for managing section 17 leave for people detained under the MHA in Annex D, should also be followed to enable informal patients to access time off the ward where possible.

Managing the care of people with COVID-19

- Isolating patients due to suspected or confirmed COVID-19 in mental health settings may be challenging for all those involved, particularly where the patient refuses to be isolated. Providers need to develop appropriate strategies to manage this safely to protect patients and staff from transmission and risk of physical injury within legal constraints, including their obligations under the Human Rights Act (1998). As already indicated in this document, colleagues should determine appropriate use of the relevant legal framework on a case-by-case basis, with reference to organisational ethics committees and support from medicolegal colleagues as required (as above, it will be helpful to consult CQC's [brief guide](#) on the use of 'blanket restrictions'). The key human right that is at risk when considering the management of people, who will not self-isolate, is the Right to Liberty, which is a limited right, and any restriction on this right has to be lawful, necessary and proportionate. NHS England and NHS Improvement and the CQC are working together – along with providers – to showcase legal and best practice frameworks to

support and guide the provision of care in such circumstances; further detail will be made available in due course.

- As specified in the [guidance on providing care in inpatient settings for individuals with COVID-19](#), it is recommended that all inpatient settings should 'cohort' all patients into those:
 - with confirmed COVID-19
 - without confirmed COVID-19
 - those who require admission and who are awaiting a test to confirm whether they have COVID-19
- It is recognised that the need to cohort patients under these circumstances may mean that providers breach [current guidance](#) on delivering same-sex accommodation. They should then complete a full assessment of the implications for individuals.
- Providers should consider the vulnerabilities of all patients they are caring for and make reasonable adjustments to care and support where required. Inpatient settings should reorganise wards/bays/en-suite facilities and staffing arrangements to separate these cohorts of patients, to maximise protection for the maximum number of patients. Specific local arrangements will need to be kept under regular review as the size and gender mix of these cohorts are likely to change over time.
- Communicating effectively and engaging patients, families and carers is more important than ever during this time of uncertainty. Providers and commissioners should ensure accessible information is available for patients, families and carers in line with the [accessible information standard](#), including easy read information. Co-producing with those with lived experience and their families will support ensuring your information is accessible.
- Providers are advised to provide refresher physical health training (eg monitoring vital signs and the management of a physically deteriorating patient, or rapid upskilling from neighbouring physical health teams) to all relevant clinical staff so they can provide some level of physical healthcare for people with COVID-19. Additionally, providers should ensure that staff don the appropriate personal protective equipment (PPE) when providing care in an inpatient setting. Further detail on training and support for staff can be found in forthcoming guidance on workforce.
- Mechanical restraints should not be used solely for infection prevention control purposes, eg during nasogastric intubation. The [latest PPE guidance](#) and information in NHS England and NHS Improvement's mental health, learning disabilities and autism [Workforce guidance](#) should always be followed.

9. Escorting patients detained under the MHA, including those on Restriction Orders (Sections 41 and 49 MHA) to and from acute general hospitals

- A number of patients detained under the MHA (including those on Restriction Orders (Sections 41 and 49 MHA) would ordinarily require escorts when they need to be transferred to an acute general hospital. Where this transfer is related to the treatment of COVID-19 related symptoms, it is important that patient, staff and public safety is considered as part of the individual risk assessment, but this must be balanced with the risks in relation to infection control for all those involved. The patient's physical presentation will also enable appropriate assessment of the escorting arrangements.
- The arrangements must be planned in conjunction with the acute general hospital's policies.
- Relevant stakeholders, including the Mental Health Casework Section (MHCS - HMPPS) have developed specific guidance in relation to these situations, which is set out in Annex C.

10. Specific considerations for specialised commissioned services

Adult and CAMHS secure services

- Much of the general guidance in this document will apply to specialised services. However, as all patients accessing these services are detained under the MHA, it is important to give them specific consideration.
- In addition, many patients within secure services will be restricted and therefore subject to special controls by the Justice Secretary due to the level of risk they pose.
- Therefore, as we consider the implications of COVID-19 on services, it is acknowledged that there is a significant additional burden on secure providers in terms of legal requirements. This relates to both the clinical and administrative resources required to ensure that this aspect of service is maintained safely and effectively in light of COVID-19.
- Practical considerations to ease this burden will enable services to function more easily where staffing may be reduced or is being used in different ways.
- Organisations can make changes now to how they discharge some responsibilities under the MHA – those that do not require a change in legislation but will reduce burden and also help to reduce community transmission. For example:
 - ensuring meetings take place via digital technology: providers should ensure they have the appropriate technology, policies and procedures in place to support this

- MHA managers’ review hearings can be conducted as paper hearings, proceeding to virtual hearings only in a proportion of cases. This ensures that safeguards to patients under sections 20 and 23 are maintained. See Annex D for further information.
- similarly, other meetings which are important for patients’ treatment and discharge, such as care programme meetings and section 117 discharge planning meetings, should also be held virtually.
- Other stakeholders, such as the Mental Health Casework Section (MHCS) in Her Majesty’s Prison and Probation Service (HMPPS), are considering contingency planning in relation to restricted patients (see Annex B for guidance), so it is important to work closely with them and align thinking and planning generally and in relation to individual cases.
- Patients at risk of being subject to restrictive practices will already have, in accordance with the MHA Code of Practice, care plans and advance statements. Clinicians and teams should therefore review these in conjunction with patients and families/carers, and consider the need for specific additional care plans in light of the need to prevent community transmission.
- As referred to earlier in the guidance, where blanket restrictions are identified as necessary and proportionate as a result of COVID-19, providers should continue to adhere to their organisational policies regarding the regular review of the restrictions and document why they have been necessary.
- Some patients will be subject to Parole Board hearings and their discharge may be impacted, please see [Guidance on Immediate cancellation of all face to face hearings](#) for information to support these situations and relevant contacts if this occurs.

High secure

- It may be necessary due to the implications of COVID-19 for high secure services to derogate from the Safety and Security Directions. Where this is required, the issues identified should be considered by the high secure provider along with potential solutions and mitigations. Any outstanding risks associated with taking these actions should also be identified.
- The position should then be shared with the relevant NHS England and NHS Improvement regional specialised commissioner and the head of mental health for specialised commissioning nationally for their consideration and onward support.
- The chief officer, or their nominated deputy, in each provider will need to authorise the actual derogation from the Directions.

- This will need to be reported to the relevant commissioners by the agreed SitRep report and a weekly summary provided to a core group from the High Secure National Oversight Group (NOG) to ensure oversight.
- Where any significant changes are enacted during this time, these will be discussed ‘by exception’ with NOG members, with the potential to also communicate these changes as required to the Secretary of State.

CAMHS – all inpatient services

- Most of the proposals in this guidance will apply to all ages, including children and young people.
- The current legislation should continue to be used:
 - the MHA and MCA (for 16 to 17-year olds) continue to apply to children and young people as current. The MHA will only change if the emergency provisions in the emergency Coronavirus Act are triggered.
 - the Children Act 1989 (and related legislations) remains applicable, such as in relation to child safeguarding matters
 - additionally, the use of parental responsibility and consent for non-competent children under 16 years and non-capacitous 16 to 17 years (depending on the decision to be made) remain as current¹
 - practitioners should continue to use consent by Gillick competent children under 16 years where applicable.
- The emotional and behavioural responses of some children to the constraints, uncertainties and significant changes to daily living, due to COVID-19, may provide diagnostic challenges when assessing individuals under the MHA. Advice from professionals with experience in children and young people’s mental health should be sought in such cases wherever possible.

11. Specific considerations for learning disability and autism services

- To have equality of access to care and treatment, people with a learning disability and autistic people may require individuals and systems to make reasonable adjustments to their practice, policy and procedures. This applies equally where legislation is used to facilitate delivery of urgent and non-consensual treatment.
- Caution should be taken when determining whether an individual with a learning disability and/or autism is detainable under the MHA.

¹ For non-capacitous 16 to 17-year olds, where the care plan amounts to a deprivation of liberty, parental responsibility and consent cannot be relied on.

- While people with a learning disability and/or autism can present with a mental illness, which requires treatment under detention, in particular circumstances they can also be detained on the basis of learning disability and autism being defined as mental disorders in the MHA.
- To prevent unnecessary admissions, and ensure appropriate care, it is important that virtual community [Care \(Education\) and Treatment reviews](#) (C(E)TRs are maintained. Please see the NHS England and NHS Improvement [managing capacity and demand guidance for more information](#).
- In the case of learning disability, the presence of ‘abnormally aggressive or seriously irresponsible conduct’ is necessary to detain an individual under section 3 or equivalent of the MHA. It is important that, if a person with a learning disability does not meet the specific behavioural criteria for detainment, non-compliance or difficulty in gaining compliance, with any restrictions and interventions required for the management of COVID-19, is not interpreted as adequate grounds on which to detain them. Further, the fundamental principle that the MHA is not for the treatment of physical disorders must be borne in mind where there is no association between a person’s physical and mental disorder.
- The emotional and behavioural responses of people with autism to the constraints, uncertainties and significant changes in daily living as a result of the management of COVID-19 may also provide a diagnostic challenge in assessments under the MHA. At a time of reduced workforce and where expedient solutions to implementing the MHA are being sought, it is essential that the support of health and social care service practitioners with particular experience and expertise in learning disability and/or autism is sought wherever possible to enable appropriate, reasonably adjusted assessments.
- People with a learning disability and/or autism in inpatient settings are already vulnerable to and disproportionately represented in the use of inappropriate and excessive restraint, seclusion and long-term segregation. This in itself may cause or perpetuate trauma. Safeguards must be put in place in hospitals to monitor and ensure that reductions in staffing ratios, the pressures on space, throughput and availability of activities, and reduced contact with family members are not leading to excessive use of restrictive interventions and segregation. Restrictive practice should always remain proportionate and never be punitive or used to inflict pain, suffering or humiliation.
- Staff leaders, managers and trainers should implement recommended and established person-centred, ‘no force first’ approaches: [reducing the need for restraint and restrictive intervention](#).

- Specific and additional consideration may need to be given to how children, young people and adults with a learning disability and/or autism can maintain regular routines and patterns of contact with families through virtual contact or innovative methods of contact – as altering these can again exacerbate anxiety, distress and behaviours that challenge.

12. Specific considerations for people with dementia

- Some people with dementia may have difficulty understanding complex instructions about self-isolation or handwashing – keeping information accessible and repeatable is key.
- People with dementia may lack awareness of the risk posed by COVID-19 and be less able to report symptoms because of communication difficulties – people should be alert to the presence of signs, as well as symptoms, of the virus ('look beyond words').
- No blanket decisions on care and treatment should be made. Advance Care Planning (ACP) will help identify the wishes and preferences of people with dementia as described in My Future Wishes – check if the person with dementia has an ACP or a Health and Welfare Power of Attorney.
- Guidance is available on [how to protect care home residents and staff during the coronavirus outbreak](#) and guidance for [residential care, supported living and home care in the event of a coronavirus \(COVID-19\) outbreak](#).

13. Specific considerations for mental health, learning disability and autism and the criminal justice system

Transfers and remissions to and from prisons/Immigration Removal Centre (IRCs) and mental health inpatient services

- During this time patients will continue to require transfer and remission across organisations based on their mental health needs.
- It is important that current service specifications and guidance are adhered to as far as possible, but it is recognised that there may be some inevitable delays that will need to be managed on an individual case by case basis.
- Where appropriate, digital technology should be used across relevant services in respect of undertaking assessments and clinical discussions.
- Where suspected and COVID-19 positive patients require transfer or remission as part of this pathway, these cases must be considered on an individual basis, taking

into account both mental health and physical healthcare needs. It will be important for respective teams across organisations to work together where such cases arise and to support decisions made.

- Robust and live communication across the mental health inpatient assessment services (secure and non-secure), prisons and IRCs is very important at this time.
- [Guidance](#) has now been developed with Her Majesty's Prison and Probation Service (HMPPS) and other relevant stakeholders to support the pathway to and from prison during this time.

Non-custodial mental health, learning disability and autism services

- There will be patients who will continue to require either liaison and diversion services or mental health treatment. Existing services should be maintained as much as possible, taking into account service abstraction and risk assessments, to support these patients.
- Where appropriate, digital technology should be used across relevant services to undertake assessments and clinical discussions.
- Relevant stakeholders, from Her Majesty's Prison and Probation Service, Ministry of Justice, Her Majesty's Court and Tribunal Service, police services and NHS England and NHS Improvement are working together to explore specific issues in relation to these pathways.

Specific considerations for restricted patients

- The Mental Health Casework Section (MHCS), in Her Majesty's Prison and Probation Service (HMPPS), has undertaken contingency planning in relation to restricted patients. **See Annex B for their latest position.**
- An emergency practice direction has been issued that will enable single judge panels and telephone hearings. The tribunal also plans to prioritise section 2 hearings and conditional discharge recalls. More information is available on Tribunal Hearings in Annex D.

14. Application of digital technology to Mental Health Act assessments

It is vital that Mental Health Act (MHA) assessments are conducted in a calm and considered way, which treats the person with dignity and as far as possible respects their wishes, while following the principles of the MHA 1983 and code of practice. Much of this relies on a close interaction between the staff and person being assessed. By its nature, social distancing and requirements for personal protective equipment (PPE), during the COVID-19 pandemic, introduce a number of barriers to building this relationship.

The following guidance sets out how digital technology can be applied to the MHA process during the COVID-19 pandemic; this includes key principles and safeguards. The guidance currently focuses on supporting teams to conduct remote assessments through the use of video. It is particularly relevant for AMHPs and local authorities, who have the overall responsibility for arranging and overseeing Mental Health Act assessments and ensuring they are carried out within the legal guidance. It will be regularly updated to reflect the rapidly changing context, as well as questions/concerns and feedback from the sector. It builds on [guidance](#) already published by the Royal College of Psychiatrists, which has helped to establish how remote psychiatric assessments and consultations (excluding the MHA) may best be carried out. As well as [guidance](#) by the Judiciary of England and Wales as to how to conduct capacity assessments remotely.

As MHA assessments inform important decisions about whether to detain a person and deprive them of their liberty – for the purposes of care and treatment – high standards are essential. Great consideration will need to be required to ensure that the use of digital technology, particularly video, does not disadvantage a person, nor inadvertently widen inequalities.

This guidance has been prepared for use during this particular pandemic only. The MHA makes it a legal requirement that doctors must “personally examine” a person before recommending that they be detained, and that an Approved Mental Health Professional (AMHP) must have “personally seen” the person before applying for a detention.

It is the opinion of NHS England and NHS Improvement and the DHSC that developments in digital technology are now such that staff may be satisfied, on the basis of video assessments, that they have personally seen or examined a person in a ‘suitable manner’. Bearing in mind the need to prevent infection and to ensure the safety of the person and staff, in some circumstances the pandemic may necessitate the use of such digital technology for MHA assessments. Providers should follow the guidance below to inform this decision. While NHS England and NHS Improvement and DHSC are satisfied that the provisions of the MHA do allow for video assessments to occur, providers should be aware that only courts can provide a definitive interpretation of the law.

Principles of applying digital technology

The use of digital technology to facilitate MHA assessment is a departure from traditional ways of working. It is therefore vital that as far as possible the use of digital technology, including video, is safe, consistent and well-governed both clinically and at trust board level, with local authority oversight.

The principles outlined in the Mental Health Act Code of Practice, and Responding to COVID-19 [Ethical Framework for Adult Social Care](#), should remain foremost when staff are considering the suitability of applying digital technology to MHA assessments. To support this, the Steering Group, advising NHS England and NHS Improvement on this work, has

developed the following checklist (see Appendix B). The contents of the checklist should be considered, and where relevant agreed with the person being assessed.

Additional guidance on ethical issues, likely to arise when providing care and treatment during the COVID-19 pandemic, are available from the [British Medical Association](#) and [General Medical Council](#).

Minimum standards and safeguards where video assessments are acceptable

Even during the COVID-19 pandemic, it is always preferable to carry out a Mental Health Act assessment in person. Under specific circumstances where this cannot happen (see below), it is possible for video assessments to occur. Decisions should be made on a case-by-case basis and processes must ensure that a high-quality assessment occurs.

Clinicians must consider the risks and benefits of undertaking an MHA assessment in person, compared to a video assessment, on a case-by-case basis. This should take into consideration:

- the person's presentation, including any complex needs
- if a video assessment is likely to cause unnecessary distress where a person might be more acutely unwell
- if reasonable adjustments can be made to ensure a fair experience for the person.

A. Situations where a video assessment can be considered

Video assessments can be considered if:

- there is significant risk of harm via transmission to the person and/or staff². For example:
 - the person and/or person living near them is showing COVID-19 symptoms.
 - personal protective equipment is unavailable, inadequate, or its use may result in significant distress to the person being assessed
 - social distancing (greater than two meters) is not possible at the assessment location. Note that the nature and degree of the person's presentation, for example hyperactivity, may present an increased risk to being able to maintain physical distancing and other safeguards against the transmission of infection
- **AND** there is a significant risk of harm due to the delay of assessment and/or subsequent intervention, in the instance that an assessment is deemed absolutely necessary and cannot be conducted in person in a safe and timely way. Delays may result from:

² See COVID-19: infection prevention and control (IPC) guidance
<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>

- limited availability of staff, including staff who might be shielding
- inability of external staff members to access the assessment location (for example a COVID-19 ward)
- **AND** the minimum quality standards and safeguards are met to ensure that a meaningful and high-quality assessment can occur in a safe environment (see Section 0).

B. Minimum standards and safeguards

i. Minimum standards of technology and environment:

In order for a video assessment to be considered, there must be robust digital technology in place and a suitable environment that can enable a high-quality personal assessment to be conducted. To ensure this, the following minimum standards should be met:

- body language and facial expressions of the person being assessed, and staff should be accurately observed
- a consistent connection must be maintained that allows uninterrupted video and audio streams. To ensure this, technology and equipment should be tested in advance of the assessment starting, for example by checking the broadband speed or by streaming a short video
- a calm, professionally appropriate environment should be maintained, which is free from distractions, interruptions, or unnecessary people
- technology must be secure and patient confidentiality should be maintained throughout. It is a requirement that the assessment must not be recorded.

ii. Taking into account a person's views

It is vital that wherever possible joint decisions, taking into account the person's views, should be made about the use of video assessments. As with all assessments, the decision whether to conduct a video assessment should ultimately be made by the staff and does not require consent. To help to ensure that a joint decision can be made:

- the person should be asked if they have used digital technology (including video) in previous interactions
- the person should be given the option to express concerns about undergoing a video assessment (noting that the alternative may be an assessment with staff in full personal protective equipment where the assessor's face may be hidden by a mask)
- the process should be discussed with the person fully, taking into account communication needs. This should include:
 - an explanation of the reasons for this approach

- instructions on how the assessment will happen
- time for questions and clarification ensuring that the process is understood
- available information in accessible formats such as, but not limited to, easy read
- where possible, agreement should be reached with the person about the use of a video assessment, this needs to take into account capacity and best interests. Staff must be satisfied that the person understands what is happening.
- the person should be given the opportunity to have a family member or advocate present during the assessment where practicable. Where appropriate, families and carers should be contacted through the usual process, and the situation (including use of video consultations) explained to them.

iii. Safeguards and ensuring quality:

Throughout the process, staff, as well as the person and their carer (if appropriate), should be confident with the quality of the video assessment and that it meets the requirements of the MHA.

Before the assessment:

- There is an expectation that the assessment team will discuss and agree the appropriateness of a video assessment, as set out in this guidance, prior to undertaking one and record this discussion as appropriate. This procedure is designed to help the team feel that a decision taken to use a video assessment will be supported by their employing organisation.
- Consideration should be given on how the video assessment can accurately capture external sources of information, such as the contribution of ‘knowledgeable informants’ or observations of the person in a particular environment
- Staff should have the appropriate competence, training, and support to conduct or facilitate a video assessment within a time-frame that supports a clinically cohesive and comprehensive assessment to occur. This should include:
 - awareness of staff biases that may emerge through the use of video assessments (for example, increased risk aversion)
 - awareness of population-specific considerations (see Section 0), including heightened risk of inequalities or risk of inappropriate detention under the MHA.

During the assessment:

Staff should:

- consider if the person is adversely impacted by the use of digital technology during the assessment. This includes, where possible, reviewing with the person any existing or new concerns about the use of a video assessment
- consider if they have adequate visual access to the person and their surrounding

- consider if the person's communication needs are adequately addressed during the video assessment, this should include:
 - the availability of translators and/or interpreters where appropriate
 - considerations for specific populations, such as whether video consultations provide sufficient clarity of sign language.

Discontinuing a video assessment

There may be instances where an assessment is started remotely and then cannot be completed. Examples include if the person reacts adversely to the situation or if there is a hardware or software failure. In such situations an assessment should be convened in person as rapidly as possible in line with a pre-determined contingency plan. This plan should be agreed with the assessment team before the video assessment commences and should consider factors such as the travel distance between the remote staff undertaking the assessment and the person being assessed.

- Staff should consider if and how a paused or failed assessment has impacted the person and their presenting their symptoms.
- The reasons for cancelling a video assessment should be clearly recorded and shared with the team to support continuous improvement.

Following the assessment

Immediately after the assessment, the assessing staff must be satisfied that the video assessment provided a satisfactory basis on which to assess the person before providing a medical opinion under section 12 of the MHA. This judgement should include a consideration of whether the circumstances of the video assessment itself affected the responses given or the person's engagement with the process.

Local and national processes should be in place to monitor the quality of MHA assessments delivered via video. This includes:

- clear, auditable, and timely documentation across the relevant organisations that a video assessment was carried out, including the reasons for this, and any limitations resulting from the use of video. This should be recorded in the patient record and MHA papers
- a reflection of the process, to ensure lessons can be learned and improvements can be made as required during this time and after the COVID-19 pandemic. Following every video assessment:
 - the person should be offered time to discuss their experience with an appropriate member of staff, advocate or carer
 - there should be appropriate staff debriefing including feedback on their experience

- the use of existing safeguards, such as independent mental health advocate and CQC investigatory functions under section 120, to specifically monitor patient experience on the use of digital technology
- clear processes to mitigate the likelihood of unintended consequences, such as:
 - increased referrals to Place of Safety
 - an increase in detentions due to more risk averse behaviour during video assessments
 - the exacerbation of existing biases or inequalities.

iv. Documentation

Clear processes should be in place which ensure that staff can safely access, complete and submit the appropriate documentation remotely. As stated in guidance on the use of the Code of Practice during the COVID-19 pandemic period only (see Appendix A), to support remote working arrangements, services may complete and communicate statutory forms electronically. This includes the use of electronic signature.

It is recommended that wherever possible this is supported by the use of encrypted/secure signing. In exceptional circumstances, other forms of signing electronically (for example, PDF of handwritten signature or typing a name into the electronic form) are also permitted during this pandemic period.

All electronic files should be processed and stored in line with the GDPR and Data Protection Act 2018. It is strongly advised that providers put in place an agreed protocol for the electronic submission of statutory forms, to ensure these are sent and received securely.

C. Specific considerations by setting:

The following section outlines how the minimum standards and safeguards in Section 0 may be applied to specific settings. The decision should be guided by the assessment team with the fundamental question being if the method proposed can ensure that a high-quality assessment can occur in a suitable manner.

i. Community settings (including home)

It is likely that the minimum quality standards will be difficult to achieve in a community setting. Therefore, video assessments should only be considered in community (home) settings in exceptional circumstances, including where there is significant risk of transmission or significant risk from delayed assessment or intervention.

In such circumstances, it is recommended that the AMHP and, at least, one section 12 doctor should attend the assessment in person and, if necessary, the second doctor may join via video.

ii. Place of Safety

In a Place of Safety, where there is high confidence that the minimum standards can be achieved, the need for video assessments can be decided on a case-by-case basis by the assessment team. This decision should be communicated to the person being assessed, and their preference should be taken into account in line with the safeguards listed in the previous section.

The requirement for an assessment in a Place of Safety will usually follow a detention made under police powers under section 136 of the MHA. This assessment is often started by a single doctor, usually approved under section 12, to determine whether the person is suffering from a mental disorder and if care and treatment is needed. If the doctor finds the person is not suffering from a mental disorder, they must be discharged immediately, otherwise they will need to be seen by an AMHP. If the doctor finds that the person needs further care, it may be acceptable for the doctor to arrange for the AMHP to interview the individual remotely, using video.

In all situations, it is a requirement that at least one mental health trained professional must attend the assessment in person.

iii. Mental health hospitals

In mental health hospitals where there is high confidence that the minimum standards can be achieved, the need for video assessments can be decided on a case-by-case basis. The principle outlined in Section C (ii) should be applied. This takes into account the expectation that appropriate mental health staff will already be available on site.

iv. Acute hospitals

It is likely that the minimum standards will be difficult to achieve in a general acute hospital (either on a ward or in A&E). Therefore, video assessments should only be considered in exceptional circumstances, including when there is significant risk from delayed assessment/ interventions. Consideration should also be given to:

- the increased access of medical professionals and liaison mental health teams in the hospital environment which may mitigate challenges of undertaking the assessment in person and in a timely manner
- whether risks are best mitigated through the use of video assessment or the use of Section 4 of the MHA.

v. Police stations

Many police secure custody suites will have access to a secure room for discrete visits which normally have a secure solid screen separating the two halves of the room. These are sometimes used for private visits where security remains a concern. In these circumstances, and where the police station is being used as a Place of Safety

following a detention under sections 135 or 136, there may be opportunities for either a single doctor or AMHP to visit in person the detainee in order to carry out an assessment without significant personal protective equipment. This might enable one (either the AMHP or the doctor) to be remote via video conference with one present at the location.

vi. Part III detentions: Prison and immigration removal centres (IRCs)

This guidance should be read in conjunction with HMPPS/NHSEI Guidance - [Prison Transfers and Remissions to and from Mental Health Inpatient Hospitals in relation to COVID-19](#).

- All routine transfers out of and between prisons have been stopped as of 31st March 2020 by Her Majesty's Prison and Probation Service (HMPPS), and all movements require permission from HMPSS Gold Command.
- In order to expedite assessment and transfer, NHS England and NHS Improvement and HMPPS therefore encourage greater use of digital technology in these settings and are supporting the expansion in use of telemedicine technology in prisons to facilitate MHA assessments.
- It is important to remember that:
 - prisons and IRCs should not be considered a place of safety, and where indicated MHA assessments and subsequent transfers must continue and be facilitated where clinically indicated during this time. This includes all individuals regardless of diagnosis, and includes access to mental health and learning disability or autism services.
 - treatment under the MHA can only take place in a mental health hospital setting, and not whilst a person is detained in a prison or an IRC, so it is imperative that MHA assessments are facilitated to enable transfer for timely treatment where required.

Additional considerations for remote assessments via video in prison or IRC settings:

- In addition to Section 0, the following should be considered:
 - need to minimise the introduction of professional visitors to the prison or IRC to reduce the risk of infection for all those involved.
 - risk of cross infection as staff access a prison or IRC and then return to the mental health settings where they work ordinarily
 - staff capacity/resource potentially being reduced due to COVID-19 impact
 - need to reduce travel for staff, recognising that these settings may be at significant distance from the staff's normal places of work

- risk of delays for persons to access appropriate assessment and intervention, which they may not be able to access whilst in a prison or an IRC
- In addition to Section 0, the following should be considered:
 - each case should be risk assessed, considering risk to the person subject to the MHA assessment, to others, and the public.
 - the person should be offered time after the assessment to discuss their experience with an appropriate member of staff from the prison or IRC MH service, and any concerns or queries should be addressed and any follow-up facilitated as required
 - ideally the assessing clinician should see the person visually to undertake a high-quality assessment; however, it is recognised that there may be occasions where this is not possible. The situation must be assessed accordingly and a plan to derogate by absolute exception, for example, to a telephone assessment out of necessity may need to be facilitated. This would be rare.
 - the use of appropriate digital technology to facilitate the gathering of additional information from the current clinical team in the prison or IRC, to enable the assessing clinician to complete the assessment

Telemedicine:

- Telemedicine technology and software is being introduced into prisons and appropriate staff issued with licences. Psychiatrists and other mental health professionals in relevant MHLDA settings will be able to access the video link via an invite sent from the prison / IRC mental healthcare team to a specific pre-approved secure nhs.net email address.

D. Specific considerations as exemplified by population:

i. Children and young people

- In addition to section 0, the following specific considerations should be applied when assessing children and young people (CYP):
 - ensuring those with parental responsibility for those under 16 are consulted and make the decision for the child unless they are assessed to be Gillick and Fraser Competent
 - the person’s age, stage of development, and capacity to consent
 - reasonable adjustments to be made so that the CYP is able to engage with the video assessment process including support for CYP with neurodevelopmental needs (for example difficulties with learning, language and communication, hearing, vision, social communication, attention and activity)

- the contribution of the parent/carer to facilitate the video assessment process by ensuring appropriate equipment is available, supporting the CYP to engage and parent/carer involvement in the assessment process itself assessing the young person on their own as part of the assessment
- assessing factors such as safeguarding concerns that would suggest an assessment in person is more appropriate
- Wherever possible, the video assessment should involve a member of staff with experience and expertise in child and adolescent mental health as recommended by the MHA Code of Practice. If this is not possible then the member of staff should be supported remotely (via video) by a CAMHS professional.

ii. Learning disability and autism

In addition to section 3, the following considerations, reasonable adjustments, and safeguards should be applied when assessing people with learning disabilities and autistic people (bearing in mind that any requirements will be specific to the person):

- staff should ensure they take time to understand the specific needs of people with a learning disability and autistic people and are mindful of the issues people may have in relation to understanding, communication and support needs. This includes:
 - checking the specific communication needs of the person, for example, a person may find it difficult to respond to questions administered via video; may find it hard to concentrate, may have a sensory impairment and therefore ensuring reasonable adjustments are made to support the assessment
 - ensuring that there is sufficient visual clarity where people are communicating using Makaton, sign language or alternative and augmented communication methods and consider the need for a signer or someone with expertise in the communication method
 - ensuring easy-to-read information about the MHA assessment, and what it means, is available to the person
 - consideration of supporting information, including if the person has a healthcare passport and involvement of ‘knowledgeable informants’ especially families, including advice on reasonable adjustments to support participation in video consultations
 - being aware of the risks of diagnostic overshadowing where the presenting behaviour / problem is attributed to the learning disability or autism label rather than physical or mental health problems. These issues may not be clear unless there is good quality supporting information and accounts from people who know the person well

- being aware that people with a learning disability or complex needs are often at heightened risk of digital exclusion and may not be confident or require additional support when using digital technology
- for people with more severe learning disabilities, non-verbal cues which experienced assessors may be able to pick up in person, are less likely to be evident during video assessments.
- staff should check that a Care, (Education) and Treatment Review has taken place and that they have seen the recommendations of the review before the assessment takes place.

In addition to Section B iii, it is essential that robust processes are in place to monitor the quality of MHA assessments and to ensure an appropriate decision is made a major concern is ensuring that people are not admitted in the absence of a diagnosed mental health problem. They should not be detained solely on the basis of behaviour. There is evidence when this occurs, it can be very difficult to achieve discharge and people frequently stay in hospital for lengthy period of time. There is also an increased risk that these people are placed under higher restrictions, such as seclusion and long-term segregation.

iii. Older adults and people with dementia

In addition to Section B, the following should be considered for older adults and people with dementia:

- people with dementia are much more prone to develop delirium if they develop an infection; those conducting an MHA assessment need to be aware of this increased risk
- some people with dementia may have difficulty understanding complex instructions particularly during video assessments; keeping information accessible and repeatable is key. Consider how therapeutic language or specific vocabulary can be simplified, paraphrased or be represented by symbols or pictures, to best support individuals understand and respond.
- people with dementia may lack self-awareness of and be less able to express themselves clearly because of communication difficulties; those conducting a consultation or MHA assessment should be alert to the presence of signs (“look beyond words”)
- assessors should identify any alternative or augmentative means of communication that may help the person understand or express themselves. This may require additional preparation with the person or their family/carers to identify the best means of communication.
- the person may need extra time to become familiar with and comfortable in using the digital technology, consider pacing the session according to the person’s needs

and monitor their concentration level. Using signs, symbols or pictures is likely to slow the pace of the therapeutic intervention; this will need to be considered.

Annex A: Resources that have been developed to support practice in mental health settings in light of COVID-19

- The Royal College of Psychiatrists has produced [Guidance for psychiatrists and other professionals working in mental health settings \(COVID-19\)](#).
- The Royal College of Nursing has produced [COVID-19 guidance](#); providing general principles to support the delivery of care.

Annex B: Mental Health Casework Section

Position as of 30 March 2020:

Mental Health Casework Section have published [guidance on temporary change in processes in response to COVID-19](#). Aside from these changes, providers should continue to follow official guidance regarding the care of their patients. Individual cases can be discussed directly with the team at mhcsqacs@justice.gov.uk

Annex C: COVID-19 - Escorting patients detained under the Mental Health Act (MHA) including those on Restriction Orders (Sections 41 and 49) to and from acute general hospitals

1. Context and purpose of guidance

- There are times when patients detained under the MHA, including those on Restriction Orders (Sections 41 and 49 MHA), ordinarily require escorts as they need to be transferred to an acute general hospital. This guidance is specifically provided to support the increased number of transfers, planned and emergency, that are required at this time as a result of COVID-19 related symptoms and treatment. Patients who are detained under the MHA require access to the same standard of physical healthcare as the rest of the general population and as such this guidance has been developed to ensure this can happen safely, effectively and in a timely manner.
- Where the transfer of a patient detained under the MHA is related to the treatment of COVID-19 related symptoms, it is important that patient, staff and public safety is considered as part of the individual risk assessment, but this must be balanced with the risks in relation to infection control for all those involved. Each case will need to be managed in its own right; decision making must be individualised and made in collaboration between the relevant MHLDA, ambulance and acute general provider and should consider:
 - the clinical presentation of the patient,
 - the expectations of the clinical team in the acute general provider,

- the potential risk to staff (escorts) considering the clinical environment the patient will be cared for in.

2. Supporting the safe transfer and admission to and from acute general hospitals

2.1 General principles for MHLDA providers

Establishing local contacts and communication

- MHLDA providers must ensure they have established robust communication links with the local ambulance service, acute general provider, and where relevant the local police force to:
 - Understand the relevant local processes.
 - Liaise with Liaison Psychiatry Services, where available, as these services can be very useful in facilitating communication and understanding between the referring MHLDA service and the acute general hospital as they already have established relationships.
 - Share information about management of infection risks in the acute general hospital setting and the personal protective equipment (PPE) requirements for escorting staff in each situation, in line with [national guidance](#).
 - Share appropriate clinical and where required security information in relation to each patient who requires transfer.
 - Maintain and agree close communication arrangements with the relevant service, especially when it is agreed that it is not required or appropriate, for escorts from the MHLDA provider to remain with the patient.
 - Share early indications of any change in the patient's presentation whilst in the acute general hospital setting, and/or establish when it is appropriate for a patient to move back to MHLDA provider, depending on level of physical health care required.

Risk assessment and management

- Each patient and situation must be assessed individually in terms of risk to self, staff and the public.
- Relevant care plans and risk management plans should be clearly communicated by the responsible MHLDA clinical team to the escorting staff, ambulance service and to the receiving team at the acute general hospital. Some MHLDA providers, particularly secure services, have proactively developed a clear one-page summary of risks for each patient (eg including information such as risk of violence or absconsion risks).
- Any specific requirements, eg for high secure services use of cuffs, must be considered on an individual basis and risk assessed as required.
- For individuals where the risk would normally involve Multi Agency Public Protection Arrangements (MAPPA) and/or a police trigger plan, appropriate liaison with the local police as per current arrangements should occur.
 - Where this relates to a planned transfer this can take place prior to the transfer.
 - In an emergency this should take place as soon as possible after the transfer but must not delay the transfer.

Escorts

- All individuals should be individually risk assessed in terms of the appropriate escort levels required.
- MHLDA providers must ensure that plans relating to escorts who are travelling and/or remaining with the patient, are fully understood by the receiving teams in the relevant ambulance service and acute general provider.
- Where patients require specific numbers of staff to escort them, additional staff can travel separately during transportation and can be deployed appropriately once the patient has arrived in the acute general hospital setting.
- Escort numbers should be predicated on the individual's physical and mental health (eg level of consciousness, severity of physical symptoms and impact on patient's ability to mobilise and the potential of risk to others) and known risk (eg as summarised on the one-page summary).
- MHLDA providers should, if practicable and as part of their contingency planning, have available more escorts than may ordinarily be necessary so staff can be flexible in approach, eg for identified high risk patients, escorts may need to cover entrances and exits to the ward area rather than remaining in close proximity to the patient. This could include liaison with security staff in acute general hospitals where appropriate.
- MHLDA providers must clearly communicate with all staff who will be/are escorting patients about the risks of potential exposure to COVID-19 infection in the acute general hospital setting and the need to adhere to PPE requirements in the relevant setting, and in line with [national guidance](#).

2.2 Patients detained under the MHA on Restriction Orders

Restricted/None Restricted Patients	Escorting requirements for planned and emergency transfers to acute general hospitals during COVID-19
<p>Restricted Patients (those subject to restrictions by the Justice Secretary due to the risk they pose: s37/41, transferred prisoners s47/49 and s48/49 and patients with a hospital direction s45A/45B) who are detained under MHA.</p>	<ul style="list-style-type: none"> • Escort levels are generally a matter for the patient's Responsible Clinician (RC), in liaison with the patient's Multi-Disciplinary Team (MDT). • In high secure settings specifically, this is a decision for the patient's RC, MDT <u>and also</u> security staff from the relevant provider. • General Mental Health Casework Section (MHCS) requirements for medical leave (planned and escorted) are set out in the guidance issued in April 2019. This describes arrangements for high secure settings and general consent for medical leave arrangements (none high secure) and associated escort expectations. However, it is noted that pressures arising from COVID-19 mean expectations around escorts may not always be practicable during this time. <p>Emergency treatment (COVID-19 related):</p> <ul style="list-style-type: none"> • Where emergency treatment is required, the priority is to deal with the physical health crisis and as such, there is no expectation from MHCS, acting on behalf of the Justice Secretary, that MHLDA providers necessarily provide the number of escorts agreed for that patient (this includes high profile patients). • As described above, where possible, escort numbers should be predicated on individual patient's physical and mental health (eg level of consciousness, severity of physical symptoms and impact on patient's ability to mobilise and the potential of risk to others) and known risk. • For all restricted patients, MHLDA providers must contact MHCS as soon as practically possible (via email) after any emergency transfer. <p>Planned transfers to acute general hospital (COVID-19 related):</p> <ul style="list-style-type: none"> • For high-profile patients, approval from MHCS, prior to transfer, is required in non-emergency situations. In all cases appropriate risk assessment should be carried out by the care team in advance of any planned medical leave.

	<ul style="list-style-type: none"> • General consent for medical leave continues to apply in non-high secure settings. There is no need to apply to the MHCS for medical leave, prior to the patient being transferred, unless the patient is high profile. • Where practicable in non-emergency situations, for all restricted patients, conditions including escort levels should be applied in line with those in place for routine day appointments. Where COVID-19 prevents these conditions from being met, escort numbers should be predicated on individual patient's physical and mental health (as described above).
Non-restricted patients detained under MHA	<ul style="list-style-type: none"> • The number of escorts should be determined by the patient's RC and the MDT taking into account the individual risk assessment, as well as physical health condition.

3. Useful contacts

Mental Health Casework Section (MHCS), HMPPS		
Angela Munley	Heads of Team	Angela.Munley@justice.gov.uk
Mike Nolan	Heads of Team	Mike.Nolan@justice.gov.uk
James Peck	Heads of Team	James.Peck@justice.gov.uk
MHCS out of hours		0300 303 2079

4. Useful resources and links

The following resources have either been mentioned in this document or are related to the issues raised here.

Document / Guidance	Link
'Authority to use medical leave' letter from MHCS to all hospitals detaining Restricted Patients	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/796656/Medical leave - letter to all hospitals.pdf

Learning Disabilities and Autism for the acute trust and ambulance re: critical frailty guidance	Link to be added when published
Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic	www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0072-MHLDA-Covid-19-Guidance-Legal-300320.pdf
DHSC Statutory Guidance on the MHA Provisions COVID-19	Link to be added when published
Guidance on supply and use of Personal Protective Equipment (PPE)	www.england.nhs.uk/coronavirus/publication/guidance-supply-use-of-ppe/
Workforce guidance for mental health, learning disabilities and autism, and specialised commissioning services during the coronavirus pandemic	www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0074-MHLDA-Covid-19-Guidance-Workforce-final-v1-1.pdf
Supporting patients of all ages who are unwell with COVID-19 in mental health, learning disabilities and autism, and specialist inpatient facilities	Link to be added when published
'Mental Health, Learning Disabilities and Autism COVID-19 Response Cell' Future NHS Collaboration Platform	https://future.nhs.uk/MHLDAcovid19/grouphome

Annex D: Guidance on using the Code of Practice during the pandemic period

This guidance has been developed with and approved by The Department of Health and Social Care (DHSC). It has been included in this NHSEI document to support the alignment and streamlining of communications to the system. DHSC will also be supporting its dissemination to the relevant Local Authority and social care partners, recognising that these important messages are applicable across the health and social care system.

A. Section 136 assessment

- As usual, if a police officer deems it necessary to take an individual to a designated health-based place of safety under Section 136 of the MHA, the duty doctor should assess the individual and determine whether they are suffering from a mental disorder or not and if care and treatment is needed (either in a hospital or otherwise). Doctors examining patients should, wherever possible, be approved under section 12 of the Act (16.46 CoP).
- We wish to remind practitioners that, if the person is found not to be suffering from a mental disorder then the person must be discharged, even if not seen by an AMHP (16.50 CoP).
- If the doctor finds that the individual is suffering from a mental disorder but is unsure if a further MHA assessment is needed, with a view to potentially detaining the individual under the MHA, or if community support needs to be arranged, the doctor should consult with the duty AMHP remotely, as a first step, during the pandemic period.
- If, after an initial discussion with the AMHP, the doctor decides that compulsory admission of the individual is not needed, the AMHP must interview the individual to establish the follow up care and support in the community that may be required. In this case, during the pandemic period, remote assessment may be deemed more appropriate (see Section 14 on the application of digital technology to Mental Health Act assessments).
- If, after an initial discussion with the AMHP, the doctor decides that compulsory admission of the individual is needed, it is preferable that the AMHP should attend, along with the doctor, to assess the individual in-person. If the person detained under section 136 is far from home, then the local authority, rather than the home authority, should arrange for the nearest AMHP to attend (16.28 CoP).
- As a reminder, during the pandemic less restrictive alternatives to the use of police powers to detain people under Section 136 of the Act should continue to be considered (see 16.22 of the CoP). Health and social workers must be consulted on other possible options (section 136, (1C), MHA).

B. Approved Mental Health Professionals (AMHPs) and responsibilities of Local Authorities

- Responsibilities of local authorities:
 - If a patient is currently detained under section 2, in order for that patient to then be placed under section 3, the Code states that the local authority which arranged the section 2 detention should arrange for an AMHP to make the section 3 application (14.37 CoP).
 - This means that, usually, in cases where the patient is placed in a hospital outside of the home authority, an AMHP from that home authority may be asked to travel to the hospital to make the section 3 assessment.
 - In view of the Government's advice to avoid all non-essential travel, during the pandemic, it should be an AMHP from the local authority where the patient is under section who makes the application. This should be agreed between local authorities.
- Local Authority authorisation of approved mental health professionals
 - The [2008 regulations](#) made under the MHA outline a range of expectations on how local authorities should authorise approved mental health professionals and thereby license them to practice.
 - Where the pandemic is increasing pressures on AMHP services, the following flexibilities, which already exist within the regulations and CoP, may be helpful for LAs to consider.
- Working across LA boundaries:
 - An AMHP must be approved by one local authority but can be authorised to act on behalf of a number of authorities who have satisfied themselves they meet the requirements to practise as an AMHP. MHA s13(3) currently permits that an AMHP can work on behalf of their own local authority in another LA area, even if the statutory duty to undertake the MHA assessment lies with the other Local Authority.
- Reapproving AMHPs whose authorisation has lapsed:
 - The [2008 regulations](#) made under the MHA provide that a Local Authority can authorise a social worker (or other health professional) to practice if they believe that the person is competent and meets the requirements to be an AMHP. For AMHPs whose authorisation has lapsed after the five year approval period, if the local authority is satisfied that the person continues to meet the AMHP competencies in the regulations, the person can be re-authorised, and is required to undertake 18 hours of appropriate training during the year following their approval. This requirement is laid out in the MHA Reference Guide 30.15.

- Approving trainee AMHPs who have not yet completed the exam board stage of AMHP training:
 - Local Authorities decide who is a fit and proper person to be an AMHP. The regulations require a person to have completed the AMHP course. Students who have finished their course, who are assessed as competent by Local Authorities but are awaiting exam board approval can therefore be authorised by the Local Authority to support the local AMHP service. We would recommend that there are clear criteria for how these new AMHPs are used in order to ensure they are not put in situations that are inappropriate for inexperienced staff.
- 18 Hours statutory training regulation for AMHPs:
 - There is a statutory requirement for AMHPs to complete 18 hours update training per year within the regulations. Each Local Authority has to make its own decision what sorts of training will suffice and how it should be delivered. It is possible for LAs to decide to be more flexible about what constitutes acceptable training, for example through the use of remote learning through presentations, webinars and online legal tests during the COVID-19 pandemic period.

C. The role of hospital managers' panel

- It has come to DHSC's attention that convening hospital managers' panels has become increasingly challenging for some Mental Health Trusts and Foundation Trusts, as a result of resource constraints and concerns around the risk of infection to patients and staff.
- The Code of Practice states that review by the managers' panel must take place if a patient's detention is renewed or their Community Treatment Order (CTO) is extended. Hospital Managers should also consider holding a review if they receive a request from a patient, IMHA, IMCA, attorney, deputy or carer, and if the Responsible Clinician makes a report to them under section 25 barring an order by the Nearest Relative to discharge a patient (38.12 CoP).
- We think that the managers' panels should be maintained as far as possible, in the interests of patient safety during the pandemic period. This particularly applies if a patient's detention is renewed or their Community Treatment Order (CTO) is extended.
- If, in line with public health advice, it is not appropriate for the managers' panel to convene in person during the pandemic period, we support the hospital utilising other means, such as holding it remotely over telephone or video conference. The managers' panel should continue to involve the patient, their Nearest Relative and, if different, carer, in the panel's review, including at the hearing. This includes ensuring that information is shared in an accessible format and using language the patient understands.

- Where hearings are held remotely, Hospital Managers should continue to ensure that the managers' panel is provided with all the necessary materials in advance. Mechanisms should be put in place to ensure that materials provided electronically are delivered securely to the panel members and other attendees.
- If holding the managers' panel either in person or remotely is rendered unfeasible due to reasons relating to the current pandemic, Hospital Managers may decide to suspend these temporarily, for the duration of the pandemic period. As this would represent a departure from the Code of Practice, practitioners should clearly record their justification for doing so. Hospital managers should also keep an overarching record of panels that should have taken place during the pandemic period and where they were requested by patients, so that they can be prioritised when normal practice resumes.
- In the case of detention renewals or an extension of a CTO, where the Code states that a review by the panel must be held, justification for departing from the Code should be especially strong and should demonstrate that reasonable measures were taken to attempt to convene the panel either in person or remotely.
- It is important to note that while the safeguard provided by the hospital managers' panel may be affected during the pandemic, other safeguards continue to apply, such as consideration of the patient's detention by the mental health tribunal, the duty of the hospital managers to scrutinise applications and recommendations for detention, and the need for the responsible clinician to review and apply to extend a patient's detention at the intervals prescribed under the MHA.

D. Mental Health Tribunal Hearings

- In response to the COVID-19 outbreak, the Senior President of Tribunals, with the agreement of the Lord Chancellor, and the Tribunal Procedure Committee have already made a series of Practice Directions and Rule changes³ to bring about temporary measures to alter how proceedings in the Tribunals can be conducted.
- These temporary measures affect the Mental Health Tribunal by:
 1. allowing cases to be decided by a single judge sitting alone, unless the Chamber President or Deputy Chamber President considers it to be inappropriate
 2. allowing certain cases to be dealt with on the papers, unless the Tribunal considers it to be inappropriate and
 3. temporarily removing the requirement for pre-hearing examinations.

³ Pilot Practice Direction: Health, Education and Social Care Chamber of the First-Tier Tribunal (Mental Health), available at <https://www.judiciary.uk/wp-content/uploads/2020/03/Mental-Health-Pilot-Practice-Direction-for-publication.pdf>; The Tribunal Procedure (Coronavirus) (Amendment) Rules 2020 (came into force 10 April)

- MoJ and DHSC support these temporary changes to enable the Tribunal to continue operating during the pandemic period. It remains the case that Hospital Managers and the local authority are under a duty to take steps to ensure that patients understand their rights to apply for a Tribunal hearing.
- The Code states that Hospital managers and professionals should enable detained patients to be visited by their legal representatives at any reasonable time. While restrictions on visits during the pandemic period may mean this is not possible, patients should be supported to speak to their legal representative via telephone or video-conferencing facilities.

E. Medical Reviews when a patient is placed in Seclusion

- When a patient is placed in seclusion⁴, a series of review processes should be instigated to assess the patient's mental and physical state and to determine whether seclusion of the patient should continue. The Code requires that medical reviews, which are conducted by the Responsible Clinician or 'duty doctor', are carried out in person and at specific times.
- We wish to remind practitioners that, for the purposes of medical reviews, where the responsible clinician is not immediately available, local policies should make provision for a 'duty doctor' to deputise for the responsible clinician (26.127 CoP). This is critical at the current time when hospital resources may be particularly constrained. The policy should also identify which of their doctors are competent to carry out a medical review (see paragraph 26.133 of the Code which describes what the medical review should include). Whenever the duty doctor is not an approved clinician, they should always have access to an on-call doctor who is an approved clinician.

F. Section 17 leave and visitors

- DHSC and NHS England and NHS Improvement are concerned that, due to efforts to minimise spread of COVID-19, some patients may not have been granted leave under Section 17 of the Act.
- We understand that hospitals are under pressure to protect the safety of patients and staff, but hospitals should, as far as possible be facilitating leave, in line with public health guidance, in order to support the health and wellbeing of patients. This may be particularly important in the case of patients with a learning disability and autistic patients, where preventing or reducing leave may represent a change in the

⁴ Seclusion is defined as supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

patient's routine, potentially having detrimental effects on the individual's mental health.

- Patients who have the capacity to understand public health advice, such as social distancing measures, should be assumed to be able to comply with this advice if granted leave, unless there is evidence to the contrary. We support hospitals in taking additional measures to reduce risk of community transmission, where appropriate. For example, if leave is granted to the grounds of the hospital, measures can be taken to reduce close interaction between patients, by staggering leave and by imposing time restrictions. If leave is granted in the community, this should be carefully planned, and consideration should be given to whether an escort is needed to help ensure compliance with public health advice.
- Providers should ensure that the welfare of patients – mental as well as physical – underpins decisions taken to limit visits during the pandemic. There are circumstances where every effort should be made to facilitate a visit by one visitor – a close family member or carer. Such circumstances include when the visitor is a parent or appropriate adult visiting a child; or a person supporting someone with a mental health issue such as dementia, a learning disability or autism, where not being present would cause the patient to be distressed. Decisions on limiting visits should be made on an individual basis and based upon active risk assessment, rather than blanket bans. Visiting may be facilitated more easily through, for example, arranging a visiting space off ward, limiting the time of visits, and establishing non-contact rules. Patients should also be supported to maintain contact with family and friends through digital means (11.6 CoP) during the pandemic, when visits will be affected due to social distancing measures. As stated in the CoP (chapter 8), patients should have readily accessible and appropriate daytime telephone and internet facilities to enable this.

G. Access to Independent Mental Health Advocates (IMHAs)

- We are aware that statutory advocates, including Independent Mental Health Advocates (IMHAs), may find it difficult to carry out their responsibilities to visit and interview qualifying patients in person, in view of public health advice. The IMHA service plays an incredibly important role in ensuring that patients are supported to exercise their rights and that they can participate in the decisions that are made about their care and treatment. During the pandemic, IMHAs and people who have a duty to facilitate the patient's contact with IMHA services (6.15 CoP) are expected to continue to meet their responsibilities under the Code of Practice.
- During the pandemic period, telephone or video-conferencing should be offered to patients as an alternative means of contacting IMHA services remotely. This may require the suspension or alteration of any restrictions on the use of mobile phones

within the inpatient unit. Those with a duty to support the patient in accessing in services should consider if there are any barriers to the patient being able to access IMHA services using digital technology means (eg accessibility issues) and should make reasonable efforts to overcome them. For example, it might be necessary to explore the IMHA attending in person where remote means are not possible. In this case, measures should be taken to adhere to social distancing measures.

H. Second Opinion Appointed Doctors service

- The CQC is currently operating temporary procedures for remote working for Mental Health Act Second Opinion Appointed Doctors (SOADs). As part of this SOADs will be sending electronic copies of certificates to services, instead of providing them in hard copy.
- DHSC supports the modifications that the CQC have made to their operating model during the pandemic period. Certificates issued electronically will remain valid after the pandemic period is over and neither the SOAD nor CQC are required to issue the original hard copy certificates retrospectively.
- In addition, during the pandemic period, DHSC reminds practitioners that, in line with the Code of Practice, signed certificates should be kept with the documents that authorise the patient's detention or CTO, and copies should be kept in the patient's notes. In the interests of patient safety, it is particularly important at this time that staff adhere to good practice and print certificates provided by the SOAD service by email so that they can be filed with the patient's notes. This minimises the risk of the patient being given treatment in contravention of the provisions of the Act (25.75, Code of Practice).
- As part of assessing and certifying medical treatment, SOADs should secure input from clinicians involved in Care and Treatment Reviews in the case of autistic patient and those with a learning disability.

I. Electronic forms and electronic delivery

- To support remote working arrangements during the pandemic period, services may complete and communicate statutory forms electronically. This includes the use of electronic signature.
- We recommend using encrypted signing, where possible, as this is the most secure method, however, other forms of signing electronically (eg PDF of handwritten signature or typing your name into the electronic form) are also permitted.
- All electronic files should be processed and stored in line with the GDPR and Data Protection Act 2018. We strongly advise that providers put in place an agreed protocol for the electronic submission of statutory forms, so that these can be sent and received securely. Providers and practitioners may also wish to review their schemes of delegation regarding sending and reception of papers and to make clear

arrangements with local AMHP services around the sending and reception of electronic forms to mitigate potential risks.

- Further guidance on best practice regarding electronic forms and where delivery in hard copy is more appropriate is being developed as part of the Government's work to respond to the Independent Review of the Mental Health Act.

The DHSC will monitor responses to this guidance and update it if needed. Its contents will cease to apply after the pandemic period.

Annex E: Checklist to support decision in line with the minimum standards and safeguards on the application of technology to the MHA assessments

Where multiple 'no' are recorded ensure mitigating steps		
Minimising adverse impacts of conducting MHA assessment by video and alternatives such as personal protective equipment?		
Have you taken into account physical & psychological risks to service user?	Y	N
Have you taken into account physical risks to clinician / AMHP?	Y	N
Have you taken into account physical & psychological risks to the carer?	Y	N
Please record the preferences of the service user regarding a clinician / AMHP wearing PPE and or / use of video:		
Person-centred and Inclusive		
Have you shared detailed instructions and information, prior to starting, on how the assessment will be carried out using video?	Y	N
Have you given the opportunity to address any concerns raised? Please record concerns raised:	Y	N
Have you considered the communication needs of the service user?	Y	N
Can sufficient reasonable adjustments be made to ensure an equitable experience?	Y	N
Have you attempted to make a shared decision with the service user that a video assessment is the best option in these circumstances?	Y	N
Have you offered the person time after the assessment to discuss their experience with an appropriate member of staff?	Y	N
Quality of the MHA assessment		
Have you tested the equipment and internet connection to ensure high quality sound and video transmission before the assessment?	Y	N
Taking into account available technology and your skills, are you confident in your ability to conduct a high-quality video assessment both before the assessment starts and during the assessment?	Y	N
Do you have adequate access to the information that you need to carry out a high-quality assessment including: verbal/non-verbal cues / information from other sources?	Y	N
Do you have an agreed contingency plan should the video assessment need to be discontinued/ stopped?	Y	N
Have you attempted to mitigate any biases that may result from use of video?	Y	N
Governance and Oversight		
Have you reached a shared judgement made in advance that video assessment is satisfactory and appropriate in the clinical circumstance?	Y	N
Have you informed the service user that the assessment will not be recorded?	Y	N
Do you have a plan in place to protect the service user's confidentiality and personal data?	Y	N
Have you clearly documented within the service user's record that a video consultation was used and the reasons and justifications for the decision made?	Y	N
Is there a mechanism in place in order to receive and monitor structured feedback from staff and service users / carers on their experience of video assessments?	Y	N
Has the Trust Board of Directors that hold the legal responsibility for the Trust's actions and Local Authority AMHP management that oversees the MHA assessments authorised the use of video MHA assessments under exceptional circumstances? Eg very high level of staff are absent from work due to COVID	Y	N
Has your trust and Local Authority put in place arrangements for the use of video MHAs to be recorded and reported to the MHA trust governance leads, DASS and to CQC?	Y	N

