Understanding and implementing the nurse’s holding power (section 5(4)) of the Mental Health Act 1983


Abstract
This article explores section 5(4) of the Mental Health Act, which permits nurses of a ‘prescribed class’ to detain an informal inpatient who is receiving treatment for mental disorder for up to six hours or until a doctor or approved clinician arrives. The article raises various issues in relation to the implementation of section 5(4), some, but not all of which are addressed by the relevant codes of practice for England and Wales. The authors raise important questions that nurses need to address if their holding power is to be applied appropriately in all cases.

Aims and intended learning outcomes
This article discusses issues relating to the implementation of section 5(4) (the nurse’s holding power) of the Mental Health Act 1983 for England and Wales. Following the style of the Mental Health Act 1983 (hereafter referred to as ‘the act’), the term ‘patient’ is used throughout.

After reading this article and completing the exercises, you will be able to:
- Appreciate the importance and extent of the use of section 5(4).
- Identify national and local guidance regarding the implementation of section 5(4).
- Explore the main implications of the use of section 5(4) for patients and nurses.
- Reflect on your own practices regarding the implementation of section 5(4).
- Identify potential areas for practice development regarding the use of section 5(4) in your clinical area.

Background
Section 5(4) of the act permits nurses of a ‘prescribed class’ to detain an informal inpatient receiving treatment for mental disorder for up to six hours or until a doctor or approved clinician arrives. ‘Prescribed class’ refers to mental health or learning disability nurses who are on sub-parts 1 or 2 of the Nursing and Midwifery Council register.

Section 5(4) may be used only when 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) (Department of Health (DH) 2008).

Section 5(4) was introduced in an attempt to resolve the uncertainties encountered by nurses when managing informal patients who expressed a desire to leave hospital but were considered at risk (Ashmore 2012). While the introduction of the holding power was welcomed by nursing organisations, others (for example, Bean 1986) argued that it was an unnecessary addition to mental health legislation. Nevertheless, the Health and Social Care Information Centre (HSCIC) has reported that section 5(4) accounts for 10% (n=1,714) of all detentions after admission to hospital; that is, 3.4% of all sections implemented during the period 2012 to 2013 (HSCIC 2013). Furthermore, between 1988 and October 2013 around 38,000 people were detained under section 5(4) of the act.
The implementation of section 5(4) is followed by further detention under the act in 66% of cases (HSCIC 2013) and may require nurses to restrain, seclude or closely observe the patient to ensure that he or she remains on the ward. Despite the fact that the major use of this section occurs on adult acute wards (Ashmore 2010), informal patients in other inpatient settings may be detained.

Research on section 5(4) has focused on nurses’ views on its use (for example, Carver and Ashmore 2000), their knowledge of the holding power (for example, Ashmore 1998), and trends associated with its implementation (for example, Ashmore 2010). There have been no formal reviews of research relating to the implementation of section 5(4) since 1999 (Churchill et al 1999). Several papers (for example, Ward 1991, Ashmore 1998) have shown that there are gaps in mental health nurses’ knowledge of section 5(4) that could impair their ability to implement the holding power. Despite its prevalence there is a chance that even nurses practising on acute wards may have had little direct involvement in the implementation of section 5(4), despite the fact that they may need to use it at any time.

This article addresses a range of issues that affect the use of this section in practice.

What written guidance exists?

Although the act covers England and Wales, there is a separate code of practice for each country (DH 2008, Welsh Assembly Government (WAG) 2008). These codes are periodically reviewed and, although similar, have differences, some of which are highlighted below. This national guidance is also increasingly supplemented by written policy at a local level. At present we are aware that of 55 mental health trusts in England and the seven health boards in Wales, 41 (66.1%) have their own written policy on section 5(4).

Now do time out 1.

Where can you implement section 5(4)?

The authors’ clinical experiences and considerable anecdotal evidence point to widespread different beliefs about the extent to which section 5(4) can be used after a patient has left the ward. Significantly, the code of practice for England (DH 2008) states that section 5(4) ‘can be used only when the patient is still on the hospital premises’ but gives no further information. In addition, the code for Wales (WAG 2008) makes no reference to this issue. Some local policies, for example, Berkshire Healthcare NHS Foundation Trust (2012) have a section titled ‘Where sections 5(2) and 5(4) can be applied’, but do not describe the extent of their ‘hospital premises’.

Others define premises more precisely; for example, Derbyshire Mental Health Services NHS Trust (2010) states: ‘Premises include not only the building where inpatient care takes place, for example, 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.’

The trust also points out that: ‘Where a trust ward is situated in a unit managed by another hospital, for example, wards 41 and 45 in the Derby Royal Infirmary, then section 5(4) can only be applied to an informal patient who is inside the ward.’

Now do time out 2.

Who can make the decision to implement section 5(4)?

Ashmore (2012) showed that nurses might encounter psychiatrists issuing instructions such as: ‘Should the patient try to leave, detain them under section 5(4).’ Both codes of practice state, however, that the decision to use the power is entirely that of the nurse, who cannot be instructed to exercise it by anyone else (DH 2008, WAG 2008).

As mentioned earlier, the act states that any nurse of the ‘prescribed class’ can implement section 5(4). Nevertheless, elsewhere the DH (1999) stated that ‘registered mental health nurses (typically ward managers)’ had the power to implement the section. This may be read as implying that in normal circumstances it should be the ward manager who implements the section. More recently, some trust policies have been clearer about defining who should implement the holding power. For example, Berkshire Healthcare NHS Foundation Trust (2012) states: ‘Application of section 5(4) of the Revised Mental Health Act 1983 should be made by the nurse in charge (shift co-ordinator) of the ward the patient is on [sic].’ In addition, at least one trust requires that nurses applying section 5(4) ‘have at least six months’ post-registration experience’.
Who can implement section 5(4)?

Does your trust or health board make it clear which qualified nurses on duty can implement section 5(4)?

A further point is that it is possible for several nurses who are legally entitled to use section 5(4) to disagree about whether it should be used in any specific instance. For example, consider a situation where two nurses on duty think that section 5(4) should be implemented, but a third, more senior nurse, does not. Little is known about how such situations are managed in practice.

Ashmore (2012) has shown that some nurses clearly prefer a team decision to be made regarding the implementation of section 5(4), while others do not. Obviously, any uncertainty about implementing section 5(4) is undesirable and these issues need resolving, if only at a local level.

Agreeing the decision

One way of managing disagreement about the implementation of section 5(4) is that the nursing teams could adopt a default position of detaining the patient. This would ensure a patient receives a more exhaustive assessment (Ashmore 2012). Does this idea have merit? What alternatives to this might there be?

Assessment

Section 5(4) of the act states that should a doctor or approved clinician be available to assess the patient, nurses do not need to use the holding power. The codes of practice for both England and Wales therefore recognise that the nurse must consider the likely arrival time of a doctor or approved clinician with regard to the patient’s intention to leave and the level of any risk to the patient or others. If a doctor or approved clinician does not arrive, the guidance provided in both codes suggests that, wherever possible, a full assessment is undertaken before implementing the section. Both suggest the assessment should involve a range of factors. Although there are minor differences between the codes in England and in Wales they are not significant (see Box 1 for the code of practice in England).

Despite these directives, practitioners should be reassured that both codes recognise that there might only be time for a brief assessment before implementing the section. It must also be remembered that in invoking section 5(4) the patient is guaranteed a full assessment following the arrival of the doctor or approved clinician.

Written information for informal patients

The codes of practice for England and Wales recognise that the act does not impose any duty to give information to informal patients. However, both suggest that it is desirable to make patients aware of their legal position and rights, although they do not specifically mention section 5(4). At present, however, we are aware that of the 55 mental health trusts in England
and the seven health boards in Wales, 29 (52.7%) provide written information to newly admitted informal patients. All of these refer to section 5(4).

Now do time out 5.

**Written information**

Does your trust give written information about section 5(4) on admission? What are the advantages or disadvantages of such a strategy?

**Persuasion or coercion?**

The authors (Ashmore and Carver 2000) have reported that significant numbers of mental health nurses have persuaded a patient to stay on the ward, rather than use section 5(4). Indeed, both codes of practice (DH 2008, WAG 2008) seem to recognise that the use of persuasion is desirable. However, as we have pointed out (Ashmore and Carver 2000), the danger is that attempts at persuasion could be experienced or described as coercive.

A detailed analysis of what constitutes persuasion as opposed to threatening and coercive statements is beyond the scope of this article. We do, however, suggest that nurses avoid making statements along the lines of: ‘If you try to leave I will be forced to detain you.’ While it may seem this gives the patient the choice of voluntarily remaining on the ward the statement is almost certainly a threat and is coercive (Ashmore and Carver 2000). If a patient was to stay on the ward in response to such a statement they have in fact been denied the choice to leave and are effectively detained without the rights the act bestows.

An attempt to persuade the patient to stay on the ward may be better framed as a ‘promise’. For example, the nurse may state: ‘If you stay on the ward for a little longer I’ll see if I can get the doctor to come and discuss how you are feeling as soon as they can.’ However, given the potentially fraught nature of the circumstances, any attempt to prevent a patient from leaving may be viewed negatively.

Now do time out 6.

**Persuasion and coercion**

The relationship between persuasion, coercion and the implementation of section 5(4) has been discussed elsewhere (Ashmore and Carver 2000). Read this article and reflect on the issues raised.

**Information for detained patients**

Section 132 of the act requires hospital managers to ensure that all patients detained under section 5(4) receive information about their legal position and their rights. Both codes state that information regarding their detention ‘should be given to the patient both orally and in writing – these are not alternatives’ (DH 2008, WAG 2008). Standardised information leaflets are available in England and Wales. In addition, managers in England and Wales are obliged to keep records of whether the information regarding any section has been understood by the patient. In practice, nurses involved in implementing section 5(4) complete the relevant form.

**Restraint, seclusion and medication**

In a situation where the patient wants to leave the ward, the nurse may consider the use of physical restraint or seclusion to prevent them. Both codes of practice recognise that this may be necessary to prevent a patient from leaving. If so, the nurse should follow the extensive guidance available in the relevant code regarding safe and therapeutic responses to disturbed behaviour. This guidance is outlined in sections 15.21 to 15.30 of the English code (DH 2008) and sections 19.18 to 19.28 of the Welsh code (WAG 2008).

Ashmore (2012) has shown that there is a belief among some mental health nurses that the seclusion of an informal patient is done through detaining them under a section of the act. This has led some nurses to implement section 5(4) to apparently legitimise the seclusion of a patient (Ashmore 2012). There is nothing in either code of practice to support this belief. However, both recognise that the seclusion of an informal patient should be taken as an indicator to consider formal detention (see DH 2008: 123, 15.46 and WAG 2008: 124, 19.35).

If medication has been prescribed before the implementation of section 5(4) it may be offered to the patient. However, section 5(4) ‘does not confer any power to treat them without their consent’ (DH 2008). As both codes state: ‘They are in exactly the same position in respect of consent to treatment as patients who are not detained under the act’ (DH 2008, WAG 2008).

Given the circumstances in which section 5(4) is often used, however, it is also possible that rapid tranquillisation may be thought to be necessary. Local policies are likely to outline the circumstances in which this can be given through urgent necessity under common law. For example, the Mersey Care NHS Trust policy (2010) states: ‘Common law provision may apply in order to save life, relieve serious suffering, prevent deterioration in an urgent setting, or if it represents the...’
minimum interference necessary to prevent a service user from behaving violently or from posing a risk to themselves.’

When does section 5(4) legally begin and end?

Both codes of practice suggest that a rationale for the use of the section should be recorded in the patient’s notes and appear to be concerned with ensuring that patients are not held for longer than the six hours. Indeed, both codes state: ‘The patient may be detained from the moment the nurse makes the necessary record’ (form H2 in England and form 013 in Wales) (DH 2008, WAG 2008).

When this point is first explained to student mental health nurses our experience is that they express surprise that the section does not start when the patient is told verbally they are detained. Students then usually express concern that preventing a patient leaving before the paperwork is completed could be seen as false imprisonment. However, Jones (1999) has suggested that the legal maxim ‘de minimis non curat lex’ (the law does not take account of trifles) may be applied in such situations. This would mean that any minimal time between informing a patient of their detention and recording it is of little consequence.

Nevertheless, it is reasonable to imagine that nurses are more likely to be concerned with the safety of those involved in any incident regarding section 5(4) rather than the completion of paperwork. This may further delay the completion of the paperwork. In response to this we suggest that nurses record the actual time the patient was informed of their detention in the ‘necessary record’. We also suggest that nurses ensure that the doctor or approved clinician completes their assessment as soon as they arrive.

Section 5(4) ends either after six hours or when a doctor or approved clinician with the power to use section 5(2) arrives (DH 2008: 99, 12.23, WAG 2008: 51, 8.29). This may generate concern that a patient is technically free to leave immediately on the arrival of the doctor or approved clinician, before they have had the opportunity to complete their assessment. Indeed, research suggests that doctors do not always conduct their assessment on arrival on the ward (Ashmore 1995).

Once again, it is likely that this time between the clinician’s arrival and their assessment of the patient could be considered insignificant from a legal point of view. In addition, if the result of this assessment is detention under section 5(2) the codes of practice state that the maximum period of detention under section 5(2) is 72 hours, including any time spent on section 5(4).

Interestingly, the issue above has been addressed under the Scottish Mental Health Act, whose code of practice (Scottish Executive 2005) states that, as long as the assessment takes place within the legal timeframe, the patient remains on the holding power until this process is completed.

Response time and nursing actions

The codes of practice in England and Wales highlight that the ‘use of section 5(4) is an emergency measure, and the doctor or approved clinician … should take steps to arrive as soon as possible … [and] …should not wait six hours before attending’ (DH 2008: 101, 12.32; WAG 2008: 51, 8.27). However, only the Welsh code (WAG 2008: 51, 8.27) suggests that: ‘Hospital managers should set target times for responses, which should be as short as practicable.’

The failure of a doctor or approved clinician to attend is seen as ‘a serious failing’ (DH 2008: 101, 12.34) and the previous code of practice (DH and Welsh Office 1999), which covered both England and Wales, did give a target time of four hours. Given this, we feel that the setting of such standards is good practice, although an examination of current English mental health trust policies suggests that it is uncommon. There is also research to suggest that setting a target time is likely to reduce the time patients have to wait to be seen by a doctor or approved clinician when detained under section 5(4) (Ashmore 2008).

Setting target times would be beneficial to patients and can underpin a consistent set of nursing responses should a practitioner not arrive within a timely fashion. For example, North East London NHS Foundation Trust (2009) suggests detailed nursing actions to be taken after three and five hours. Even without such policy guidance we suggest that nurses ascertain the likely time of arrival of a doctor or approved clinician.

Indeed, the Welsh code states: ‘All discussions, including attempts to contact the doctor or approved clinician, should be recorded in the patient’s notes’ (WAG 2008). If the nurse feels that the section might expire before a clinician arrives, and they are convinced that the patient remains a risk to themselves and others, we believe that they should seek urgent advice from their manager.

Now do time out 7.
What if section 5(4) expires without an assessment being done?
The intention of all guidance is to facilitate an assessment within the six-hour period of the holding power. Both codes suggest that, should this not occur, it is 'a serious failing' (DH 2008: 101, 12.34, WAG 2008: 51, 8.28). Research by Ashmore (1995) showed that 29% of section 5(4)s ran their course without an assessment.

More recent work (Ashmore 2010) reported a figure of 8%. It is difficult to account for this disparity. However, both illustrate that nurses must be clear about what actions need to be taken should they believe a section 5(4) will expire before an assessment.

The English code states (DH 2008: 101, 12.34) that if the doctor or approved clinician has not attended within six hours 'the patient is no longer detained and may leave if not prepared to stay voluntarily'. The Welsh code is more emphatic and says that the patient 'must be released ... if not prepared to stay voluntarily' (WAG 2008: 51: 8.28).

The nurse, however, may still believe that the patient continues to pose a significant risk to themselves or others. It may be thought that another section 5(4) could be applied in these circumstances. Indeed, Jones (2008) has emphasised that, where relevant, powers under statute such as section 5(4), should be used rather than resorting to common law. However, the English code notes that the holding power 'cannot be renewed' (DH 2008: 99, 12.23) and the Welsh code states that it cannot be 'extended' (WAG 2008: 51, 8.29).

Nevertheless, the Welsh code also says 'it is recognised that circumstances may arise after the patient's reversion to informal status where the use of the holdings powers [sic] may be considered again' (WAG 2008: 52, 8.37).

Despite this latter statement it is unclear in English law how soon after the expiry of one section 5(4) another could be applied (Kinton, personal communication 2013b).

Even given such uncertainty, provisions exist under common law that would enable a nurse to prevent an at-risk patient from leaving before another section of the Mental Health Act may be used. Jones (2008) states that these powers 'provide sufficient authority for a mental health professional ... to act swiftly to prevent a mentally disordered person from causing harm.'

He goes on: 'It must be emphasised that these powers allow for an informal patient to be detained for a limited period and will fall away when the crisis has subsided.'

In addition, reasonable force can be used as long as it is in proportion to the potential harm. We suggest that if nurses find themselves in these circumstances that they act to ensure their managers are fully aware of the situation and that a full assessment of the patient is arranged immediately.

Now do time out 8.

Current beliefs

Anecdotal evidence suggests that there are various beliefs about the multiple use of section 5(4). For example, mental health nursing students have reported to us that some clinical staff think that 24 hours must elapse before the same patient can be detained again on section 5(4). Establish whether any such beliefs exist within your team and consider the rationale for them.

An at-risk patient leaves the ward
Should a patient leave the ward while detained under section 5(4) then legally the police can return him or her, for the duration of the holding power. However, nursing staff may be in a position where they think that they can safely return the patient to hospital premises themselves.

As far as we are aware there is no case law directly resulting from these circumstances. However, the legal power mentioned earlier (Jones 2008) may be relevant as long as the level of restraint used by nursing staff is reasonable. Given the patient is subject to section 5(4) then these actions are further justified because they are based on an assessed level of risk in which there is a danger to the patient and/or others.

However, it is possible that an at-risk patient may leave the hospital premises before staff are able to detain them using section 5(4).

Again, as far as we are aware there is no directly relevant case law and the police can also be contacted. However, it may be that the legal powers mentioned above may also apply, with a section 5(4) being implemented as soon as practicable.

Aftermath
Although nurses’ attitudes towards section 5(4) vary (Carver and Ashmore 2000), it does seem that they wish to avoid using the holding power where possible (Ashmore 2012). This may partly be based on a belief that section 5(4) could have a negative impact on the therapeutic relationship (Rogers and Topping-Morris 2000, Ashmore 2012).

Even if there is agreement about the implementation of section 5(4), the circumstances of its use could be emotionally charged.

Now do time out 9 (see page 36).
Debriefing

Reflect on the likely impact on patient and staff of implementing section 5(4). What potential consequences may arise from not implementing the section? Do you believe that discussion aimed at debriefing may be beneficial following the implementation of section 5(4)?)

Conclusion

A number of issues have been raised concerning the implementation of section 5(4) of the Mental Health Act 1983. While the relevant codes of practice offer considerable guidance regarding the implementation of the holding power this guidance is not exhaustive in scope. In addition to the codes, several mental health trusts in England and health boards in Wales have produced policies relating to the implementation of section 5(4). We hope this article has answered some questions mental health nurses may have regarding section 5(4) and helped them to develop best practice in relation to its implementation.

References


