

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

30 March 2020, Version 1

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

1. Introduction

This guidance provides advice and support to commissioners (CCG and specialised commissioning), providers, social workers, local authorities, experts by experience, clinical experts, independent chairs for Care and Education and Treatment Reviews, and others who may be involved in pathways of care, as well as regional NHS England and NHS Improvement colleagues, to help with the local planning already underway.

It covers:

- key messages
- the Mental Health Act 1983
- operational considerations for the MHA
- the Mental Capacity Act 2005
- the Care Act 2014
- restraint and restrictive practice
- specific considerations for specialised mental health services
- specific considerations for learning disability and autism services
- specific considerations for mental health and the criminal justice system.

Future versions will include:

- management of patients in mental health settings with COVID19 – case studies
- further information relating to the enactment of the emergency MHA provisions and key considerations for their local application.

This guidance is one of a [suite of resources](#) to support the mental health and learning disability and autism sectors in responding to the outbreak. These 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
- legal guidance on applications of the Mental Health Act and emergency Coronavirus Bill.

2. Key messages

- There are currently no changes to the Mental Health Act 1983 (MHA) legislation and colleagues should continue to adhere to the MHA Code of Practice as it currently stands until further notice.
- MHA powers must not be used to enforce treatment or isolation for any reason unrelated to the management of a person's mental health.
- While the NHS is facing unprecedented challenges relating to COVID-19, wherever possible we must continue to guard against overly restrictive practice.
- Robust and live communication across services is hugely important at this time when there significant resource shortages across the sector are likely. Colleagues should take advantage of digital technologies to support communication. [NHSX guidance](#) supports mental health providers in using digital and virtual channels such as MS Teams, Skype, WhatsApp and FaceTime.
- Emergency changes to the current MHA legal framework will only be enacted if patient safety is deemed to be at considerable risk – the overarching aim of the powers is to ensure that those people in critical need of mental healthcare are able to access this throughout the emergency period.
- 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 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 and support from medicolegal colleagues as required.

3. The Mental Health Act 1983

- Currently, no changes have been made to the MHA or MCA legislation and all organisations and staff should continue to operate in line with existing MHA law and Code of Practice.
- The emergency [Coronavirus Bill](#) was passed on 26th March and , contains a number of emergency provisions which will amend certain aspects of the MHA regarding second opinion safeguards and detention period. However, they will only be enacted if it is deemed nationally that the mental health sector is experiencing unprecedented resource constraints that put patients' safety at significant risk. The emergency Coronavirus Bill makes no changes to the MCA.
- Even if enacted, the powers should only be used when local systems decide that they are absolutely necessary. In preparation for these circumstances, NHS England and NHS Improvement will regularly update this guidance for local systems, clearly setting out:
 - the conditions that would make it appropriate for the powers to be exercised locally
 - the key considerations locally to ensure that any decision to rely on these powers is safe and proportionate.
- **Box 1** below summarises the emergency powers. We will provide further communications in accessible formats to both the sector and people who use services on changes to the legal position, but for now we are reminding everyone that they should **continue to work within the current legislation**.
- It remains the case, even in the wake of the emergency powers, that the MHA should only be used 'with respect to the reception, care and treatment of mentally disordered patients and other related matters'. Under no circumstances can the MHA be used to enforce treatment, restrictions or isolation that is unrelated to the management of a person's mental health.
- As communicated in [the letter](#) from NHS England and NHS Improvement to all NHS system leaders on 17 March on the NHS response to COVID-19, mental health, learning disability and autism providers must plan for COVID-19 patients in all inpatient settings. This includes identifying areas where COVID-19 patients require urgent admission and could be most effectively isolated and cared for (eg single rooms, en-suite or mental health wards on acute sites). Please see the recently developed NHS England and NHS Improvement [guidance on managing capacity](#)

[and demand within inpatient and community mental health and learning disability and autism services for further information and advice.](#)

- 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.
- **Case-by-case reviews will be required where any patient is unable to follow advice on containment and isolation.** Providers should decide the appropriate use of the relevant legal framework for each case, with support from medicolegal colleagues as required. Future iterations of this guidance will seek to include case studies where possible to support decision-making. **Annex A** includes links to helpful resources developed by the Royal College of Psychiatrists to support practice in mental health settings in light of COVID-19.
- **Note:**
 - The Mental Health Casework Section (MHCS) in Her Majesty’s Prison and Probation Service (HMPPS) is also considering contingency planning in relation to restricted patients. **See Annex B for their latest position.**
 - An [emergency practice direction](#) has been issued that will enable single judge panels and telephone hearings. The tribunal also plans to prioritise S2 hearings and conditional discharge recalls.

Box 1: What does the emergency Coronavirus Bill do?

If enacted, the emergency powers relating to the Mental Health Act will allow:

- Approved mental health professionals (AMHPs) to obtain a medical recommendation from one section 12-approved doctor (who does not necessarily need to have previous acquaintance with the person being assessed) rather than two, when applying to detain a person with mental disorder. But this would only be allowed in circumstances where the AMHP is of the view that, because of staff shortages caused by coronavirus, seeking the advice from two doctors would either be impractical or unduly delay the application. The legislation also makes clear that the AMHP would be required to justify and record their decision in these circumstances.
- Patients may be detained for slightly longer than they would otherwise have been under normal circumstances – in two areas of the law:

- under section 5 (emergency detention for people already in hospital, which would extend from 72 hours to 120 hours; and nurses' holding powers which would extend from 6 to 12 hours)
- under sections 135 and 136 (police powers to detain a person found in need of immediate care at a 'place of safety', which would extend from 24 hours to 36 hours).
- Clinicians in charge of a patient's treatment to certify that it is appropriate for the patient to be given medication without consent (usually this must be certified by a separate doctor).
- More time for defendants and prisoners with a mental health condition to be both:
 - kept on remand in hospital
 - transferred from prison to hospital by allowing more time before a direction to transfer expires (under s47 only).

4. Operational considerations for use of the MHA

- Over the coming weeks, it is possible that local operational challenges arising from resource constraints may start to impact on the use of the MHA. It is important that steps are taken to enable mental health services to deal with potential increased staff shortages while maintaining the safeguards for patients set out in the MHA. In particular, there is a need to ensure that the MHA can continue to be used to detain and treat people in a timely way, where this is necessary.
- The emergency provisions, referenced above, are intended to help address these operational challenges in the situation that they start to pose a significant risk to patient safety, but their implementation should ultimately be seen as a last resort, with the primary aim to continue to operate in line with the current MHA legislation.
- **Box 2** below lists the areas in relation to the use of the MHA where workforce shortages can be expected to have the most significant impact, along with some suggested actions to help mitigate this:

Box 2: Possible areas impacted by workforce shortages

- MHA assessments due to inadequate access to s12 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.

Suggested mitigating actions

- Additional administrative resource to support the local section 12 rota: there will be staffing changes locally and these need to be well-managed and communicated.*
- NHS providers and local authorities to consider how to support each other in operating out-of-hours services.
- If necessary, access to and support from IMHAs should be arranged virtually, with the assistance of appropriate digital technology, to ensure this critical safeguard is 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.
- Close working with the ambulance service, and in some instances secure transport, with regards to conveying individuals detained under the MHA.
- 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 assessments, transfers and remissions.
- Strong communication between the management of the section 12 rota and AMHP rota locally.

- 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.
- Dedicated senior operational resource to co-ordinate demand for MHA work, bringing together all requests across admissions, s136 suites, community treatment order recalls, section renewals, the Criminal Justice System, tribunals, etc.

* The Department of Health and Social Care is extending the licences of section 12 doctors and approved clinicians and will formally communicate this shortly. Licences 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. The Mental Capacity Act

- The Department of Health and Social Care (DHSC) is developing guidance in relation to COVID-19 to support decisions about the care and treatment of people who lack the relevant mental capacity. This will be made available shortly and will set out practical measures, within the current legislative framework, to support the sector while managing the impact of COVID-19. This document will be updated to align with DHSC's advice as soon as possible.

6. The Care Act

- The emergency Coronavirus Bill also has a section on temporary changes to the Care Act. Guidance will be made available to support these. If provisions are enacted, they will impact on many people who are within mental health services and detained under the MHA, who also have important rights under the Care Act.
- Provisions in the emergency bill make changes to the Care Act 2014 in England and the Social Services and Well-being (Wales) Act 2014 to enable local authorities to prioritise the services they offer. This is so they can ensure the most urgent and serious care needs are met, even if this means not meeting everyone's assessed needs in full or delaying some assessments.
- Local authorities will still be expected to do as much as they can to comply with their duties to meet needs during this period, and these amendments would not remove the duty of care they have towards an individual's risk of serious neglect or harm.
- These provisions, if enacted, will provide local areas with the discretion to cease current practices such as panels to make decisions about funding placements. They

are intended to be used in periods of significant staff shortage to reduce operational burden so that local authorities can prioritise the services they offer to ensure the most urgent and serious care needs are met.

- 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.

7. 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.
- The impact of COVID-19 may result in a justifiable need for restrictive practice in particular circumstances. However, it is important that at every opportunity providers use the least restrictive methods possible. Any use of restriction must be proportionate to the risks involved and providers should refer to their ethics committees where required.
- For example, 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. See the Care Quality Commission's (CQC) [Brief guide: the use of 'blanket restrictions' in mental health wards](#)
- Isolating patients due to suspected or confirmed COVID-19 in mental health settings may be challenging for all those involved, particularly where the patient refuses to be isolated. Providers need to develop appropriate strategies to manage this safely to

protect patients and staff from transmission and risk of physical injury within legal constraints, including their obligations under the Human Rights Act (1998). As already indicated in this document, colleagues should determine appropriate use of the relevant legal framework on a case-by-case basis, with reference to organisational ethics committees and support from medicolegal colleagues as required. 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 non-absolute right. This means that any restriction on this right has to be lawful, necessary and proportionate.

- Any use of restrictive practice should end at the earliest opportunity that ensures 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. As with blanket restrictions, decisions to increase other forms of restrictive practice resulting from the impact of COVID-19 should also be documented.
- If 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.

8. Specific considerations for learning disability and autism 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, we acknowledge 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. We are aware that these are being explored centrally and that providers are thinking about

how they can carry out these functions within the limited capacity they may have available to them.

- 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:
 - exploring the possibility of meetings taking place via digital technology: providers should ensure that 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
 - 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 where possible.
- Other stakeholders, such as the Mental Health Casework Section (MHCS) in Her Majesty's Prison and Probation Service (HMPPS), will also be considering contingency planning in relation to restricted patients, so it is important to work closely with them and align thinking and planning.
- 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.

High secure

- It may be necessary due to the implications of COVID 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 unless the emergency provisions in the emergency Coronavirus Bill are triggered
 - the Children Act 1989 (and related legislations) remains applicable, such as in relation to child safeguarding matters
 - additionally, the use of parental responsibility and consent for non-competent children under 16 years and non-capacitous 16 to 17 years (depending on the decision to be made) remain as current¹
 - practitioners should continue to use consent by Gillick competent children under 16 years where applicable.
- The emotional and behavioural responses of some children to the constraints, uncertainties and significant changes to daily living due to COVID-19 may provide diagnostic challenges when assessing individuals under the MHA. Advice from professionals with experience in children and young people's mental health should be sought in such cases wherever possible.

9. Specific considerations for learning disability and autism services

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

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

- While people with learning disabilities 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.
- In the case of learning disability, the presence of ‘abnormally aggressive or seriously irresponsible conduct’ is necessary to detain an individual under section 3 or equivalent of the MHA. It is important that, if a person with a learning disability does not meet the specific behavioural criteria for detainment, non-compliance or difficulty in gaining compliance with any restrictions and interventions required for the management of COVID-19 is not interpreted as adequate grounds on which to detain them. Further, the fundamental principle that the MHA is not for the treatment of physical disorders must be borne in mind where there is no association between a person’s physical and mental disorder.
- The emotional and behavioural responses of people with autism to the constraints, uncertainties and significant changes in daily living as a result of the management of COVID-19 may also provide a diagnostic challenge in assessments under the MHA. At a time of reduced workforce and where expedient solutions to implementing the MHA are being sought, it is essential that the support of health and social care service practitioners with particular experience and expertise in learning disability and/or autism is sought wherever possible to enable appropriate, reasonably adjusted assessments.
- People with a learning disability and/or autism in inpatient settings are already vulnerable to and disproportionately represented in the use of inappropriate and excessive restraint, seclusion and long-term segregation. 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 – as altering these can again exacerbate anxiety, distress and challenging behaviours.

- Please see the NHS England and NHS Improvement managing capacity and demand guidance for information on managing [Care \(Education\) and Treatment reviews](#) (C(E)TRs).

10. Specific considerations for mental health, learning disability and autism and the Criminal Justice System

Transfers and remissions to and from prisons/immigration removal centre (IRCs) and mental health inpatient services

- During this time patients will continue to require transfer and remission across organisations based on their mental health needs.
- It is important that we work within the current service specifications and guidance – if these need to be amended, we will discuss and notify the system of any changes.
- Where appropriate, we would want to encourage the use of digital technology 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.
- Relevant stakeholders, from Her Majesty's Prison and Probation Service, Ministry of Justice, Home Office and NHS England and NHS Improvement will be working together to explore specific issues in relation to this pathway.

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, we would want to encourage the use of digital technology across relevant services in respect of undertaking assessments and clinical discussions.
- Relevant stakeholders, from Her Majesty's Prison and Probation Service, Ministry of Justice, Her Majesty's Court and Tribunal Service, police services and NHS England and NHS Improvement will be working together to explore specific issues in relation to these pathways.

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 message – position as of 19 March 2020

At this point in time there are no changes to the Mental Health Casework Section policies and procedures regarding restricted patients as a result of Covid-19. If you have queries specific to an individual restricted patient that you would like to discuss then please contact us at mhcsqacs@justice.gov.uk. Hospitals and other providers should continue to follow official guidance for their sector with regard to the care of their patients.