

**Section 5(4) of the Mental Health Act 1983: a review of local policy and guidance in England and Wales**

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**Section 5(4) of the Mental Health Act 1983: a review of local policy and guidance in England and Wales**

## **Abstract**

**Purpose** – The purpose of this study is to review policy or guidance on the implementation of Section 5(4) written by NHS mental health trusts in England and health boards in Wales.

**Design/methodology/approach** - A Freedom of Information request was submitted to all trusts in England (n = 57) and health boards in Wales (n = 7) asking them to provide a copy of any policy or guidance on the implementation of Section 5(4). Documents were analysed using content analysis. Specific attention was given to any deviations from the national Mental Health Act Codes of Practice.

**Findings** - Forty-one (67.2%) organisations had a policy on the implementation of Section 5(4). There was a high level of consistency between local guidance and the Mental Health Act Codes of Practice. There were however; different interpretations of the guidance and errors that could lead to misuse of the section. Some policies contained useful guidance that could be adopted by future versions of the national Codes of Practice.

**Research implications** - The research has demonstrated the value of examining the relationship between national and local guidance. Further research should be undertaken on the frequency and reasons for any reuse of the section.

**Practical implications** - Greater attention should be given to considering the necessity of local policy, given the existence of national Codes of Practice.

**Originality** - This is the only research examining the policy framework for the implementation of Section 5(4).

Keywords: Best practice, in-patient, Mental Health Act, Nurses' holding power, Policy, Section 5(4).

Paper type: Research

## Introduction

In England and Wales the Mental Health Act 1983 [hereafter the Act] (Department of health [DH], 2007) is the legislative framework governing the admission, detention and treatment of people with a 'mental disorder'. The Health and Social Care Information Centre (2014) reported that in the period 2013-2014 the Act was used 53,176 times to detain people in hospital. In 34,806 of cases, detentions were made on admission to hospital. In a further 14,087 of cases detentions were made following informal admission to hospital. A person who is admitted to hospital informally is; "Someone who is being treated for a mental disorder and is not detained under the Act" (Department of Health, 2008a: 361). The term 'patient' is used throughout the Act and this usage is followed in this article. It does not imply it is preferred to other terms, for example 'service user' or 'client'.

Section 5(4) (the nurse's holding power) of the Mental Health Act 1983 (DH, 2007) permits nurses of a 'prescribed class' (mental health and learning disabilities) to detain an informal in-patient if the patient expresses an intention to leave and the nurse believes:

- that the patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital either for the patient's health or safety or for the protection of other people; and
- it is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2).

(DH, 2008a: 98, 12.22)

The section can only be applied to a patient who is receiving treatment for mental disorder. They can be held for up to six hours or until a doctor or approved clinician arrives to conduct an assessment and establish whether the patient should be detained under the Act for a longer period of time.

The extent of the use of Section 5(4) is not insignificant. For example, in the period 2013-2014, Section 5(4) accounted for 13.1% (n = 1839) of all detentions after

admission in England (Health and Social Care Information Centre (HSCIC), 2014). This represented a 4% increase in use when compared to the period 2012-2013 (HSCIC, 2014). In total, Section 5(4) of the Act has been applied approximately 40,000 times in England between 1988 and October 2014 (DH, 1995; HSCIC, 2014). Approximately 73% of patients held under the holding power go on to be admitted under another section of the Act (HSCIC, 2014). The use of Section 5(4) may result in nurses having to restrain, seclude or closely observe the patient to ensure they remain on the ward.

Although the Act applies to both England and Wales, national guidance on the implementation of Section 5(4) is provided in separate codes of practice for both countries. The versions of the Codes in place at the time of undertaking the research reported here were both written in 2008 (DH, 2008a; Welsh Assembly Government [WAG], 2008). In England a new Code of Practice has recently been published (DH, 2015a) but the guidance on Section 5(4) has not been revised from the previous edition. In addition, at the time of the study a 'Reference Guide' (DH, 2008b) to the Act existed. The purpose of this document was to act; "as a source of reference for people who want to understand the provisions of the Mental Health Act 1983" (DH, 2008b: 15). However, it also states; "Guidance on the way the Act should be applied in practice is given in the Code of Practice" (ibid). The 'Reference Guide' was updated in 2015 (DH, 2015b).

Both Codes (DH, 2008a; WAG, 2008) place obligations on local hospital managers to create policies, procedures and guidance for a variety of clinical circumstances, for example, the physical restraint of patients. There is no obligation however for organisations to write additional guidance on Section 5(4). Nevertheless, some mental health trusts (England) and health boards (Wales) have done so (Ashmore and Carver, 2014). It is not clear why organisations have made this decision.

Despite this guidance it is known that mental health nurses lack detailed knowledge of the section (Ashmore, 2015) and that wide variations exist in how and why it is implemented (Ashmore, 2012). Ashmore (2015) has also recently reported that research on Section 5(4) has focused on nurses' views on its use (for example, Carver and Ashmore, 2000); trends associated with its implementation (for example

Ashmore, 2010); and nurses' knowledge of the section (for example Ashmore, 1998). There is no research on local policy and guidance on the implementation of Section 5(4). This study addresses this omission.

### **Aim**

The purpose of this study was to review policy or guidance on the implementation of Section 5(4) written by NHS mental health trusts in England and health boards in Wales.

### **Methods**

A Freedom of Information (FOI) request was submitted to all mental health trusts in England (n = 57) and health boards in Wales (n = 7). Each organisation was asked to provide a copy of any policy or guidance on the implementation of Section 5(4).

### **Ethics**

There was no need to seek formal ethical approval to undertake this study as it did not involve service users, NHS staff or premises or seek access to patients' records or other confidential information. Nevertheless, the study was reviewed and approved by the university research ethics review panel. In addition, all replies to the FOI requests stated that for the; "...information supplied... You are free to use it for your own purposes, including any non-commercial research you are doing and for the purposes of news reporting."

### **Analysis**

Data were analysed using a content analysis approach (Stemler 2001). The analysis focused on both the manifest and latent content of the data (Hsieh and Shannon, 2005; Elo and Kyngäs, 2008). Manifest content analysis included some quantification of data, including frequency counting and the calculation of percentages (Hickey and Kipping, 1996). Latent analysis focused on the meaning of the policy content.

The analysis consisted of a number of steps. Using the guidance contained within the Codes of Practice for England and Wales, both authors read and re-read each policy line-by-line to identify words, sentences and paragraphs (meaning units)

relevant to the aim of the study. Therefore, the analysis can be described as a guided or directed content analysis (Hickey and Kipping, 1996; Hsieh and Shannon, 2005). Particular attention was given to identifying deviations from the two Codes. These consisted of omissions, additions and unique interpretations of the guidance.

The identified meaning units were discussed by the authors and an agreed code allocated to each one. Codes were then grouped together to form preliminary categories. Meaning units identified in subsequent policies were compared to those from previous documents. This constant comparative process led to some meaning units being re-categorised and the preliminary categories refined to produce the minimum number discussed below. Throughout the remainder of the article each organisation (O) is identified by a code number.

## **Findings**

FOI responses were received from all organisations contacted (n = 64). Based on the responses three organisations were excluded from the study as they did not provide in-patient services and therefore did not use Section 5(4). Of the remaining 61 organisations (**mental health trusts = 55, health board = 6**), 41 (67.2%) had a Section 5(4) policy or "procedural guidance" (O24) **and 20 did not (32.8%)**. All policies (**n = 41**) included in this study were implemented in 2005 or later and the majority (n = 23) were introduced from 2010 onwards. Four **of the 41** organisations did not state when their policies were written. All but nine (21.9%) organisations gave a date when their policy would be reviewed. Twelve (29.3%) policies did not appear to have been reviewed by their stated review date.

### **Organisations that do not have a policy**

Of the 20 organisations that did not have a policy, three stated that they were in the process of writing one. They therefore exercised their Section 22 exemption of the Freedom of Information Act (2000). Section 22 allows organisations, in certain cases, to withhold documents, for examples any in draft form.

Seventeen **of the 20** (85%) organisations declared that they had no specific policy. Although not asked to do so, some organisations commented on this. One stated that; "The MHA is clear in defining the use of Section 5(4) (therefore a policy is not

necessary)" (O56). Another said that they did not have a specific "protocol" as the holding power "is rarely used" (O23). Others indicated that: they referred to the Mental Health Act; used "... generic MHA policies..." (O17); and followed the Code of Practice (DH, 2008a). When commented on, the Code of Practice (DH, 2008a) was described as containing; "... full and complete" (O4) or "ample" (O23) guidance. Two organisations referred to additional guidance. For example, one (O13) referred to 'The MAZE' (South London and Maudsley NHS Foundation Trust, 2013) and another (O45) to the Mental Health Act Manual (Jones, 2014).

### **The purpose of policies**

Thirty-nine per cent (n = 16) of the 41 organisations that had a policy did not specify its purpose. Some, for example O5, merely suggested that they were giving information about Section 5(4). Others were more directive and described their policies as "guidance" (for example, O8). In general terms, the main concerns of the policies were to ensure compliance with the Act and to enable best practice on behalf of nurses. One policy (O29) addressed the issue of guidance by emphasising that the policy aimed to give assurance to patients that Section 5(4) would be used correctly. Two others (O25 and O33) emphasised that their policy aimed to ensure that the organisation meets its responsibilities to patients.

### **Persuasion and other nursing interventions**

Most policies implied, but do not overtly state, that avoiding the use of Section 5(4) is better than using it. However, this was sometimes made clear, for example one organisation stated that; "Only after all avenues of persuasion have failed... should the nurse consider Section 5(4)" (O27). In addition, one organisation (O41) was overt in stating that the nurse "must" attempt to persuade the patient to remain on the ward. Another (O35) used the word "convince" with no apparent difference in meaning.

One organisation suggested that only after all attempts at persuasion have failed and; "...there is no other least restrictive option available, should the nurse consider invoking a Section 5(4)" (O41). Another two (O5 and O54) went further and identified options for interventions to encourage the patient to stay. These included;



unspecified diversion activities, use of PRN medication and addressing any concerns that the patient may have, even if they seem minor.

On the other hand, one policy suggested that some attempts to prevent people from leaving could "amount to a deprivation of liberty" (O32) including the statement "you cannot leave until you have seen a doctor" (O32). One (O53) also recognised that explicit threats of using compulsory powers were unacceptable. Two policies (O30 and O53) referred to the concept of 'de facto detention', described by one as; "...a term used to describe situations where informal patients who are unwilling to remain in hospital are nevertheless compelled to stay without the imposition of formal legal detention..." (O29).

### **Securing the attendance of a medical practitioner or approved clinician**

As one organisation pointed out the Act "makes clear" (O42) that where possible a patient should be held under Section 5(2) rather than the nurse's holding power. However, no policy offered any strategies to secure the immediate attendance of a clinician, although one organisation stated that the clinician is informed that the; "...delay in his/her arrive will necessitate a Section 5(4)..." (O44).

Some organisations commented on how long a patient may be held before the clinician attends and without recourse to Section 5(4). This period of time was described alternatively as; "a few minutes" (O5, O17 and O43), "10 minutes approximately" (O29), a "maximum of 15 minutes" (O30) and "a short time" (O54). A further organisation stated a patient may be held if the attending "doctor" (sic) is already "... in the building but ...not on the ward" (O27).

### **Where Section 5(4) can be used**

All but five (12.2%) organisations referred to the fact that Section 5(4); "...can be used only when the patient is still on the hospital premises" (DH, 2008a: 99, 12.22). Sixteen (39%) organisations simply re-stated this guidance (or a variation on it) but did not clarify the extent of their premises. However, six (14.6%) organisations (O5, O15, O21, O28, O32 and O35) went further by highlighting that 'premises' included hospital buildings and grounds. One policy (O15) offered a more detailed description of premises based on the organisation's specific geographical layout;

## "WHERE SECTION 5(4) CAN BE APPLIED

- To any informal in-patient receiving treatment for a mental disorder who is still on the hospital premises.
- Premises include not only the building where in-patient care takes place e.g. a ward, but also the land surrounding it owned or leased by the trust. Therefore 5(4) can be applied not only in buildings but also up to the boundaries of trust premises.
- Where a Trust ward is situated in a unit managed by another hospital... then section 5(4) can only be applied to an informal patient who is inside the ward."

A small number of organisations (n = 3, 7.3%) did not use the term 'premises' at all but instead referred to; using Section 5(4) on wards, preventing patients "from leaving hospital" (O22) and "prevent[ing] an inpatient from leaving a unit" (O20).

Three (O5, O7 and O41) added additional information regarding where the section *cannot* be applied, for example; "...5(4) cannot be applied to patients attending... non ward setting [sic] for mental health treatment, such as an out-patient clinic or CMHT office" (O5). One policy however stated that in some circumstances (see below) Section 5(4) may be used "in a general hospital setting" (O22). Finally, one organisation suggested that if the **patient had left the hospital prior to the documentation (Form H2) of their detention being completed they**; "cannot be returned to the hospital under Section 5(4)...however Common Law (sic) powers to detain may be appropriate" (O30).

## **Who can implement the section**

Of the 41 organisations, all but six (14.6%) stated that the person implementing the power was required to be a nurse of the 'prescribed class' as defined in the Act. One policy emphatically stated that nurses of the 'prescribed class' cannot use the section if they are "doing a shift on a general ward as the patient will not be in a hospital for the purpose of receiving treatment for their mental disorder" (O7). However, as

mentioned above, one policy (O22) stated that; "The power cannot be used in a general hospital setting, except by a nurse of the 'prescribed class' working on the ward and the patient is already receiving treatment for a mental disorder" (sic). Another (O14) recognised that implementation is by any nurse of the 'prescribed class' but then stated that "the senior nurse on the ward" explains to the patient their rights.

Four policies (9.8%) stated that Section 5(4) should be implemented by the nurse in charge (sometimes described as the shift co-ordinator) of the ward. One policy stated that; "...the Nurse in Charge must review with the Ward Manager/On call Manager whether the patient should be detained under section 5(4)" [sic] (O16). One also suggested that the nurse in charge would have "a previous knowledge of the patient and their mental condition..." (O47). Another stated that the section would be implemented by "...preferably the nurse in charge of the ward..." but always by; "A suitably qualified and experienced nurse of the prescribed class..." (O10). In addition they stated that; "...the Trust requires that nurses applying this order have at least six months post-registration experience" (O10).

Finally, one policy stated that Section 5(4) would be implemented by a; "...suitably qualified, experienced and competent nurse of the prescribed class..." (O19). They added; "All ward staff should be informed of which nurses on duty have authority to implement section 5(4)" (sic). Unfortunately this policy did not offer further clarify on the criteria used to determine which nurses may use Section 5(4) in their trust.

### **Instructing the nurse**

All policies made reference to the fact that the Codes of Practice state that no one can instruct the nurse to implement Section 5(4). In addition, one organisation (O29) quoted the Guide to the Mental Health Act (DH, 2008b: 40, 2.83); "Nurses who make reports under section 5(4) do not have to detain patients personally." This was the only reference in any policy to this Guide.

In relation to psychiatrists, one policy specifically emphasised that under no circumstances must they; "...instruct the nurse to apply section 5(4) in his/her absence..." (O54). However, they went on to say that; "...It would be reasonable

however for a consultant psychiatrist to ask a nurse to consider section 5(4) over the phone while he/she was in transit to the ward" (O54). They also added that; "If the nurse applied section 5(4) as a result of a doctor's instruction, this would be deemed to be unlawful..." and; "Any coercion to implement the 5(4) would invalidate the section" (O54). One policy (O7) stated that 'Senior Nurses' should not leave advance instructions for others to implement the Section 5(4). Two policies (O7 and O57) also pointed out that any pre-signing of forms by senior nurses or others was forbidden. Both suggested that such practices may be illegal.

### **Managing disagreements**

Although there is some recognition that where possible other professionals' views be sought or taken into account in assessing the need to implement Section 5(4), none of the policies addressed how disagreements may be managed throughout the entire process. The only exceptions to this are statements by two organisations (O27 and O34) who stated that a nurse cannot refuse to accept the 'handover' of a detained patient; simply because they do not think they should have been detained.

### **Securing the attendance of a doctor or approved clinician**

Both Codes state that the implementation of Section 5(4) constitutes an "emergency measure" and stress the doctor or approved clinician should arrive as soon as possible, and not wait the full six hours. The Welsh Code adds that; "Hospital managers should set target times for responses, which should be as short as practicable" (WAG, 2008: 51, 8.27). Four of the six Welsh health boards that had a policy did not include a target time.

Fifteen policies (36.6%) offered guidance to staff in relation to securing the attendance of a doctor or approved clinician within the six hour period. Of these, 12 (29.3%) suggested nursing staff should take action after four hours should the doctor or approved clinician not have arrived on the ward. This may involve a repeat telephone call or by contacting the duty consultant. One policy overtly stated that attendance in four hours is the "Trust's target time..." (O47). Eight organisations (O9, O27, O34, O41, O48, O52, O60 and O61) suggested action be taken at additional time intervals. For example, one policy specifically mentioned actions after three and five hours to secure the attendance of the relevant clinician as well as

suggesting the "the nurse in charge of the ward must make repeated efforts to contact them..." (O29).

### **When the section begins**

Both Codes state that the holding power begins when the nurse completes the statutory form (Form H2 in England and Form 013 in Wales). One policy appeared to differ from this and suggested that the six hours of Section 5(4) "...begins at the time the decision is made to exercise the authority to detain the patient" (O20). One further policy recognised that there may be a time lapse between preventing the patient leaving and the completion of Form H2 and stated that; "The patient is held under common law whilst the form is being completed" (O11).

### **If a clinician does not attend**

It is clear from the Codes of Practice that should Section 5(4) expire before a clinician attends this would be a "serious failing" (DH, 2008a: 101; WAG, 2008: 51) and should be avoided. As one policy pointed out; "Under no circumstances..." should this happen (O5). Fifteen policies do not mention the potential for this situation to arise. Five policies (O5, O31, O38, O42 and O53) followed the Codes of Practice in highlighting that Section 5(4) cannot be immediately renewed but that it can be used on a future occasion. The issue of when the section can be used again has never been clarified in law. Both Codes of Practice do not offer any guidance on this and nor did any of the sampled policies.

The Codes of Practice are clear that if a clinician does not attend before the section expires the patient is no longer detained and "may leave [the hospital] if not prepared to stay voluntarily" (DH, 2008a: 101, 12.34; WAG, 2008: 51, 8.28). Some organisations (O9, O10, O25 and O29) however recognised that it is possible for a patient in these circumstances to continue to be a risk to themselves or others. One of these policies (O29) acknowledged that staff may be able to persuade a patient to stay but gave no other guidance on what do should the patient still wish to leave. Of the remaining three policies two (O9 and O10) emphasised that common law may be utilised in such a crisis. One of these stated staff may rely on common law to; "...detain any patient in order to prevent serious self-harm or injury to others" (O9). The final policy (O25) suggested that the patient is free to leave unless; "...the

provisions of the Mental Capacity Act could be used..." in their best interests. This policy did not mention the potential to use common law.

### **Consent to treatment**

Of the 41 policies reviewed, 31 (75.6%) organisations referred to the issue of treatment in relation to Section 5(4). All 31 correctly stated that Part IV of the Act does not apply to Section 5(4) (Part IV of the Act enables treatment without consent of the main groups of detained patients, for example those held under Section 3). Seven of these (O7, O8, O20, O21, O33, O52 and O58) simply paraphrased the guidance in the Codes of Practice. For example one said the; "Patient is not subject to Part IV consent rules" (sic) (O21). Another stated that; "Detaining patients under s.5(4) does not confer any power under the Act to treat them without their consent" (O52).

However, 24 (63.4%) organisations recognised that it may be necessary to treat a patient detained under Section 5(4) without their consent in an emergency. As one said enforced treatment without the patient's consent would be justified in; "...extreme circumstances where, due to the distress caused to the patient by their mental state, it would be negligent not to...as we have a duty of care..." (O38).

Others added that treatment must be given in the belief that it is in the patient's "best interests" (O5) and that it is; "...immediately necessary to save life, prevent a serious deterioration in the patient's health, alleviate serious suffering or prevent the patient from behaving violently and being a danger to themselves or others" (O16). Another added that the treatment must be given to; "...ensure an improvement in the patient's physical or mental health" (O31). Two highlighted that not all treatment would be appropriate. As one said treatment; "should be the least restrictive and the minimum necessary" (O16). This meant for another that it should only involve; "short acting drugs prescribed by the doctor...and certainly not a regular long acting depot injection, as it would have no immediate affect (sic) on the patient's mental state" (O38).

However, there were differences among the 24 organisations on the relevance of the Mental Capacity Act (DH, 2005) in administering emergency treatment to patients

detained on Section 5(4) (The Mental Capacity Act (DH, 2005) is the legislative framework that protects and supports people in England and Wales who do not have the ability to make decisions for themselves). The differing positions regarding this framework are summarised below:

1. Three organisations (O29, O31 and O54) distinguished between a patient with capacity and a patient without capacity. All three stated that the treatment of a non-consenting patient with capacity should be justified under common law. They then stated the treatment of any patient without capacity should be undertaken within the provisions of the Mental Capacity Act (DH, 2005). A further three (O16, O25 and O40) were a little unclear but seem to appear to say the same.
2. Nine policies (O9, O15, O27, O34, O38, O42, O44, O47 and O57) did not mention the Mental Capacity Act but stated that emergency treatment can be given under common law. The wording of one policy (O15) seemed to suggest that any patient (with or without capacity) detained under Section 5(4) could be treated in an emergency under the provisions of common law. Two policies (O44 and O47) stated that the use of common law was justified under the “doctrine of necessity”.
3. Eight policies (O5, O11, O14, O22, O32, O35, O48 and O53) stated that if capacity exists treatment can *only* be given with the patient's consent. Of these, seven (O11, O14, O22, O32, O35, O48 and O53) stated that a patient detained under Section 5(4) who ‘lacked capacity’ should be treated “under the provisions of the Mental Capacity Act...” (O11). Another policy (O43) implied both the above points.

## Discussion

This article has examined policies specifically relating to the implementation of Section 5(4). Although several organisations gave reasons for not writing a specific policy on Section 5(4), our findings only give limited insight into why some chose to do so. Given that the effort in writing a policy is not insubstantial it does seem odd that many simply reiterated existing national guidance. Future work could address

why organisations chose to do so as well as others included additional guidance. One finding is confusing. Despite the fact that the Codes of Practice do not oblige organisations to write a policy the Welsh Code does suggest that; "Hospital managers should set target times for responses..." (WAG 2008: 51, 8.27). It is difficult to see where these target times would be available to staff, other than in a local policy. It is also noteworthy that judged against this statement only two Welsh policies gave such target times.

In terms of content most policies accurately reflect their Codes of Practice however others contain **some contentious statements**. The first of these is the assertion, in one policy, that Section 5(4) could be used in a general hospital setting. We cannot find any evidence to support this assertion, even if, as the policy stated, the patient was receiving treatment for a mental disorder. **Certainly neither the Act (DH, 2007) or the Codes of Practice (DH, 2008a; WAG, 2008) mention this, but** it is possible that this occurred as a result of confusing the *nurse's* holding power with the *doctor's* holding power (Section 5(2)), which *can* be used in a general hospital setting (DH, 2008a).

The second issue concerns who could implement the section. Some organisations in the study suggested that it must be the nurse-in-charge/shift co-ordinator/senior nurse on the ward who implemented the section or in one case someone with "...at least six months post-registration experience" (O10). However, the Codes of Practice (DH, 2008a; WAG, 2008) state that *any* nurse of the prescribed class may implement Section 5(4). Whilst recognising the value that clinical experience may bring to implementing Section 5(4), Kinton (personal communication, 2013) has suggested that these policies should also state that "where necessary any nurse of the prescribed class" is empowered to use Section 5(4)."

Thirdly, one policy (O25) suggested that nurses may use the Mental Capacity Act (DH, 2005) to prevent the patient leaving should a Section 5(4) expire before the patient has been assessed. However, Jones (personal communication, 2015) has stated that "...the MCA could not be used" since the patient is "within the scope of the MHA" (sic). Perhaps oddly, this policy (O25) failed to mention that nurses could in these circumstances prevent a patient leaving under common law.



Fourthly, in relation to consent to treatment, Jones (personal communication, 2015) has confirmed that of the three positions identified in the findings, only position 1 fully reflects current legislation. This would enable non-consenting patients with capacity and any patient without capacity to be given emergency treatment. In position 2 patients would not be denied treatment, although the legal justification for the emergency treatment appears confused. Of more concern is position 3, which claimed that non-consenting patients *with* capacity could not be treated at all. At minimum the above discussion seems to indicate a degree of uncertainty in relation to the relevance of common law, the Mental Capacity Act (DH, 2005) and the Mental Health Act (DH, 2007) in emergency situations.

The final problematic issue concerns when Section 5(4) begins. The Codes of Practice state that the holding power begins when the nurse completes the statutory form (H2 in England and 013 in Wales). One policy however suggested that the six hours of Section 5(4); "...begins at the time the decision is made to exercise the authority to detain the patient" (O20). Although strictly inaccurate, this is not a surprising deviation. **Ashmore (1998) showed that the majority (65%) of** mental health nursing students believed that the holding power begins when the patient is prevented from leaving.

One concern is that since Form H2 may not be filled in for some time after the patient is prevented from leaving, they are held illegally. Similarly, **Ashmore (1998) reported that** student **mental health nurses** are concerned that a patient could not be stopped from leaving during the period between the **medical practitioner** arriving on the ward and carry out the actual assessment.

Our response to these issues is to suggest that the time periods in both instances are likely to be very small and of little concern in law. In addition, we suggest that the time of detention recorded on Form H2 should be the point at which the patient was prevented from leaving. In relation to when the section ends, we would also advocate that the Codes of Practice are amended to reflect the position adopted under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Health Department, 2003). Their Code of Practice (Scottish Executive, 2005) states that as

long as the assessment takes place within the legal timeframe of the holding power, the patient remains held on the section until this process is completed.

Turning to those policies that contain additional material to national guidance, it is worth noting that evidence has recently emerged that suggests that there are elements of uncertainty around the implementation of Section 5(4) (Ashmore and Carver, 2000; Ashmore, 2012; Ashmore and Carver, 2014). Many of these uncertainties appear to have led to organisations elaborating the guidance offered in the Codes of Practice. However, there is not full consistency between policies in relation to these elaborations.

Most policies echoed the Codes of Practice which state that practitioners should "minimise the restrictions they impose on the patient's liberty" (DH, 2008a: 5, 1.3). Some however go further in clarifying the differences between persuasion and behaviours which may result in the patient feeling coerced to remain in hospital resulting in their illegal detention (Ashmore and Carver, 2014). Others appear concerned that the Codes of Practice have not identified the length of time a patient could be prevented from leaving without resorting to implementing Section 5(4). This at least ensures a standard against which the response time of clinicians could be audited and could offer reassurance to nurses that this limited use of common law is justified.

A further issue in relation to enacting the section is that a small number of organisations have also chosen to clarify exactly where Section 5(4) may be used. They highlighted that the term 'premises' includes the grounds owned by the organisation. **This is a welcome clarification and we feel this could be further enhanced by organisations providing a simple map indicating clearly where the boundaries of these grounds lay.**

In relation to response times, it is worth noting that an earlier Code of Practice (DH, 1999) stated that a doctor should assess the patient within four hours, rather than "as soon as possible" as stated in the 2008 Code (DH, 2008a: 101, 12.32). It does seem however as if several organisations wished to retain the spirit of the 1999 Code in specifying target times and actions to be taken to secure the arrival of the

medical practitioner or approved clinician. There is also evidence that would support this guidance. For example, Ashmore (2008) reported that having specific target times within the six hour period correlates with a significant reduction in the length of time patients must wait for an assessment. Where organisations give target times they also specify actions to be taken by nursing staff at these times. This may reduce the anxiety of nursing staff in an uncertain situation, and help minimise the impact of this emergency measure on patients (Ashmore, 2012). We would suggest that targets times should appear in all guidance regarding the implementation of the holding power.

It is known that there are some incidences of the holding power running its course before the patient could be assessed (Ashmore, 2010), although national statistics are not available. This situation is not problematic for nurses to manage if the patient is willing to remain on the ward voluntarily. However, it is possible that an at-risk patient may still wish to leave. The lack of guidance here may reflect a view that this situation is so rare that it is not worth addressing in policy. However, it may also reflect a degree of uncertainty as to the best course of action. The one policy (O25) that suggested that the Mental Capacity Act (DH, 2005) may apply has been discussed above and, of course two policies (O9 and O10) offered some support to staff in recognising the potential to use common law to prevent serious harm occurring in this event.

The option to use another Section 5(4) in this situation is complicated by the fact that it is not obvious in any guidance how soon the holding power could be used again with the same patient (this issue is of course also relevant if a patient has been assessed, returns to informal status and then immediately deteriorates again). Kinton (personal communication, 2013) has suggested it may be difficult to give a timescale for this and each use of Section 5(4) would have to be justified on its own merits. Certainly if the criteria for the section still applied and the patient continued to express a desire to leave it may be, as Kinton (personal communication, 2013) notes; "...irresponsible not to use the holding power again."

Given the above and in the absence of relevant case law it may remain unclear whether common law or a reuse of Section 5(4) may be the best option for nurses in

maintaining the safety of all concerned. We suggest therefore that future codes of practice and local policies at least reassure staff that these options, applied in the best interests of patients, are legitimate.

### **Limitations**

We must acknowledge that there is no publically available evidence examining whether the implementation of Section 5(4) varies depending on the existence or absence of any particular policy or its content. It is also possible that there are other organisational policies (for example those dictating when informal patients may take leave) which may affect how practitioners implement Section 5(4).

### **Conclusions**

This study has reviewed all extant policy on the implementation of Section 5(4). While many organisations appear content with the Codes of Practice a significant number offer additional guidance. However, this guidance is not always consistent and on a small number of occasions is contentious, if not inaccurate. Regardless of whether the Codes of Practice are considered adequate or not, it would appear desirable that there is greater standardisation of policy. One solution to this may be the production of national good practice guidelines.

### **Declaration of interests**

None

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