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Legal guidance for services supporting people of all ages during the coronavirus pandemic:

Mental health, learning disability and autism, specialised commissioning

Version 4, 25th January 2021

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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)
- healthcare professionals
- social workers
- approved mental health professionals
- local authorities
- experts by experience
- clinical experts

- independent chairs for Care and Education and Treatment Reviews (CETRs)
- regional NHS England and NHS Improvement colleagues.

It aims 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).

This is the **third iteration of this published guidance** 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 several 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 no 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 were initially set out in the Coronavirus Act as a last resort in the scenario that the impact of the pandemic was deemed to be putting patient safety at considerable risk by impeding access to essential care. However, on 30 September 2020 it was announced in parliament that the Government would seek to remove the

MHA emergency provisions in the Coronavirus Act (see section 3 for more information).

- While there are no legislative changes to the MHA, 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.
- 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.
- Blanket bans should be avoided, and services should continue to operate in the least restrictive way possible and in accordance with the MHA and MCA codes of practice (see Section 8). However, 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, such as isolating someone who is suspected or confirmed COVID-19 positive without their consent.

In most cases, when a patient is already detained under the Mental Health Act 1983 (MHA), the powers provided by this legislation can be relied upon to isolate someone against their consent, as long as the patient's refusal to self-isolate is demonstrably connected to their mental disorder, or is necessary to support the overall purpose of the MHA, ie detaining patients in a safe and secure environment, where they can be treated for their mental disorder. We strongly advise against swab testing or other invasive testing procedures in absence of consent from the individual. More information can be found in Annex F.

- 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

- 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 contained a number of emergency provisions which, if enacted, would have amended certain aspects of the MHA regarding second opinion safeguards and detention periods. However, based on the experience and outcomes of wave 1 of the pandemic, the Government has decided not to renew these emergency powers, believing they are not warranted due to the hard work of mental health services to continue the safe operation of the MHA. Government is seeking to expire the powers, meaning that they will no longer be a part of the emergency Coronavirus Act.
- Local areas will not be able to seek to switch on the powers going forward to manage operational pressures. It is therefore essential that systems continue their hard work to mitigate against any potential negative impact of the pandemic on the safe operationalisation of the MHA. Examples of the types of mitigations that may be used are detailed in the subsequent section.

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.
- **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.
- Timely COVID-19 testing for staff, in line with the latest [NHSEI guidance](#).
- 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 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 we (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).

- In most cases, when a patient is already detained under the Mental Health Act 1983 (MHA), the powers provided by this legislation can be relied upon to isolate someone against their consent, as long as the patient's refusal to self-isolate is demonstrably connected to their mental disorder, or is necessary to support the overall purpose of the MHA. That is, detaining patients in a safe and secure environment, where they can be treated for their mental disorder. We strongly advise against swab testing or other invasive testing procedures in absence of consent from the individual. More information can be found in Annex F.
- 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. We have worked with DHSC – along with a range of stakeholders including experts-by-experience, providers and Arm's-length bodies (ALBs) to develop more detailed guidance to support and guide the provision of care in such challenging circumstances, which is set out in [Annex F](#).

This provides more information on the relevant legal frameworks, sets out recommended procedures for supporting people who need to be isolated without their consent and shares practical tools and best practice examples that were developed by providers during wave 1 of the pandemic.

- COVID-19 patient testing should be undertaken in line with the latest [NHSEI guidance](#).
- 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 our 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 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.
- 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](#)

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.

(C(E)TRs are maintained. Please see our [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 detention, 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/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 our organisation here, 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.**

- In March, an emergency practice direction was issued to enable single judge panels and telephone hearings. This practice direction was extended until March 2021 to ensure that the tribunal can continue to operate safely and effectively. More information is available on tribunal hearings in Annex D.

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

Table 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 absconson 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](#).

Table 2: Patients detained under the MHA on restriction orders

Restricted/Non-restricted Patients	Escorting requirements for planned and emergency transfers to acute general hospitals during COVID-19
<p>Restricted Patients</p> <p>(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. 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).

Restricted/Non-restricted Patients Escorting requirements for planned and emergency transfers to acute general hospitals during COVID-19

- Non-restricted patients** detained under MHA
- 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.

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).

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.

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.

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,

made a series of temporary practice directions and rule changes to alter how proceedings in the tribunals can be conducted. After six months, these practice directions were reviewed and extended until March 2021.

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, unless the Chamber President, Deputy Chamber President or an authorised salaried judge deem one necessary due to the exceptional circumstances of the case.
- 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.

Medical Reviews when a patient is placed in Seclusion

- When a patient is placed in seclusion,² 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.

² 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.

Section 17 leave and visitors

- We and DHSC 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 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.

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.

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 with the patient's notes, either in hard copy or electronic form. 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 patients and those with a learning disability.

Electronic forms and electronic delivery

- The government has amended legislation to allow for the electronic communication of forms through the Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 in October 2020, which will come into force on 1 December 2020. We anticipate that this change will enable staff to work more flexibly and efficiently, in doing so, ensuring that patients can access the care they need in a more timely manner.³ We intended to publish separate guidance to support professionals to interpret and implement these changes.
- The new legislation and guidance will supersede current guidance, which until the 1 December still applies.
- 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.

³ The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020: <https://www.legislation.gov.uk/uksi/2020/1072/made>

- 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: Guidance on the testing and isolation of people of all ages in inpatient mental health, learning disability, autism, dementia and specialist inpatient facilities during the coronavirus pandemic

Introduction

This guidance has been prepared by us and the Department of Health and Social Care, to support providers of mental health, learning disability, autism and dementia inpatient services in managing patients who have or are suspected to have coronavirus, or are at risk of contracting it. It does not apply to community mental health services or to the management of people subject to a Community Treatment Order (CTO), section 17 leave, guardianship or conditional discharge.

We recognise that during the pandemic, providers may face difficult decisions regarding the management of patients who are unable to follow clinical advice on isolation and testing to reduce the spread of COVID-19. For some patients, their illness may have affected their ability to adhere to this advice. Others may lack the relevant mental capacity to make these decisions.

This guidance advises on the procedures and safeguards providers should put in place, and the legal frameworks hospital staff should apply in relation to patients who are suspected or confirmed to have COVID-19 but are not consenting to infection control measures. It focuses primarily on the procedures around safely

isolating patients who are not consenting, rather than the procedures around testing. This is because we generally advise against enforcing testing in the absence of compliance from the patient.

In most cases, when a patient is already detained under the Mental Health Act 1983 (MHA), the powers provided by this legislation will be available and can lawfully be relied upon, so long as the patient's refusal to self-isolate is connected to their mental disorder, or the measures are necessary to support the overall purpose of the MHA, ie detaining the patient in a safe and secure environment, where they can be treated for their mental disorder. Crucially, the decision about whether these MHA powers should actually be used to isolate a patient should still be made on a case-by-case basis, considering the individual circumstances of the patient.

This guidance builds on previous iterations of NHE/I's legal guidance and on practical [guidance](#) for providers on actions and key considerations when caring for people with suspected or confirmed COVID-19, or those at risk of contracting it. It is intended to support and inform existing procedures and safeguards that we know providers have already put in place during the pandemic, with the advice of local ethics committees and medico-legal colleagues.

Throughout this guidance, the term 'provider' refers to providers of inpatient services for people with mental health needs, a learning disability, autism or dementia.

Special considerations that should inform decision-making

MHA Code of Practice guiding principles

Those undertaking functions under the MHA should always be led by the MHA Code of Practice's guiding principles. The most pertinent, in this context, are set out below:

- **Least restrictive option and maximising independence:** where a patient's movements are restricted for the purposes of managing the transmission of the virus, then those restrictions should be the minimum necessary to prevent harm to the person or others. Blanket restrictions should be avoided, and measures should be proportionate and specific to the risk of harm that the individual represents.

- **Empowerment and involvement:** Patients should be enabled to participate in decision-making as far as they are capable of doing so. Providers should always prioritise seeking the patient's valid consent before enforcing measures to reduce the spread of COVID-19. This should include explaining the reasons for isolation and/or testing to the patient and the potential consequences of consenting or not consenting.
- **Respect and dignity:** Providers should respect the rights and dignity of patients and their carers, while also ensuring their safety and that of others. They should also recognise and respect the diverse needs, values and circumstances of each patient.

Human Rights Act 1998 and the Equality Act 2010

Consideration should continue to be given to any human rights issues which may arise in the context of isolation and/or testing. Of particular relevance to the management of people who will not self-isolate is the Right to Liberty (Article 5), and any restriction on this right must be lawful, necessary and proportionate.

It is also important to consider the impact of enforced isolation or testing on the patient's right to respect for their private and family life under Article 8, which include the patient's rights when it comes to matters such as medical treatment, where and how they live and who they have contact with. Depending on the circumstances Articles 2 (the Right to Life) and 3 (Protection from torture or humane/degrading treatment) may also be engaged.

Article 8 is a qualified right, which means it can be restricted for certain purposes including the protection of health and public safety. A restriction on a person's right to respect for private and family life must still be proportionate to be lawful. By contrast, Articles 2 and 3 are absolute rights, and cannot be restricted for any purpose.

The provisions of the Equality Act 2010, such as the public sector equality duty, must also guide decision making where appropriate.

The provisions of the Equality Act 2010 must also guide decision making where appropriate. This makes it unlawful (either directly or indirectly) to discriminate against a person on the basis of a protected characteristic (as defined in that Act). Imposes a public sector equality duty on public bodies.

The protected characteristic of disability includes a mental impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities. Under the Public Sector Equality Duty public authorities must have due regard to the need to: eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity between people who share a protected characteristic and those who do not, and foster good relations between people who share a protected characteristic and those who do not.

Vulnerable Groups

There is clear evidence that people from a Black, Asian or other minority ethnic (BAME) group are more likely to be detained under the MHA, to be subject to restraint and restrictive practice, and to have poorer outcomes from their care. It is critical that services continue to use local data and information to identify if BAME people under their care are being disproportionately subject to restrictive practice, including being subject to enforced isolation. Local work to address these inequalities should continue in partnership with experts by experience.

Special consideration should also be given to children and young people and people with a learning disability and/or autism in inpatient settings, the latter of whom are disproportionately represented in the use of inappropriate and excessive restraint, seclusion and long-term segregation. Restrictive measures, to enforce isolation, should be used with caution in relation to these groups. The focus of enforced isolation should be to maintain therapeutic engagement to the greatest degree possible, whilst taking appropriate steps to mitigate the risk of viral transmission.

Where restrictive measures are applied, providers should continue to clearly document their rationale for why these are necessary and proportionate in each case.

Isolation and testing of patients to manage infection control

In line with published [guidance](#), where an individual in inpatient care is suspected or confirmed to have COVID-19, or is told to self-isolate by the contact tracing system, then self-isolation procedures should be followed and they should be tested immediately and regular observations taken.

It is unlikely that in these circumstances a failure to self-isolate will constitute a criminal offence, under the self-isolation regulations in England.⁴ **This is because, if the refusal to self-isolate can be linked to the patient's mental disorder or their lack of capacity or competence to consent, then they would have a reasonable excuse not to follow the instruction.**

Isolating and testing patients in an inpatient setting can sometimes be challenging for all those involved, particularly where the patient is not consenting to measures to manage infection control, either because they refuse or lack the relevant mental capacity. In these circumstances, decisions should be made on a case by case basis, weighing up competing considerations. For instance, the need to:

- prevent the transmission of COVID-19 to other patients and staff
- subject the patient to minimum distress, which may have a detrimental effect on their mental and physical wellbeing
- comply with the MHA or MCA and the relevant Codes of Practice
- comply with the Human Rights Act, including the Convention rights of the patient, staff and other patients on the ward and the Equality Act.

Supporting the patient to make the decision

If a patient lacks capacity to decide to self-isolate or to be tested, practicable steps should first be made to support them to make the decision. This may include involving an advocate, presenting the relevant information in different formats (using appropriate communication aids where required), or making reasonable adjustments to accommodate neurodevelopmental needs or disabilities. Paragraph 19.25 of the MHA of the Code of Practice provides examples of the types of support that may help a child or young person to make the decision and to check whether all practicable steps have been taken.

The relevant information, which the patient will need to understand, retain, or use or weigh in order to be considered to have capacity (or 'competence' in the case of children aged under 16), should include the reasons for the isolation or testing,

⁴ On 28 September 2020 the Health Protection (Coronavirus, Restrictions) (Self- Isolation) (England) Regulations 2020 became law in England. The regulations provide that a person may be committing a criminal offence and fined if they do not stay at home and self-isolate following a positive test result for COVID-19, or if they are contacted by specified professionals and instructed to self-isolate because of contact with someone who has had a positive test result. Failure to comply with these requirements without a reasonable excuse is a criminal offence and may result in a fine of up to £10,000.

process (such as what isolation or testing will entail), and the consequences of consenting or not consenting. Ascertaining if the individual has the relevant mental capacity or competence should not be onerous and the person will only need to understand the salient information. The patient may have the capacity or competence to consent, even though they may be unable to make decisions in respect of other aspects of their care and treatment.

You may need to consider delaying the discussion until a time when the patient is feeling well enough or making repeated attempts within an appropriate timescale, having regard to whether the person is likely to regain capacity or competence and the urgency of the situation. If the patient continues to lack the relevant capacity or competence and needs to be isolated, then the MCA or MHA or common law powers may be available (see Section 5 below)

If the patient with the relevant capacity or competence continues to refuse, then enforced isolation should be considered. We strongly advise against enforcing testing in the absence of valid consent. For patients who lack the relevant capacity, the appropriateness of testing is discussed below (Section 4).

Even where an individual is found to lack the capacity or competence to consent to isolation, staff should continue to seek their consent on all other aspects of care and treatment to which the individual can consent.

Testing only if the patient consents or is in their best interests

COVID-19 testing should be undertaken in line with the latest [NHSEI guidance](#). **However, we strongly advise against swab testing in the absence of valid consent from the patient who has the relevant capacity or competence**, as carrying out the test without the patient's cooperation is likely to be highly traumatic to the patient and could lead to physical injury. Swab testing, or any other form of invasive test for COVID-19, should not, be undertaken using physical restraint.

If the person lacks the relevant capacity or competence, swabbing or other forms of invasive testing should only occur if in their best interests. In assessing the best interests of the patient, clinicians should pay close attention to the risks of attempting to swab someone who is not compliant. As in the case of those with capacity, these risks include traumatising or physically injuring the patient, as well as the difficulty of obtaining an accurate sample without compliance. In light of these risks, it is unlikely that enforced testing will be in the best interests of a

potentially infectious, non-compliant patient, though it depends on their particular circumstances.

It may not always be straightforward to tell whether someone is compliant. There may also be cases where a patient has fluctuating compliance, and this should be taken into account when determining whether it is in the patient's best interests to be tested. If a patient switches continuously between compliance and non-compliance, then the dangers associated with non-compliance (trauma, injury and inaccuracy) may be present, and this should be factored into the clinician's decision. Again, the fact that a patient is non-compliant or has fluctuating compliance does not in itself preclude enforced testing. However, it is unlikely that it will be in the best interests of such a patient to be swabbed. An individualised assessment will have to be made. Refer to paragraphs 13.51 and 14.20 of the MHA Code of Practice for guidance on establishing whether a person is objecting and is not compliant.

Enforcing isolation

The decision to enforce isolation should follow a risk assessment, taking into account the patient's individual circumstances. Providers may find it useful to use a checklist to ensure a consistent approach, and to support staff. A practice example is available in Appendix A, developed by the Tees, Esk and Wear Valleys NHS Foundation Trust.

When a patient is already detained under the Mental Health Act (MHA), in most cases the powers provided by this legislation will be sufficient to allow hospital staff to take necessary and proportionate measures to safely isolate the individual, without their consent. The exception to this is where the patient's refusal (or inability to consent) to self-isolate cannot be connected to their mental disorder, or the measures are not necessary to support the overall purpose of the MHA ie detaining the patient in a safe and secure environment, where they can be treated for their mental disorder.

If the MHA cannot be applied, it may be appropriate to apply the Mental Capacity Act or to make an assessment of Gillick competence (for patients who are under 16). Providers should refer to separate [guidance](#) issued by Department of Health & Social Care to help them decide if the MCA should be applied. If this is found to be appropriate, a best interests' decision could provide the legal authority to safely isolate the individual. For those aged under 16, if they are found not to be Gillick

competent, it may be that a person with parental responsibility can consent on behalf of the child, although it is suggested that further legal advice is sought to establish whether this applies.

In the case of patients who have been admitted on a voluntary basis, the powers under the MHA cannot legally be applied to enforce isolation. Therefore, if providers are unable to secure consent from the individual to self-isolate, then a number of options may be explored:

- a) As above, if the individual is found to lack capacity or competence to consent, it may be appropriate to isolate them on the basis of a best interest decision (for those aged 16 or over see separate [guidance](#))
- b) Safe discharge of the patient. In this case, clinicians should consider if there is robust community care provision in place, the potential physical and psychological risks to the patient, any co-habitants, and potentially to members of the public, if this course is followed. Risks to others may stem from a number of factors including the patient's behaviour and the onward spread of coronavirus in the community. These particular considerations are over and above the usual considerations that should be taken into account when considering if a patient should be discharged, including their overall mental and physical health, and social circumstances.
- c) Clinicians should also consider whether the detention criteria under the MHA are met, and if so whether MHA powers would be more appropriate in the circumstances of the case.

In the rare event that clinicians have determined that use of the MHA, MCA or Common Law (Gillick competence) cannot be relied on, providers may consider contacting their local Public Health Officer (PHO). This may be required if an individual with the relevant capacity is detained under the MHA and refuses to consent to isolation or treatment, where the refusal is unrelated to the person's mental disorder and the measures are purely for the purposes of the patient's physical health. Under Schedule 21 to the Coronavirus Act 2020 (CA), PHOs have the power to impose requirements and restrictions in connection with isolation and testing of the patient, in order to reduce the spread of COVID-19. PHOs are unable to use reasonable physical force where individuals are not compliant, but they can request support from police constables to assist them, although this will only ever

be used as a last resort. For example, the PHO might request a constable to assist in keeping an individual in a place that is suitable for screening and assessment.

Involvement of police constables will rarely offer an appropriate or proportionate measure in the case of a patient with a mental health disorder, learning disability or autism who is not consenting to isolation or testing. Section 7 below provides further advice if the involvement of a PHO is considered necessary.

Section 6 provides a more detailed description of which legal powers may apply to infection control measures in mental health units. Please note that this is not a substitute for legal advice.

Procedures and safeguards when a patient is placed in isolation without their consent

Where a patient's movements are restricted for the purposes of managing the transmission of the virus, then they should be the minimum necessary to prevent harm to the person. For instance, isolation should continue for no longer than is necessary according to the [current government guidelines](#).

The environment in which the patient is isolating should be comfortable and humane and consideration should be given to how the environment can be improved, for example by making items available to the patient that could enhance their experience of isolation. Blanket restrictions should be avoided, and measures should be dignified and respectful towards the patient and considered necessary and proportionate, given the specific circumstances of the individual.

The decision to isolate non-consenting patients in order to control infection, should not be considered as equivalent to the decision to place an individual in seclusion or long-term segregation within the meaning of chapter 26 of the MHA Code of Practice. The seclusion and long-term segregation frameworks were created with different circumstances in mind to the current pandemic: the purpose of seclusion is to manage patients who display severe behavioural disturbances, and segregation addresses longer-term harm that a patient poses to others as a constant feature of their mental disorder. By contrast the purpose of isolation is to prevent the onward spread of coronavirus – and as such, the focus of the care plan will be on how to maintain therapeutic engagement to the greatest degree possible, whilst taking appropriate steps to mitigate the risk of viral transmission.

The following procedures should be followed when a patient is isolated without their consent:

- a. **Isolation should be authorised.** by a psychiatrist, an approved clinician who is not a doctor or the professional (eg a nurse) in charge of a ward. If the professional who authorises enforced isolation is neither the patient's responsible clinician (RC) nor an approved clinician (AC), the RC or duty doctor (or equivalent) should be informed as soon as is practicable of the decision. However, this does not mean that ending enforced isolation needs to be a medical or management-level decision. Any appropriately trained health professional may determine this.
- b. **An individualised care and treatment plan** should be compiled, documenting the rationale for enforced isolation, a description of the self-isolation environment, how it will be managed to reduce the spread of viral transmission, the specific mental and physical health needs of the individual and how they will be met while they are in isolation, and how the patient's involvement in ward rounds, Care Programme Approach meetings (CPAs), Care Treatment (and Education) Reviews (CT(E)Rs) (where applicable) etc. will be facilitated. Safeguarding colleagues should be consulted on the care and treatment plan and, where appropriate, family and or carers should be involved.
- c. **Measures to enhance the patient's experience** should be factored into the patient's care and treatment plan, for instance: access to personal care facilities, fresh air and exercise, meaningful therapeutic, leisure and educational activities; smoking/vaping/nicotine replacement therapy (where applicable); access to family and friends via the use of telecommunications, social media etc.; access to money and shopping for personal items; access to advocacy services. 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.
- d. **Each interaction with the patient should be used as an opportunity to review restrictive interventions** and determine if these can be removed or reduced. This should involve providing a clear explanation to the person of

why the isolation is necessary, the consequences of them not self-isolating, to give them the opportunity to consent to the isolation requirements. Providers will need to consider whether any consent offered by the patient after a period of compulsory isolation has already started is freely given. These interventions should be clearly documented/recorded.

- e. **Regular assessments of the patient's mental capacity or competence**, their ability to consent and therefore which legal framework applies should be conducted and recorded.
- f. **The views of the patient regarding self-isolation** and the reasons why they are not consenting to self-isolation should be explored regularly and recorded. It may also be appropriate to consult with the patient's family or carer to identify less restrictive measures and progress the patient towards consenting to self-isolation.
- g. The patient must be supported by a member of staff and/or their advocate to make representations to whoever is conducting the physical and mental health reviews, in particular so that clinicians constantly monitor whether forced isolation continues to be necessary.

Ending enforced isolation

Enforced isolation should end when there is no longer a clinical need. This may be the case either after receiving the outcome of a swab test, or where a swab has been refused, after the patient has isolated for the amount of time required by the latest government guidelines.

If at any time the patient requests to self-isolate, enforced isolation should cease and this must be explained to the patient and recorded. The decision to cease enforced isolation and to commence self-isolation does not require the approval of the individual who originally authorised isolation, or a medical or management-level decision. Any appropriately trained health professional may determine this.

Deciding which legal framework applies

Seeking consent from the individual

In line with the principle of empowerment and involvement, in all cases where a patient needs to be tested or isolated for COVID-19, the starting point should always be to seek the patient's valid consent, as discussed above. There will be a small number of cases where the patient will refuse to consent or lack capacity or competence to consent. In these instances, the MHA will mostly apply if the patient is already detained under the MHA, however there are some exceptions to this. The following provides guidance on which legal framework/s can be applied depending on the circumstances of the case.

What if the patient is not consenting to isolation or testing and is detained under the MHA?

If a patient is detained under the MHA, these powers can be used to isolate the individual, as long as the patient's refusal to isolate (or inability to consent) can be connected to their mental disorder, or the measure is necessary to support the overall purpose of the MHA ie detaining the patient in a safe and secure environment, where they can be treated for their mental disorder. As mentioned earlier, we strongly advise against swab testing in the absence of valid consent from a patient who has the relevant capacity or competence. If the person lacks the relevant capacity or competence, swabbing or other forms of invasive testing should only occur if in their best interests.

The specific powers available for enforcing isolation under the MHA are section 63 and the implied powers. Section 63 gives the authority to provide medical treatment for mental disorder, including symptoms and manifestations, without consent. The implied powers allow providers to exert a degree of control over a detained patient to maintain a safe and therapeutic environment. In addition to our position that testing should not be carried out without valid consent from the individual, we also think that both section 63 and the implied powers are less likely to extend to testing.

Section 63 and the implied powers can be exercised in respect of infectious (or potentially infectious) patients, as well as those who are not suspected of having COVID-19 but need to be isolated in their ward to keep them apart from others who are infected.

On the rare occasion that the clinical team find that a detained patient's refusal (or lack of consent) **is not related to their mental disorder** and isolation cannot be said to be either connected to their mental disorder or necessary to support the

overall purpose of the MHA (ie detaining the patient in a safe and secure environment, where they can be treated for their mental disorder), then the MHA cannot be used to isolate the patient without their consent.

In these circumstances, consideration should be given to whether an assessment should be carried out of the individual's capacity or competence to consent. If the person is lacking such capacity or competence, then the isolation and/or testing may be carried out on the basis of a best interests' decision.

Providers should refer to separate [guidance](#) issued by Department of Health & Social Care to help them decide if the MCA should be applied. Note that Deprivation of Liberty Safeguards (DoLS) cannot be used if the patient is already detained under the MHA (see below). However, the arrangements for isolating a patient will very rarely in and of themselves amount to a deprivation of liberty.

For those aged under 16, if they are found not to be Gillick competent, providers should consider whether it is appropriate for a person with parental responsibility to consent on behalf of the child or whether an application to Court is required. Providers should seek legal advice in these circumstances.

What if the patient is not consenting and is voluntary/informal?

Voluntary patients fall outside the scope of the powers under the MHA to isolate or test a non-consenting patient. Therefore, if providers are unable to secure consent from the individual to self-isolate or to be tested, then several options may be explored:

- a. If the individual is found to lack capacity or competence to consent, it may be appropriate to isolate them on the basis of a best interests' decision (Note, in a small number of cases these arrangements may amount to a deprivation of liberty. Decision makers should refer to separate [guidance](#), which sets out how to identify a deprivation of liberty. Unlike patients detained under the MHA, the Deprivation of Liberty Safeguards (DoLS) may be available in respect of informal patients aged 18 and above. The courts may authorise a deprivation of liberty for those aged under 18, and in some cases, for those under 16, a parent may consent (but it is suggested that further legal advice should be sought). Whatever provisions are used, any deprivation of liberty must be necessary and proportionate in order to be authorised.

- b. Safe discharge of the patient.
- c. Clinicians should also consider whether the detention criteria under the MHA are met, and if so whether MHA powers would be more appropriate in the circumstances of the case.

Where use of the MHA, MCA or common law (eg Gillick Competence) cannot be relied on, providers may consider contacting their local Public Health Officer (PHO), who have powers under Schedule 21 to the Coronavirus Act impose requirements and restrictions on people, in order to reduce the spread of COVID-19.

What if there is ambiguity over which legal framework applies?

It may sometimes be difficult for clinical teams to identify with confidence which legal framework applies to authorise a course of action. A patient's presentation can change quickly or fluctuate and it might be unclear whether their conduct regarding testing or isolation is related to their mental disorder. Similarly, a patient may have fluctuating capacity or compliance. In such cases, staff should record the reasons why a particular decision was made and the legal authority that was relied on. Following the MHA CoP's guiding principles can be particularly important in this context, as is recording how clinical decisions (ideally made by a multidisciplinary team) were reached.

To help support decision making around which legal framework applies in each case, we have developed a series of hypothetical case studies to illustrate how the frameworks might be practically applied (See Appendix B). We have also developed, in collaboration with Sheffield Health and Social Care NHS Foundation Trust, tools to help guide decision making in common scenarios (See Appendix C).

Coronavirus Act 2020 Powers

It is the view of NHSE and DHSC that the MCA and the MHA provide the legal basis for isolating or testing patients in most cases (although as set out above, testing without consent or compliance should be avoided). In a minority of cases, staff working in providers of mental health, learning disability, autism and dementia services may need to engage with local Public Health Officers (PHOs) to exercise their powers under Schedule 21 to the CA in order to compel patients to isolate for COVID-19 purposes. These measures should only be used where it is considered appropriate and proportionate to do so and when the MHA, MCA or Common Law

(Gillick Competence) have been considered and discounted as appropriate legal frameworks based on the considerations set out above.

The following advice is for providers who need to engage PHOs to exercise their powers to enforce isolation of mental health patients. Note that, for the reasons stated earlier, we strongly advise against swab testing, or similarly invasive testing approaches, in the absence of valid consent from the patient, due to the potential distress and trauma this may cause to the patient. The use of PHO powers to enforce isolation should be used with caution and should only be considered on a case by case basis. See Appendix D for a summary of the PHO's powers under Schedule 21 of the Coronavirus Act.

Using the Coronavirus Act Powers

We strongly encourage providers and police forces to agree joint protocols, based on existing agreements around, for example, mental health crisis care and the use of section 136 of the MHA, that set out how they will work together if these situations arise, to ensure that all professionals and patients are kept as safe as possible under potentially very challenging circumstances. This should give due regard to existing frameworks such as [the College of Policing National Decision Model Authorised Professional Practice on use of restraint](#) and [recent guidance from the National Police Chiefs Council and College of Policing regarding the Coronavirus Act 2020](#).

The use of PHO powers to enforce isolation should be used with caution and should only be considered on a case by case basis. Providers who need to employ the PHO powers to enforce isolation and/or testing of patients with a mental health condition, learning disability or autism should adhere to the following steps:

- Before the provider contacts a PHO regarding an inpatient, they should explore use of the MHA, and MCA, or common law/'parental consent' in the case of under 16-year olds), to enforce isolation of the individual. PHOs may wish to request written justification that these alternatives have been sufficiently explored before proceeding with the use of Schedule 21.
- Prior to exercising the powers provided by Schedule 21 in relation to an inpatient, the PHO should consult with the patient's responsible clinician to decide whether and how to use their powers, in order to determine how to proceed safely and proportionately in the individual's case. Where the

patient lacks the relevant mental capacity or competence, the responsible clinician should assist in involving the patient's carer or nearest relative or, where appropriate, those with parental responsibility, in any decisions concerning the patient.

- In deciding whether to impose a requirement to remain in a place or a requirement to remain in isolation on an inpatient unit, the PHO should give regard to the potentially detrimental effect this may have on the individual's mental health. If the patient is known to belong to a group for which specific expertise is desirable appropriate, eg people with autism or a learning disability, the PHO should seek advice from a specialist or a specialist service to support in decision making. In the case of children, the PHO should also seek support from an individual with responsibility for the child (defined earlier).
- It should be noted that it may be a criminal offence not to comply with a requirement imposed by a PHO. This underscores the importance of the PHO clearly recording in writing any requirement imposed on a patient, so that the patient and others involved in their care and treatment know exactly what the requirement entails.
- Only rarely will it be appropriate for the PHO to move a patient from an inpatient unit to other premises (whether or not in isolation). Wherever possible, a suitable place within the inpatient unit should be found.
- Where a PHO requires a patient to remain in a particular place or in isolation, the patient's clinical team should consult with the PHO to come to agreement on how these measures can be safely enforced (see guidance on reviews and safeguards above in section 5). It may also be appropriate to involve their carer or nearest relative.
- If the patient does not comply with a requirement or restriction placed on them under Schedule 21, the PHO should consult with the patient's clinical team to establish the least restrictive approach. Where the patient lacks the relevant mental capacity, or competence, their carer or nearest relative or, where appropriate, those with responsibility for the child, should be involved in the consultation.

- Where enforcement is necessary, the PHO should, in the first instance, seek assistance from appropriately trained health professionals to impose requirements on the person, without having to rely on constables to apply reasonable force. It is important to note that, in an inpatient setting, health professionals do not have the power to use reasonable force for the purposes of enforcing Schedule 21 of the Coronavirus Act.
- In circumstances where support from a Constable is considered necessary by the PHO and the patient's clinical team, it must be proportionate and used with caution. Consideration should also be given to the potential detrimental impact this might have on the person and others in the vicinity, particularly in an inpatient setting where the presence of a uniformed police officer may cause distress to other patients. Appropriately trained health professionals should be present (and where appropriate those with responsibility for the child) when Constables are brought in for this purpose. In addition, the Constable should, if possible, have training in dealing with mental health inpatients or people with severe mental disorder, learning disabilities and autism.
- If restrictions or requirements under paragraph 14 of Schedule 21 to the Coronavirus Act 2020 are applied (in relation to someone who has tested positive for coronavirus, someone whose test has proved inconclusive, or whom the PHO believes is potentially infectious), providers should ensure that the patient is aware of their right to appeal to a Magistrates' Court to challenge the use of the powers. This includes providing assistance to obtain access to a lawyer where necessary eg providing the telephone numbers of local Citizens Advice Bureaux or other sources of legal advice. If the patient lacks the capacity to make an appeal, the provider should ensure that the relevant people are informed as they may wish to make to make an appeal on the patient's behalf. This may, in some cases, be necessary even if the person is not objecting or does not appear to understand that they can make a challenge.

Appendix A: Practice example checklist if enforced isolation is being considered

Risk factors	Yes / No	Comments
Does the manifestation of the mental disorder increase the risk of catching and/or spreading COVID19?		
Has the person been recently exposed to the virus?		
Does the person come from a high-risk area?		
Are they from a higher risk group (underlying health condition, age, pregnancy, BAME)?		
Protective factors	Yes / No	Comments
Are they willing or able to agree to self-isolation?		
Are they willing / able maintain good hygiene?		
Are they willing / able to maintain social distancing?		
Have alternatives to enforced isolation been considered by the person and the team?		
Decision making	Yes / No	Comments
Has sufficient information been gathered to make an initial decision (from person, family, other professionals etc.)?		
Is there a significant risk to the patient that cannot be reasonably mitigated against?		
Is there a significant risk to other patients that cannot be reasonably mitigated against?		
Is there a significant risk to staff that cannot be reasonably mitigated against?		
Has there been consideration of the patient's human rights in this case ?		
Decision	Yes / No	Comments
Does the person require enforced isolation?		
Is this necessary and proportionate?		
Has anything been identified which can lessen the restriction of enforced isolation?		
Has an intervention plan been written which identifies how the person's needs are being met, and what the review process will be?		
Has a Datix form been completed?		

Appendix B: Case vignettes

Below are a number of hypothetical case studies illustrating when the MHA, the MCA, the Coronavirus Act and common law (such as Gillick competence and the inherent jurisdiction of the High Court) may be applied to isolate and test patients for the purposes of reducing the spread of COVID-19, and how this might work in practice.

In all the cases below, it is expected that a provider would, clearly document their decisions and have a process in place for sharing this with provider executives. Local ethics committees should be consulted with when developing local policies and to support with decision-making in particularly difficult cases.

Case 1: The individual is detained under the MHA and tests positive for COVID-19 but is not consenting to self-isolation. This is clearly identified as being related to their mental disorder.

Lilly is a 21-year-old woman, previously unknown to services, who is admitted to hospital with a first episode of acute psychosis. She is paranoid and highly thought disordered. On admission Lilly tests positive for COVID-19 so will need to isolate from other patients for at least seven days.

The clinical team attempt to explain the need for isolation to Lilly but find it difficult to engage her in dialogue. Lilly agrees and disagrees with the request in rapid succession and when left alone in her room, she attempts to leave almost immediately. The clinical team are confident that her inability to comply with isolation is directly linked to her mental disorder.

The team agree that Lilly needs to be treated in hospital for her psychosis before she can be safely discharged and therefore rely on the MHA to isolate Lilly in a private room. Because Lilly continuously attempts to leave the room, initially, a member of staff with adequate PPE is placed on 1:1 observations with her, in order to redirect her when she tries to leave.

Whilst Lilly is not aggressive in her behaviour, she does begin to try and push past the escort, who is concerned at the frequency with which she (who is coughing, and COVID-positive) is coming into contact with them and other patients nearby. The team decide that on balance, the risk of transmission means it is now proportionate

to keep her bedroom door locked. They maintain 1:1 observation in order to maintain engagement and meet her therapeutic needs.

The team regularly review Lilly, explaining to her why she needs to be kept separately from other patients. The treatment for her psychosis is begins to take effect and after two days Lilly is able to consent to the need to isolate for a further 5 days, after which she will either be able to return to main ward or be discharged, if she is well enough.

Case 2: The patient is detained under the MHA, appears to have the relevant mental capacity, is showing signs of COVID-19, but is not consenting to self-isolation. This is potentially related to their mental disorder.

Paul is a 27-year old man with diagnoses of schizoaffective disorder (currently well-managed on a depot antipsychotic) and antisocial personality disorder (ASPD). A routine physical health check has revealed that Paul has a high temperature and has developed a new dry cough.

The clinical team decide that Paul needs to be isolated from the other patients, pending a test for COVID-19. Paul appears to have the relevant decision-making capacity and a member of the team tries to explain to Paul that they wish to move him from the dormitory to a private area, where he can be isolated from the other patients as they suspect he might have COVID-19 and is therefore a risk to others. However, Paul says he has a much right to the shared living area as the other patients.

The clinical team decide that Paul's refusal to self-isolate is linked to his ASPD, and that this is putting patients and staff at risk. They consider discharge from hospital but believe this would cause a significant deterioration in Paul's mental health and would result in unacceptable risks both to Paul and to others.

The team rely on the MHA to enforce isolation of Paul in a private bedroom, where he is given access to a mobile phone and the internet and is placed under observation by MH staff. Paul's care and treatment and the restrictions placed on his movement are reviewed on a regular basis.

If the team had instead found that there was no link between Paul's ASPD and his decision not to self-isolate, they may seek advice from a PHO. The PHO is likely to carefully explore with the team the reasons they believe that MHA/MCA are not

available. Nonetheless if Paul is felt to have the relevant decision-making capacity and there is felt to be no link between his mental disorder and refusal – the PHO may make an order that Paul self-isolate in his bedroom. In doing so, the PHO would also inform Paul of their reasons for doing so and that it is an offence to not comply with the requirement. Paul should also be informed of his right to appeal the PHO's order in the Magistrates' Court.

Faced with the prospect of a monetary fine if he didn't comply with this order, Paul may now comply with the request. If he doesn't, it may be necessary to work with the police to enforce the order – this should be undertaken carefully in line with this guidance.

Case 3: The patient is voluntary (ie not detained under the MHA) and are showing signs of COVID-19. They appear to have the relevant mental capacity but are not consenting to self-isolation. This appears to be connected to their mental disorder.

Susan is 47 years old and has an established diagnosis of Schizophrenia. Her symptoms have recently worsened, and Susan's psychiatrist decides that she requires treatment in a psychiatric hospital. Susan recognises that her symptoms are causing distress to her family and is able to consent to voluntary ('informal') psychiatric admission and does so.

Susan has developed a new persistent cough and fever and the clinical team are concerned that she might have COVID-19. Susan appears to understand the reasons why the clinical team wish to test her for the virus and consents to a nurse taking a viral swab. While the clinical team await results of the test, they ask Susan to self-isolate in her bedroom for 3-4 days. Susan refuses to stay in her room as she thinks she is the victim of a conspiracy and that her bedroom is bugged. This behaviour resembles previous episodes and, based on Susan's clinical history, there is risk her symptoms will become more severe.

The clinical team re-assess Susan's decision-making capacity and conclude that whilst she is having difficulty weighing up the options available to her in light of her paranoia, she still has capacity in this respect. The team considers whether her mental health could be safely managed in the community, given the risk of transmission she poses on the ward. The team consults with Susan's family, and are satisfied that her mental health can be safely managed in the community and

that risk of transmission will be lower at home. Susan would prefer to be treated at home than in hospital, especially if she must self-isolate in hospital. In line with the 'least restrictive' and 'empowerment and involvement' principles of the CoP, the team therefore decide that Susan should be discharged into the community, where she will self-isolate at home, pending the results of the test. Her mental health will be closely monitored by the community mental health team.

Case 4: The patient is detained under the MHA, is showing signs of COVID-19, but is not consenting to self-isolation or testing. It is unclear if the patient lacks the relevant competence (mental capacity for an over 16-year-old) to consent to isolation or testing. It is also unclear whether their refusal is related to their mental disorder and therefore if the MHA can be relied upon.

Faisal aged 15 has severe clinical depression and anorexia. He has been detained in a psychiatric hospital under the MHA following a serious loss in weight and refusal to agree to treatment. His doctors continue to believe that this is the only way to ensure that he receives the appropriate care and treatment. Faisal is currently compliant with his care and treatment plan. He has been subject to a recent assessment of his competence and is found to be able to give his valid consent to most aspects of his care and treatment.

Faisal develops a fever and mentions in passing to a nurse that he has lost his sense of smell. When nurses ask to swab his throat and nose to test him for coronavirus he objects vociferously. He has the same reaction when he is asked to isolate in his room. He says he feels worthless and does not care if he has coronavirus. His parents are immediately contacted to discuss the concerns. They both have Parental Responsibility for Faisal and agree that in his best interests he should be isolating and have the test. They are also unable to persuade him when they call him on his phone.

Clinicians are concerned that Faisal's refusal indicates that his mental health is further deteriorating.

Clinicians will need to decide whether the refusal is linked to Faisal's mental disorder (in which case the MHA could potentially be used to isolate). They may also feel they have good reason to undertake another competence assessment in respect of the relevant decisions. For example, it might be felt that his lack of maturity means he lacks competence to understand the decisions, in which case

legal advice should be sought on whether consent of those with parental responsibility for him would be sufficient to support enforced isolation.

Case 5: A 15-year-old patient who is admitted to a General Adolescent Unit on an informal basis tests positive to COVID-19 but refusing to isolate. Assessment of her competence is required and consideration of the least restrictive way to ensure her isolation.

Hannah is a 15-year-old girl who has been an inpatient in a General Adolescent Unit for the past three weeks on a voluntary (informal) basis for risk management of severe self-harm in the context of marked emotional instability.

She develops symptoms of COVID-19 and agrees to a swab test and the result is positive. However, she does not agree to self-isolate in her room, stating that she wishes to continue to mix with other young people on the ward.

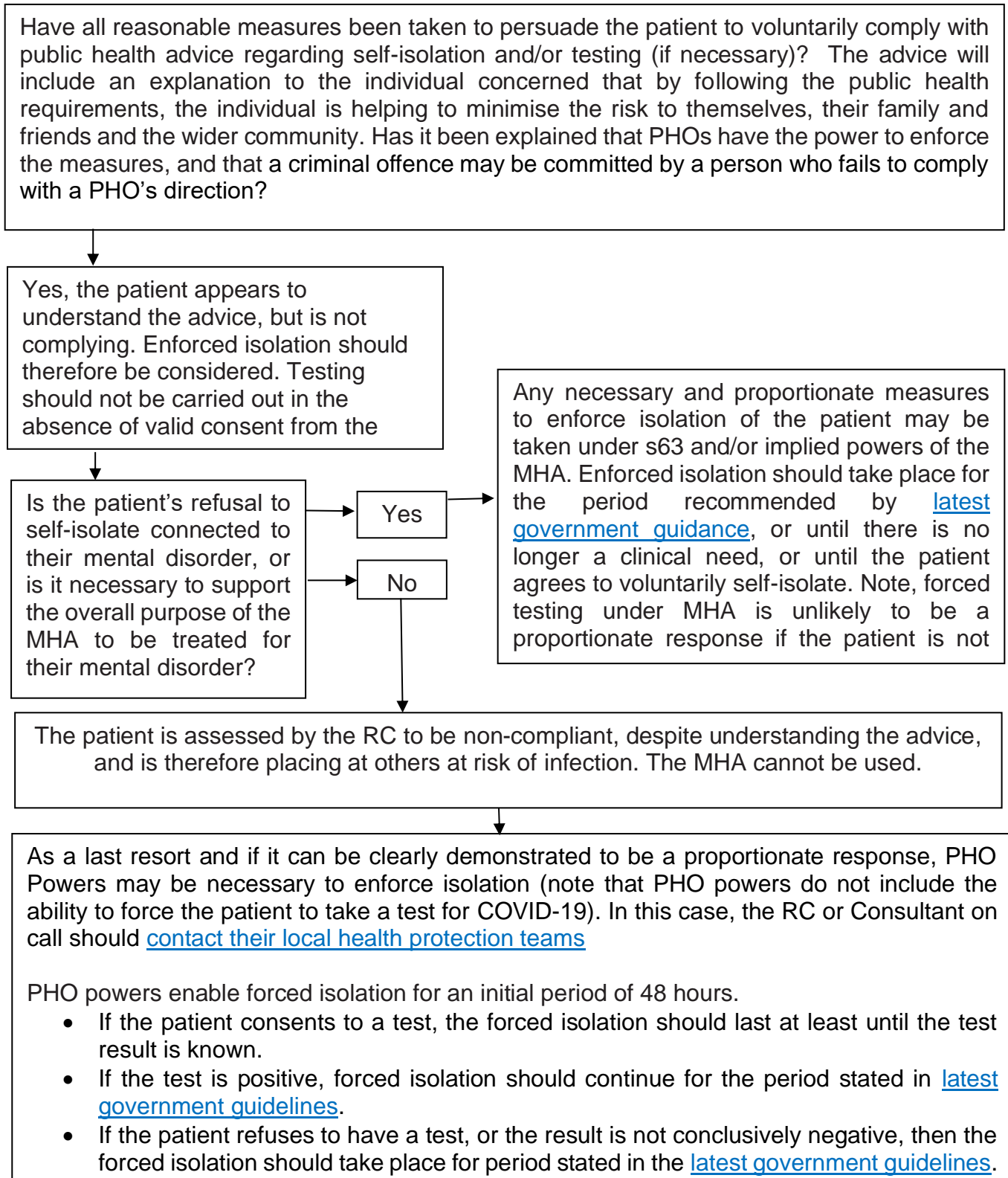
The clinical team discuss her ability to make decisions in respect of the need to self-isolate via the Gillick competence framework. They conclude that she does not have consistent competence to understand and weigh up the implications of not isolating, due to her mental disorder.

Consideration will need to be given as to whether the Mental Health Act could be used to isolate Hannah, or whether someone with parental responsibility could give consent on her behalf (depending on legal advice).

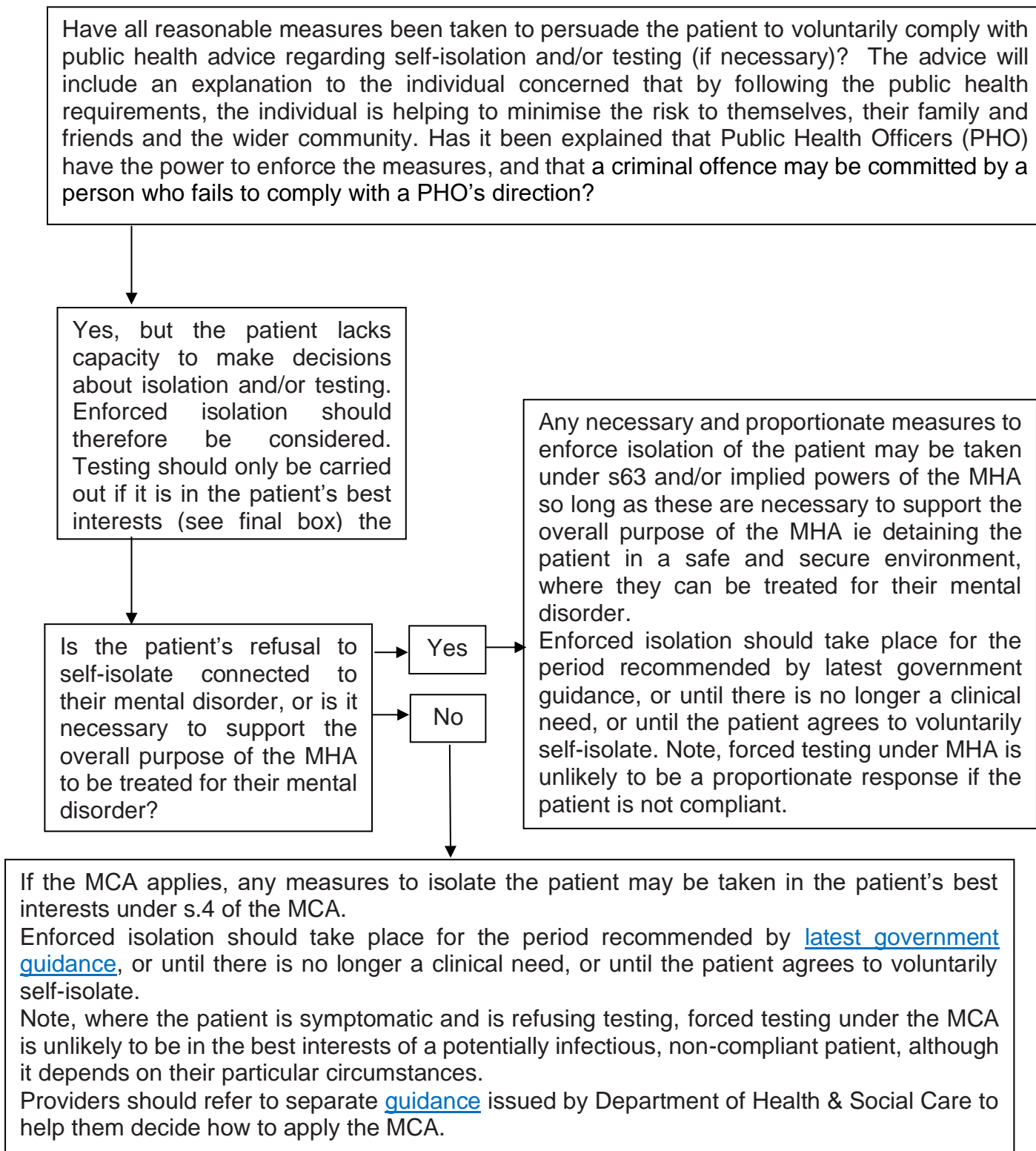
Appendix C: Decision trees on applying this guidance in common scenarios (made in collaboration with Sheffield Health and Social Care NHS Foundation Trust)

The charts below were adapted from those developed by Dr Sobhi Girgis and Anne Cook from Sheffield Health and Social Care NHS Foundation Trust.

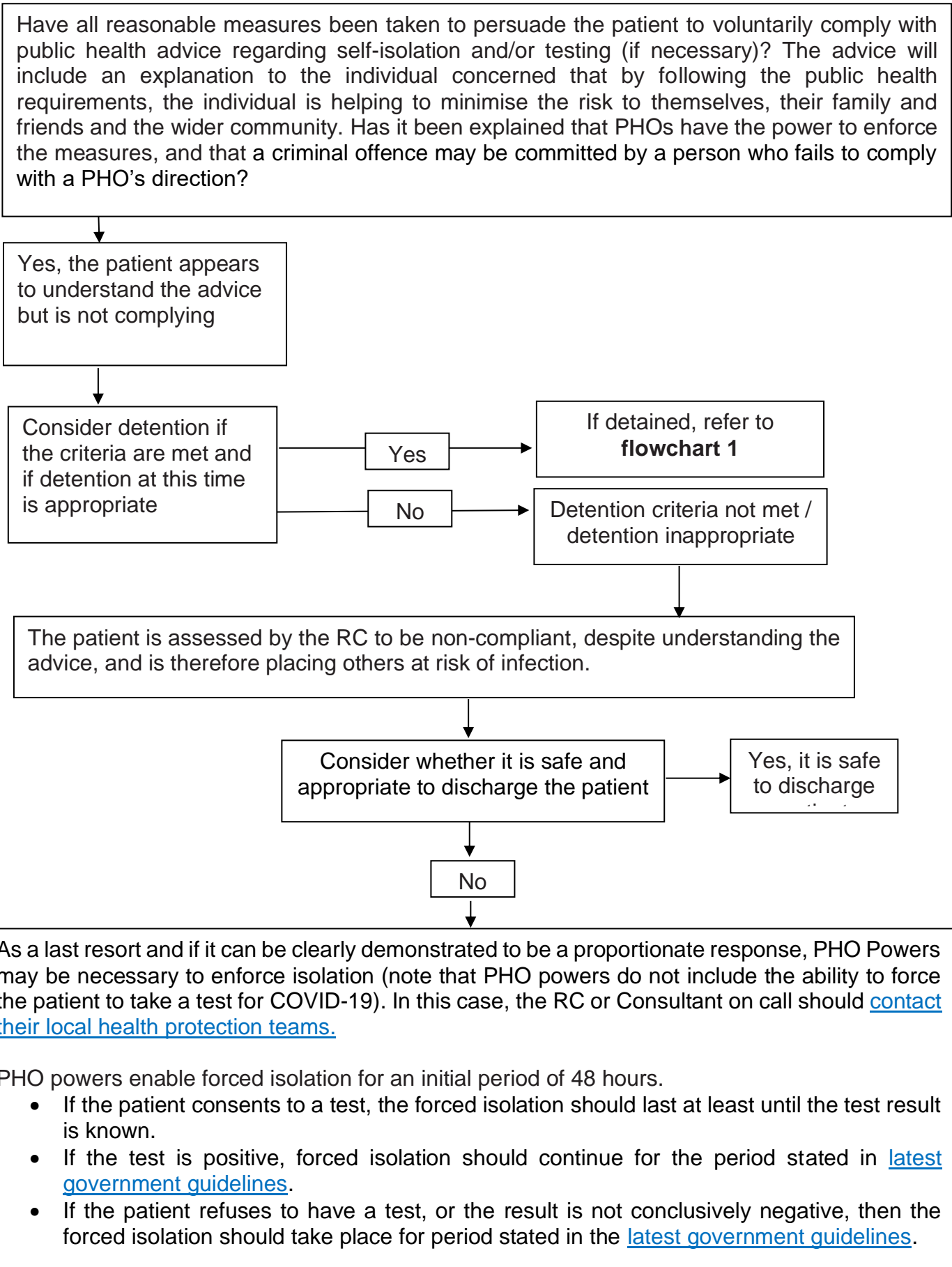
Flow-chart 1 – Isolating detained patients aged 16 or over who have tested positive for or are symptomatic of COVID-19 who have the relevant mental capacity.



Flow-chart 2 – Isolating detained patients aged 16+ who have tested positive for or are symptomatic of COVID-19 who lack the relevant mental capacity.



Flow-chart 3 – Informal Patients aged 16 + who have tested positive for or are symptomatic of COVID-19 who have the relevant capacity



Appendix D: Public Health Officer's powers under Schedule 21 of the Coronavirus Act

The following provides a summary of PHO's powers under Schedule 21 of the Coronavirus Act. See also published [guidance](#) for PHOs:

- Schedule 21 sets out that if a PHO has reasonable grounds to suspect that a person in England is potentially infectious, they may direct a person to go to a place suitable for screening and assessment or remove the person to a place suitable for screening and assessment or request a police constable to remove the person to such a place if this is in the interests of the person, for the protection of other people, or for the maintenance of public health. If they are a child (ie under 18), an individual who has responsibility for a child⁵ must take practicable steps to ensure that they comply with the PHO's instructions.
- A PHO may require the person to remain at the place for screening and assessment purposes for a maximum period of 48 hours so they can provide, or so healthcare professionals can take, a biological sample. A constable can keep someone at a place for screening and assessment (with the option of extending to 48 hours, with the consent of the PHO) until a PHO can execute relevant screening and assessment functions.
- For someone who has tested positive for coronavirus, for whom a test has proved inconclusive, or whom the PHO believes is potentially infectious, under Paragraph 14 a PHO may impose restrictions and requirements, including a requirement to remain at a specified place in isolation for up to a maximum of 14 days. This may be revoked or extended on the same public health grounds with reassessment required every 48 hours.
- Paragraph 16 sets out that where a person is required to remain at a place, the requirement may be enforced by: a constable or PHO removing the person to the place; by a constable or PHO keeping the person at the place; or, if the person absconds, by a constable taking the person into custody and returning them to that place or another place a PHO may specify.
- Paragraph 20 adds that for the purpose of the exercise of these powers, a constable may use reasonable force, if necessary, and that a constable may enter any place.

⁵ an individual has responsibility for a child if:

- (a) the individual has custody or charge of the child for the time being (without being a person on whom powers are conferred by this Part of this Schedule), or
- (b) the individual has parental responsibility for the child (within the meaning of the Children Act 1989).

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

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