Compulsory Hospitalisation

People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed. The patient must have a mental disorder, ie any disorder or disability of mind but alcohol or drug addiction are insufficient on their own to detain a person under the Mental Health Act. The patient's mental disorder must require hospital detention for assessment or treatment and the detention must be necessary in the interests of the patient's health or safety, or with a view to the protection of others. The Mental Health Act 1983 gives a statutory framework for non-consensual detention of patients in hospital. The 1983 Mental Health Act has been amended by The Mental Health Act 2007. It applies to people in England and Wales.

The Mental Capacity Act (2005) gives the power to have a person lacking capacity, who is self-neglecting and becoming undernourished, to be admitted to hospital for treatment, as long as their treatment in hospital does not amount to a deprivation of their liberty. The Mental Capacity Act (2005) does not apply to any treatment for mental disorder which is being given in accordance with the rules about compulsory treatment set out in the Mental Health Act.

The Health and Social Services Act 2012 transferred certain powers and functions from Strategic Health Authorities and Primary Care Trusts established in the 1983 Mental Health Act (and 2007 amendments) to Clinical Commissioning Groups and the NHS Commissioning Board. These changes were mainly technical.

Mental Health Act 2007

The main changes made to the 1983 Mental Health Act by the 2007 Mental Health Act are:

- Definition of mental disorder: a single definition of mental disorder applies throughout the Act.
- Criteria for detention: it introduces a new 'appropriate medical treatment' test which will apply to all the longer-term powers of detention. It is now not possible for patients to be compulsorily detained unless appropriate medical treatment is available.
- Professional roles: it broadens the group of practitioners who can take on the functions previously performed by the Approved Social Worker (ASW) and Responsible Medical Officer (RMO).
- Nearest Relative (NR): it gives to patients the right to make an application to the county court to displace their NR and enables county courts to displace an NR whom it thinks is not suitable to act as such. The provisions for determining the NR have been amended to include civil partners amongst the list of relatives.
- Supervised community treatment (SCT): it introduces SCT for patients following a period of detention in hospital (see Section 17a, below). This allows patients with a mental disorder to be discharged from detention, subject to the possibility of recall to hospital if necessary.
- Electroconvulsive therapy (ECT): it introduces new safeguards for patients:
  - If a detained patient has capacity then they can decide whether they wish to have ECT - except in emergencies.
  - A detained patient with a valid advance decision opposed to being given ECT cannot be treated by it, except in an emergency.
- Tribunal: it reduces the periods after which hospital managers must refer certain patients' cases to the Tribunal if they do not apply themselves and introduces an order-making power to make further reductions in due course.
- Advocacy: it places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.
- Age-appropriate services: hospital managers must ensure that patients aged under 18 who are admitted to hospital for a mental disorder are accommodated in an environment that is suitable for their age (subject to their needs).
Professional roles

- Applicant Approved Social Worker (ASW) is to be replaced by Approved Mental Health Professional (AMHP). An AMHP may be a social worker, nurse, occupational therapist or psychologist, who has undergone specialist training and been approved to act in that role by a local social services authority. A registered medical practitioner may not be an AMHP.
- Medical recommendations are to be made by two doctors, one of the two being Section 12 approved (all medical Approved Clinicians (ACs) are deemed also to be approved).
- The AC: an AC is a person approved by the appropriate national authority to act as an AC for the purposes of the Act. The power to approve is held by Strategic Health Authorities but may be delegated to primary care trusts (PCTs). To act as a patient's responsible clinician, a professional must first be approved as an AC. The AC in charge of a particular episode or type of treatment may or may not be the Responsible Clinician (RC).
- The RC: a patient's RC is defined as the AC with overall responsibility for the patient's case. All patients subject to detention or SCT have an RC, who may be a doctor, nurse, occupational therapist, psychiatrist, psychologist or social worker.

GP’s role in arranging compulsory hospital admission

- A GP often has detailed knowledge of the patient, which aids the decision as to whether compulsory powers should be used. A GP’s role can also include arranging or carrying out assessments for possible compulsory admission to hospital.
- After making an initial assessment, the next step is to discuss the case with a psychiatrist and, if it is required, request a domiciliary visit by an approved psychiatrist.
- If the psychiatrist feels that a patient needs admission to hospital but informal admission is not appropriate, an AMHP or NR should be contacted to make arrangements for a formal ‘application’ to be made.
- Detention of a patient for treatment of a mental health disorder requires a formal ‘application’ by either the NR or, preferably, the AMHP. It is now very rare for an NR to be the applicant and it is generally acknowledged that an AMHP should fulfil this role in order to avoid any familial conflict, or potential conflicts of interest.
- In situations where the process needs to take place rapidly and it is not practical for a psychiatrist to come to examine the patient before compulsory admission, the GP can approach the AMHP or NR directly.
- Informal admission should always be considered as first option.
- Medical recommendations for the application to compulsorily admit:
  - Before an application can be made for admission to hospital, two doctors (who have both examined the patient) both need to give a ‘medical recommendation’. One doctor must be approved under the Mental Health Act - usually a consultant psychiatrist (but a GP can apply to become approved under Section 12(2) of the Mental Health Act). If possible, one doctor (eg, the GP) should have met the patient before.
  - However, an application for an emergency admission requires only one medical recommendation, which can be provided by a GP.
  - Occasionally, GPs are asked to examine a patient in hospital and provide a second medical recommendation to detain a patient who is already voluntarily admitted, or is already detained under another Section (eg, Section 4, emergency admission).
  - A medical recommendation should not be given if there are any conflicts of interest.
  - The RC replaces the role of RMO being in overall charge of the care of the sectioned patient. This person has powers to grant leave and discharge.

Section 2: admission for assessment

- The period of assessment (and treatment) lasts for up to 28 days and is not renewable.
- Patients’ appeals must be sent within 14 days to the mental health tribunal (composed of a doctor, lay person and lawyer).
- An AMHP or the NR makes the application on the recommendation of two doctors, one of whom is ‘approved’ under Section 12(2) of the Act (in practice a consultant psychiatrist or a specialist registrar of sufficient experience). The second medical recommendation is given by a doctor who knows the patient personally in a professional capacity. If this is not possible, the Code of Practice recommends that the second doctor should be an ‘approved’ doctor.

Section 3: admission for treatment (up to six months)

- The exact mental disorder must be stated.
- Detention is renewable for a further six months (annually thereafter).
- Two doctors must sign the appropriate forms and know why treatment in the community is contra-indicated. They must have seen the patient within 24 hours and there may not be more than five clear days between the time the first doctor saw the patient and the time when the second doctor saw them. They must state that treatment is likely to benefit the patient, or prevent deterioration; or, that it is necessary for the health or safety of the patient or the protection of others. The AMHP has 14 days after the second doctor has signed their recommendation in which to make an application to hospital.

Section 4: emergency treatment (for up to 72 hours)

- The admission to hospital must be an urgent necessity.
- May be used if admission under Section 2 would cause undesirable delay (admission must follow the recommendation rapidly).
- An AMHP or, very rarely, the NR makes the application after recommendation from one doctor (eg, the GP).
- The GP should keep a supply of the relevant forms, as the AMHP may be unobtainable.
- It is usually converted to a Section 2 on arrival in hospital, following the recommendation of the duty psychiatrist. If the second recommendation is not completed, the patient should be discharged as soon as the decision not to convert to Section 2 is made. The Section should not be allowed to lapse.
Section 5(2): detention of a patient already in hospital (up to 72 hours)

- The doctor in charge (or, in the case of a consultant psychiatrist, his or her deputy) applies to the hospital managers, day or night, so it is often helpful to obtain early joint care for these patients with a consultant psychiatrist. The duty AMHP should be informed as soon as a 5(2) is applied, because they have the responsibility for co-ordinating the full Mental Health Act Assessment which should follow.
- A patient in an Accident and Emergency department is not an inpatient, so cannot be detained under this Section. Restraint permitted by The Mental Capacity Act or Common Law is all that is available to provide temporary restraint for individuals who are a manifest danger either to themselves or to others while awaiting assessment by a psychiatrist.
- Plan where the patient is to go before the 72 hours have elapsed - eg, by liaising with psychiatrists for admission under Section 2.

Section 5(4): nurses' holding powers (for up to six hours)

- Any authorised psychiatric nurse may use force to detain a voluntary 'mental' patient who is taking their own discharge against medical advice, if such a discharge would be likely to involve serious harm to the patient (eg, suicide) or to others.
- During the six hours, the nurse must find the necessary personnel to sign a Section 5(2) application or allow the patient's discharge.

Section 7: application for guardianship

- This enables patients to receive community care where it cannot be provided without the use of compulsory powers.
- Application is made by an AMHP or, very rarely, the NR and also needs two medical recommendations.
- The guardian, usually a social worker, can require the patient to live in a specified place, to attend at specified places for treatment and to allow authorised persons access.
Section 17a: Supervised Community Treatment (Community Treatment Order)

Section 25 of the 1983 Mental Health Act has been removed and replaced by Section 17a of the Mental Health Act 2007, which makes provisions for Supervised Community Treatment (SCT):

- An application for a Community Treatment Order (CTO) can be made by the RC with a supporting recommendation by an AMHP.
- Other people who should be consulted include the NR (unless the patient objects), any carers (unless the patient objects), anyone with authority to act on the patient's behalf, the patient's GP, the multidisciplinary team involved in the patient's care and any other relevant professionals.
- To be eligible for SCT, a patient must be liable to be detained under Section 3 or subject to certain specified provisions under Part III Mental Health Act (ie a hospital order, a hospital direction or a transfer direction without restrictions).
- A CTO cannot be made unless the RC is of the opinion that the 'relevant criteria' are met and an AMHP states in writing their agreement with this opinion and that it is appropriate to make a CTO.
- The Mental Health Act 2007 states that SCT should be considered when:
  - The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment.
  - It is necessary for their health or safety or for the protection of other persons that they should receive such treatment.
  - Such treatment can be provided without them continuing to be detained in a hospital.
  - Appropriate medical treatment is available for the patient.
  - It is necessary for their health or safety or for the protection of other persons that the RC should be able to exercise the power to recall the patient to hospital.

Section 20(4): renewal of compulsory detention in hospital

- The patient continues to suffer from a mental disorder and would benefit from continued hospital treatment.
- Further admission is needed for the health or safety of the patient - which cannot be achieved except by forced detention.

Section 117: aftercare and the Care Programme Approach

- Section 117 requires the provision of aftercare for patients who have been detained on the longer-term Sections (3, 37, 47 or 48).
- The Care Programme Approach (CPA) is not part of the Act but stipulates that no patient should be discharged without planned aftercare: the systematic assessment of health and social needs, an agreed care plan, the allocation of a keyworker and regular reviews of progress.

Section 136 (for up to 72 hours)

- Allows police to arrest a person ‘in a place to which the public has access’ and who is believed to be suffering from a mental disorder.
- The patient must be conveyed to a ‘place of safety’ (usually a designated Accident and Emergency department) for assessment by a doctor (usually a psychiatrist) and an approved social worker.
- The patient must be discharged after assessment or detained under Section 2 or 3. The patient may also accept the offer of a voluntary admission into hospital.

Section 135

- This empowers an AMHP who believes that someone is being ill-treated or is self-neglecting to apply to a magistrate for a warrant to search for and remove such patients to a place of safety in order to carry out a Mental Health Act assessment.
- The AMHP or a registered medical practitioner must accompany the police.

Sections 135 and 136 are under review. There have been questions over whether a police station is an appropriate place to detain people suffering a mental health crisis, especially young people, and whether a maximum length of detention of 72 hours is too long.

EMS would like to acknowledge Nick Woodhead, Mental Health Act Co-ordinator, Somerset Partnership NHS Trust for his input to this article.

Further reading & references

- The Mental Health Act 1983: Guidance for general practitioners - medical examinations and medical recommendations under the Act; Dept of Health 1
- Mental Health Act 2007
- Health and Social Care Act 2012; The National Archives
- Post-legislative assessment of the Mental Health Act 2007; Dept of Health, 2012
- Barcham C; Understanding the Mental Health Act changes – challenges and opportunities for doctors, BJMP 2008:1(2) 13-17.
- Review of the operation of Sections 135 and 136 of the Mental Health Act; GOV.UK, 2014