Legal Issues

Assessment under the Mental Health Act England and Wales 1983

Introduction

General Practitioners can be involved in Mental Health Act assessments in a variety of settings:

- **Home** - the patient may be causing serious concern to family or neighbours.
- **Hospital** - the patient may have already been admitted informally, or even admitted for treatment for a physical illness and is now needing to be detained under an emergency, assessment or treatment section of the Act as they meet the criteria for mental disorder under the Act and are unwilling to accept treatment as an informal patient.
- **Police station** – the patient may have been taken to a police station following arrest for an offence or as a place of safety after being found in a public place exhibiting symptoms of mental disorder (section 136 of the Act).

Use of the Mental Health Act

The Mental Health Act 1983 makes statutory provision for the compulsory assessment, care and treatment in hospital of patients with a mental disorder as defined in section 1 of the Act. The patient may be in the community or in hospital at the time of assessment.

Mental disorder comprises mental illness, mental impairment, severe mental impairment and psychopathic disorder. In the Act, mental illness is not defined but is a matter for clinical judgement.

The most common civil sections of the Act under which patients are compulsorily admitted to a hospital are:

- section 2 : admission to hospital for up to 28 days for assessment,
- section 3 : admission to hospital for up to 6 months for treatment and
- section 4 : admission on an emergency basis for up to 72 hours.

Criteria for detention under the Mental Health Act 1983

Compulsory admission for assessment and / or treatment can only occur when:

- the patient is suffering from mental disorder within the meaning of section 1 of the Act; and if so,
- the mental disorder is sufficiently serious to need further assessment and/or medical treatment in hospital; and
- the patient needs to be compulsorily admitted under the Act in the interests of his or her own health or safety, and/or for the protection of other people.

When assessments under the Act may be needed

GPs are frequently approached in the first instance by a relative or other carer of a patient, worried about the mental health of a patient. Following his/her own assessment it is normal practice for the GP to request a domiciliary visit by a consultant psychiatrist where this is warranted.

If following an examination by the consultant psychiatrist a patient needs admission to hospital and it appears that informal admission is not appropriate an Approved Social Worker (ASW) should be contacted to make arrangements for the patient to be formally assessed for admission to hospital under the Act.

The Act allows the compulsory admission of a patient who is very distressed or ill (for example, actively psychotic or manic) solely in order to improve their health, even if they are not thought to be at immediate risk of harming themselves or others.

There will be situations where an emergency admission is required and it may not be possible or practicable for a consultant psychiatrist to examine a patient before a request for a compulsory admission to hospital is made. In these situations the GP should approach the ASW directly.

Where the patient is thought to need hospital admission but is unwilling to be admitted to hospital as an informal patient the ASW will make the arrangements for the patient to be formally assessed for admission under the Act. The ASW will usually ask the GP to carry out a medical examination and, if appropriate, provide a written medical recommendation for detention of the patient under the Act.

A patient may also in some circumstances be detained by the police under section 136 of the Act to enable him to be examined by a registered medical practitioner and interviewed by an ASW. Where this occurs the patient's GP, where known, will usually be contacted.

The Act cannot be used for the compulsory treatment of addictions unless the criteria for detention under the Act are also met.

The Medical Recommendations

The recommendations required for the purposes of an application for admission to hospital under the Act have to be provided by two doctors ("registered medical practitioners") who have personally examined the patient either jointly or separately. In the case of an application for an "emergency admission" under section 4 however only one medical recommendation is required. This recommendation may also be provided by a GP.

GPs may apply to become "section 12 approved". The local Strategic Health Authority should be able to provide further information.

First medical recommendation: Every application must be supported by a recommendation from a practitioner approved under section 12(2) of the Act "as having special experience in the diagnosis or treatment of mental disorder". Health Service Guidelines HSG (96)3, available from the Department of Health sets out criteria for approval under section 12(2) of the Act. In the wake of devolution of powers to Strategic Health Authorities with effect from 1 April 2002, revised guidance was issued (December 2002) to recognise the new structure and impact. The revised guidance indicated that the regional and approval arrangements that existed prior to 1 April 2002 would effectively continue to operate as before. (Both publications are available on the Department of Health website at http://www.doh.gov.uk.)

Second medical recommendation: In accordance with section 12(2) of the Act the second recommendation shall, if practicable, be provided by a doctor with "previous acquaintance" with the patient unless the doctor making the first medical recommendation has previous acquaintance with the patient. GPs are often best placed to undertake this role, and do not need to be specially approved under the Act to do so. Where there is no obvious person to provide the second medical recommendation, for example, because the patient is not registered with a GP or is not known to local mental health services, another section 12 approved doctor is usually asked to assess the patient. In cases where this is not practicable any registered medical practitioner may provide the second recommendation as long as they do not work in the same hospital as the doctor providing the first recommendation.

How to arrange a Mental Health Act assessment

A Mental Health Assessment is activated by telephoning the Duty ASW. Other arrangements may be in place depending upon local policy.

Where a GP does not have a telephone number for the ASW Service it should be possible to contact the duty ASW both during and out of normal office hours by ringing the general telephone number for the social services authority or local council.

He or she will need the following information:

- name
- date of birth
- address
- reason for assessment
- previous history, including name of keyworker, next of kin (if known) and past history of violence of self harm (if known).

He or she will need enough information to decide if there is the possibility of an admission under the Mental Health Act 1983 and that the full assessment process is warranted.

Management of the patient should be discussed with the duty ASW (or the duty consultant, depending on local policy.)

The ASW will then take responsibility for co-ordinating the assessment, bringing relevant papers, ensuring the process complies with the law and arranging for the transport of the patient.

Before the assessment

Information is an important component of the assessment.

If you can access your records, check for previous history and response to treatment, risk of neglect, violence or self harm, any known contact names.

If there is a relative or informant, ask about the recent situation, its duration, whether there is any support, whether there have been threats or violence and if the patient is known to carry or have access to weapons.

Liaise with the ASW about directions, access to premises, where to meet and the need for police attendance.

It is good practice because it is safer, communication is better and disruption of the patient is minimised if the medical assessments take place jointly with the ASW at the same agreed time, (though if this is not possible, they are legally allowed to be 5 days apart. In any case, the two doctors must discuss their decision).

If the patient is suffering from the short term effect of drugs, alcohol or sedative medication, discussion should take place about deferring the assessment until a more productive interview can take place.

If access to home is denied, section 135 (Warrant to search for and remove patients) may need to be used. This warrant is obtained by an Approved Social Worker (ASW) from a Magistrates' Court.

During the assessment

Except in the case of emergencies, an application for assessment (section 2-28 days) or treatment (section 3 - 6 months) must be founded on two medical recommendations from:

- A medical practitioner approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder (usually a psychiatrist, often the duty consultant or specialist registrar)
- A doctor with prior knowledge of the patient (ideally the GP)

The GP and others in the primary care team often have prior knowledge of the patient, including access to records and an existing relationship with the patient and or family which facilitates the assessment. The psychiatrist may not know the patient, but often contributes clinical experience and expertise. The ASW makes a more comprehensive assessment of the social aspects of the case and advises on the legal issues which may arise during the process. He or she sees that the patient is interviewed "in a suitable manner", ie. taking into account of the guiding principles set out in Chapter 1 of the Code of Practice to the Mental Health Act 1983 (1999).

The patient is interviewed as comfortably as possible with the following questions in mind:

- Is there any possible evidence of mental illness?
- Is there a risk to the health or safety of the patient or a danger to others?

If the answer to both of these questions is yes:

- Will the patient consent to informal admission and if so, is that realistic based on past experience or aspects of the current interview?
- Are there any community alternatives to admission? e.g. giving medication at home, CPN visits, crisis services, day hospitals.

All professionals strive to reach a consensus and if the doctors agree to make the medical recommendations for compulsory admission, the ASW makes the application to the admitting hospital managers.

Section 2 is appropriate if there is no previous history, the diagnosis is unclear or no treatment plan is in place.

Section 3 specifies the category of mental disorder and is mainly used for patients already known to the service. If the nearest relative objects to the detention, the application cannot proceed.

Arranging admission

If the decision of the team is to admit the patient, the level of security required should be considered. Arrangements for a bed are usually made by the psychiatrist and for appropriate transport by the ASW. The ASW usually accompanies the patient and delivers the section papers in person. He/she is responsible for securing the premises. The ASW informs the patient and nearest relative (see Notes) of the decision.

If the patient is not admitted

When the patient is not admitted to hospital, a package of follow-up care needs to be agreed with the patient and nearest relative, if appropriate. Arrangements may need to be made to contact mental health or social work teams during working hours to inform them of the assessment and / or to make a referral.

You are entitled to submit a claim form (usually held by the ASW).

This is not intended to be a comprehensive guide to the Mental Health Act 1983. The Code of Practice (1999 version) provides guidance to doctors, managers and staff of hospitals and registered mental nursing homes, and ASWs on how they should proceed when undertaking duties under the Act.

The Department of Health published guidance to assist GPs in understanding the processes involved in undertaking mental health assessments under the Mental Health Act 1983 and to clarify their role in those processes. It can be accessed on the Department of Health's website on http://www.doh.gov.uk/mhact1983.htm.

Notes

Forms to be used in making medical recommendations for admission to hospital under the Mental Health Act 1983

- First and second medical recommendations must be made on the relevant statutory forms.
- There are different forms for separate and joint medical recommendations and care should be taken that the correct form is completed in each case. An incorrectly completed form may make an application for detention invalid.
- The second medical recommendation may be completed before the first but the medical examinations must be completed within 5 clear days of each other.
- The Code of Practice states that "unless there are good reasons for undertaking separate assessments, assessments should be carried out jointly by the ASW and doctor(s)". When this is not possible a doctor may undertake the examination, make the recommendation and, where clinically appropriate, leave the scene. However, he/she must make arrangements for the form to be given to the ASW or to the admitting hospital in those instances where the patient is already an in-patient. But "it is essential that at least one of the doctors undertaking the medical assessment discusses the patient with the applicant (ASW or nearest relative) and desirable for both of them to do this". (Code of Practice, para 2.3).
- Primary Care Trusts (under the umbrella of their respective Strategic Health Authorities) are required to maintain and provide lists of doctors approved under section 12 of the Mental Health Act 1983 as having special experience in the diagnosis or treatment of mental disorder.

Clean and sample copies of these forms are attached at Appendix 1 to the Department of Health's 'Guidance for GPs: Medical Examinations and Medical Recommendations under the Act'. It can be accessed at http://www.doh.gov.uk/mhact1983.htm.

Key Action Points for GPs in making Assessments and Recommendations for Admission

These can be accessed at Appendix 2 of the above Guidance.

The role of the "nearest relative":

The nearest relative has powers to:

- make an application for detention of the patient
- object to an application for the detention of a patient (an application can be made to the county court for the functions of the nearest relative to be transferred to the local Social Services authority or another person if relative objects unreasonably)
- apply to the Hospital Managers for the discharge of the patient (application must be made in writing giving 72 hours notice, patient must be discharged unless within the 72 hours, the RMO reports to Managers that patient is likely to be a danger to self or others)
- receive information about the detention and treatment of a patient.

Payment and claiming fees

- Currently the fees payable are £162.70 for section 12 approved doctors, and £50.45 for other registered practitioners excluding travel expenses.

Use of the Mental Health (Scotland) Act 1984

Introduction

The 1984 Mental Health (Scotland) Act provides the legal framework in Scotland for compulsory admission and treatment of patients suffering from mental disorder. A new Act - the Mental Health (Care and Treatment) (Scotland) Act 2003 - has been passed by the Scottish Parliament and is expected to come into effect after October 2004 (see below). Until it does, the 1984 Act remains in force.

GPs can be involved in using the Mental Health Act in a variety of circumstances:

- **Emergency recommendation for detention (Section 24):** This is used where admission is urgently required and use of Section 18 would introduce undesirable delay. Admission under Section 24 allows for a period of 72 hours of assessment. Any doctor can legally make the recommendation, but the consent of a mental health officer (MHO; a social worker with special training) or a near relative must be obtained, wherever practicable.

- **Non-emergency admission for up to six months (Section 18):** This is used where admission is required less urgently (eg where the patient's mental state deteriorates over time). In practice, this mainly used for patients known to the service. An application is required from a MHO (or occasionally the nearest relative) and recommendations from a Section-20-approved doctor (usually a psychiatrist, and, where the patient is known to the service, the patient's own consultant psychiatrist) and the GP or another doctor with previous knowledge of the patient.

- **Power of Entry (Section 117):** This might need to be used where a patient with possible mental disorder in the community refuses assessment and help. For example, the patient may be behaving eccentrically, live in very poor conditions, be ill-treated or neglected by others or alone and unable to care for themselves. This warrant is obtained by a MHO from a Justice of the Peace. It allows a police officer, accompanied by a doctor, to force entry. The person may then be removed to a place of safety with a view to assessment for admission under Section 24.

- **Treatment of a patient who is on leave of absence:** A detained patient may be allowed out of hospital on `leave of absence' for up to one year. GPs must only prescribe psychiatric medications that are consistent with the agreed treatment plan, set out on form 9 (where the patient is consenting to treatment) or form 10 (where the patient is not consenting to treatment) - see http://www.show.scot.nhs.uk. GPs should expect to be told of the conditions of the leave of absence, of the circumstances in which the patient is likely to be recalled to hospital and the arrangements in relation to treatment.

Use of the Mental Health Act

Compulsory admission can only occur when:

- there is a mental disorder; and
- the patient requires hospital admission in the interest of the health or safety of the patient or the protection of others; and
- such admission cannot be achieved without compulsory measures.

The Act allows the compulsory admission of a patient who is very distressed or ill (e.g. actively psychotic or manic) solely in order to improve their health, even if they are not thought to be at immediate risk of harming themselves or others.

Mental disorder comprises mental illness, mental impairment, severe mental impairment and persistent disorder manifested only by persistent abnormally aggressive or seriously irresponsible conduct. In the Act, mental illness is not defined but is a matter for clinical judgement, but it excludes those for reasons only of promiscuity or other 'immoral' conduct, sexual deviancy, or dependence on alcohol or drugs (although psychiatric symptoms secondary to drug and alcohol abuse - for example drug-induced paranoid psychosis and Korsakoff psychosis - are included). Mental disorder manifested only by mental impairment or only by abnormally aggressive or seriously irresponsible conduct might be grounds for detention under Section 18 only where treatment in hospital is likely to alleviate or prevent a deterioration in the patient's condition.

Before the assessment

Information is an important component of the assessment, including information about domestic, employment and social factors as well as a person's mental state.

- If you can access your records, check for previous history and response to treatment, risk of neglect, violence or self-harm, and any known contact names.
- If there is a relative or informant, ask about the recent situation, its duration, whether there is any support, whether there have been threats or violence and if the patient is known to carry or have access to weapons.
- Contact the duty MHO. For Section 24, involvement of an MHO is desirable. For Section 18, involvement of an MHO is essential. They will need the following information: name, date of birth, address, reason for assessment, previous history, including name of keyworker, next of kin (if known) and past history of violence or self-harm (if known). They will need enough information to decide if there is the possibility of an admission under the Mental Health Act.
- Liaise with the MHO about directions, access to premises, where to meet and the need for police attendance. It is good practice (because it is safer, communication is better and disruption of the patient is minimized) if the medical assessment(s) take place jointly with the MHO at the same agreed time. For Section 24, only one medical recommendation is needed; for Section 18, two are required. They can be provided up to five days apart.
- If the patient is suffering from the short-term effect of drugs, alcohol or sedative medication, discussion should take place about deferring the assessment until a more productive interview can take place.
- Take copies of form A (the emergency detention form) with you. If no copies of Form A are available, take practice headed notepaper if possible.
- If you want to discuss the management of the patient, either telephone the duty MHO or the duty consultant.

During the assessment

The patient is interviewed as comfortably as possible with the following questions in mind:

- Is there any possible evidence of mental disorder?
- Is there a risk to the health or safety of the patient or a danger to others?

If the answer to both of these questions is yes:

- Will the patient consent to informal admission? And if so, is that realistic based on past experience or aspects of the current interview?
- Are there any community alternatives to admission, eg giving medication at home, community mental health nurse visits, crisis services, day hospitals?

For Section 24:

- Seek the consent of the MHO or a near relative. A list of who is considered a 'relative' under the Act can be found on form A. Being involved in the compulsory admission of a relative to hospital can sometimes damage family relationships; therefore, if practicable, advise the relative that there is an alternative (ie an MHO can perform the consent role). If it is not practicable to seek consent from either an MHO or a near relative, a single doctor's recommendation is sufficient, but the reason for failure to seek consent must be explained on the recommendation form. If the relative and MHO refuse consent, compulsory admission cannot go ahead.
- Complete the recommendation on form A (or on practice-headed notepaper). Include the following: full details of your qualifications; a declaration that you have examined the patient at the time of the application; that the patient is subject to a mental disorder; that treatment is necessary in the interests of the health or safety of the patient or the protection of others; state the reasons why detention is urgently necessary and use of section 18 is precluded; whose consent has been obtained or reasons why it has not been possible to obtain the consent of an MHO or a near relative. The documentation must be completed on the same day as the patient examination.

For Section 18:

The MHO will normally take responsibility for co-ordinating the assessment, bringing relevant papers and ensuring the process complies with the law.

The team needed for a Section 18 (six months for treatment) is:

- A Section -20-approved doctor. Where the patient is known to the service, this doctor should be the patient's own consultant psychiatrist.
- The nearest relative or a MHO (the MHO makes a more comprehensive assessment of the social aspects of the case and advises on the legal issues that may arise during the process).
- A doctor with prior knowledge of the patient (ideally the GP).

All professionals strive to reach a consensus and if the two doctors agree to make the medical recommendations for compulsory admission, the MHO makes the application to the Sheriff within seven days. The MHO must make the application even if the two doctors disagree with the medical recommendations. The Sheriff may call a hearing, which may involve the attendance of the GP to court.

Arranging admission

If the decision of the team is to admit the patient, the level of security required should be considered.

Discuss with the MHO how the patient is to be managed, including who is to accompany the patient and deliver the section papers, who will secure the premises and who will inform the

patient and relative of the decision. Liaise with the receiving hospital to ensure a bed is available, to discuss arrangements for the patient's admission, transport to hospital and patient's need for care during removal, including medical and nursing escorts if required.

Emergency detention is not a treatment order and the patient cannot therefore be forced to accept any form of treatment. However, in emergency circumstances, medication can be given under the common law principle of necessity to control acute symptomatology or behavioural disturbance where risk to life and safety are involved.

If the patient is not admitted

When the patient is not admitted to hospital, a package of follow-up care needs to be agreed with the patient and nearest relative, if appropriate. Arrangements may need to be made to contact mental health or social work teams during working hours to inform them of the assessment and/or to make a referral.

This is not intended to be a comprehensive guide to the Mental Health Act. Reference should be made to the relevant Code of Practice, which is available from the Stationery Office, http://www.hmso.gov.uk

The Mental Health (Care and Treatment) (Scotland) Act 2003

Mental health law in Scotland is in the process of being reformed. This new Act has been passed by the Scottish Parliament and is expected to be brought into force on a staged basis from October 2004. Sections relating to civil compulsion are expected to come into force from April 2005.

The new Act retains the current three-pronged structure of civil compulsion:

- 72-hour (emergency detention)
- 28-day (short-term detention)
- longer-term (through what are called ‘Compulsory Treatment Orders’).

However, the criteria for compulsion are more clearly spelt out, as are the procedures that must be followed. More detail on these procedures will be provided in a Code of Practice on the new Act, which will be published in advance of the Act being brought into effect. A draft of the Code of Practice will be published for consultation during 2004.

For more information on the new Act and on its implementation, contact the Mental Health Division of the Scottish Executive Health Department, St Andrew’s House, Edinburgh EH1 3DG; http://www.scotland.gov.uk/health/mentalhealthlaw.

Use of the Mental Health (Northern Ireland) Order 1986

Introduction

The 1986 Mental Health (Northern Ireland) Order provides the legal framework in Northern Ireland for compulsory admission and treatment of patients suffering from mental illness. GPs can be involved in Mental Health Order assessments in different settings:

Community: The patient may be causing serious concern to family or neighbours. An application can be made for compulsory hospital admission for seven days, renewable to 14 days for assessment (Article 4). In extreme circumstances, if access is denied, a warrant authorizing a police constable to secure access may need to be used (Article 129). This warrant is obtained by an approved social worker (ASW), other officer of the Health and Social Services Trust or a police constable from a Justice of the Peace. If the constable has to enter the premises, by force or otherwise, they must be accompanied by a medical practitioner (usually a GP) who will administer medical treatment if required.

Hospital: The patient may have been admitted informally and now wants to leave or is refusing treatment. An application for assessment involves the patient's own GP (or another practitioner who has previous knowledge of the patient) in attending hospital to give the medical recommendation. A doctor on the staff of the hospital in which it is intended that the assessment should be carried out cannot give the recommendation except in a case of urgent necessity.

Use of the Mental Health Order

Compulsory admission for assessment of a patient can only occur when:

- they are suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or for assessment followed by medical treatment); and
- failure to detain the patient would create a substantial likelihood of serious physical harm to themselves or to other persons

Criteria for likelihood of serious physical harm are evidence of one of the following:

- the patient has inflicted, or threatened or attempted to inflict, serious physical harm on themselves
- the patient's judgement is so affected that they are, or would soon be, unable to protect themselves against serious physical harm and that reasonable provision for their protection is not available in the community
- the patient has behaved violently towards other persons or so behaved themselves that other persons are placed in reasonable fear of serious physical harm to themselves.

Mental disorder comprises mental illness, mental handicap, severe mental handicap and severe mental impairment. In the Order, mental illness is defined as a ‘state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons'.

The Order cannot be used for the compulsory treatment of addictions, personality disorders or sexual deviancy, unless the above criteria are also met.

How to arrange a Mental Health Order assessment

An application for compulsory admission needs to be made by either the nearest relative (on form 1) or an ASW (form 2), supported by a medical recommendation (form 3), usually the patient's own GP or, if not, a doctor who knows the patient personally and is not (except of urgent necessity) on the staff of the receiving hospital. Guidance on who is considered the 'nearest relative' under the Order can be found on the back of form 1. See http://www.n-i.nhs.uk

A Mental Health Order assessment is activated by telephoning the duty ASW. An ASW might be essential (in order to make the application) or highly desirable in order to support and advise the relative making the application. The ASW also assesses the social aspects of the case and provides a social report. Telephone them with the following information: name, date of birth, address, reason for assessment, previous history, including name of key-worker, next of kin (if known), and past history of violence of self-harm (if known).

They will need enough information to decide if there is the possibility of an admission under the Mental Health Order and that the full assessment process is warranted.

If you want to discuss the management of the patient, either telephone the duty ASW or the duty consultant

Before the assessment

Information is an important component of the assessment.

- If you can access your records, check for previous history and response to treatment, risk of neglect, violence or self-harm, and any known contact names.
- If there is a relative or informant, ask about the recent situation, its duration, whether there is any support, whether there have been threats or violence and if the patient is known to carry or have access to weapons.
- Contact the duty ASW. An ASW might be essential (in order to make the application) or desirable in order to support and advises the relative who is making the application. Liaise with the ASW about directions, access to premises, where to meet, and the need for police attendance.
- Where no ASW is involved, liaise with the nearest relative or other informant about directions, access to premises, and the need for police attendance. Bring forms 1 and 3 with you (available from the H&SS Trust [Health and Social Services Trust]). Arrange police attendance, if necessary.
- It is good practice (because it is safer, communication is better and disruption of the patient is minimized) for the professionals involved in the application for admission to be present at the same time (although it might be helpful for each to interview the patient separately). Everyone involved should be aware of the need to provide mutual support. In any case, the applicant - whether relative or ASW - must have seen the patient within two days of signing the application and the doctor must examine the patient not less than two days before signing the application.

If the patient is suffering from the short-term effect of drugs, alcohol or sedative medication, discussion should take place about deferring the assessment until a more productive interview can take place.

During the assessment

The team necessary to make an application for compulsory admission is either:

- the nearest relative and a doctor (patient's own GP or doctor who knows the patient personally); or
- an ASW and the patient's own GP or a doctor who knows the patient personally.

Where the nearest relative makes the application, advise them that they can ask for an ASW to consider making the application in their stead (because sometimes making such an application can be detrimental to family relationships).

Where an ASW makes the application, they must consult the nearest relative, unless this causes unreasonable delay. If the nearest relative objects to the application, the ASW must consult another ASW. Where no ASW is involved, a social worker (not necessarily an approved one) must interview the patient as soon as is practicable and provide a social report to the RMO (Responsible Medical Officer) in the receiving hospital.

The patient is interviewed as comfortably as possible with the following questions in mind:

- Is there any possible evidence of mental illness?
- Is there a substantial risk of serious physical harm to the patient or others?

If the answer to both of these questions is yes:

- Will the patient consent to informal admission? And if so, is that realistic based on past experience or aspects of the current interview?
- Are there any community alternatives to admission (such as giving medication at home, community mental health nurse visits, crisis services, day hospitals)?

The relatives and, if practicable, other significant informants, are interviewed to find out their views of the patient's needs and whether and in what ways the patient's behaviour is different from their normal behaviour.

All parties strive to reach a consensus, and if the doctor agrees to make the medical recommendation for compulsory admission, the social worker or the nearest relative makes the application to the admitting hospital managers.

The doctor's recommendation must be made on form 3 and must include the following information: the grounds, including a clinical description of the mental condition of the patient, for the opinion that the detention is warranted; the evidence for the opinion that failure to detain the patient would create a substantial likelihood of serious physical harm. Examples of what might be considered in assessing the likelihood of serious physical harm include uncontrolled overactivity likely to lead to exhaustion, gross and protracted neglect of diet which would lead to malnutrition, gross neglect of hygiene and personal safety which would create a hazard to the patient or others, disinhibited behaviour likely to lead to serious physical harm to the patient, their family or other persons. A diagnosis of the specific form of mental disorder is not required

Arranging admission

If the decision of the team is to admit the patient, the level of security required should be considered.

If an ASW is involved, arrangements for a bed are usually made by the doctor and the ASW for appropriate transport, unless an ambulance is required, in which case the doctor arranges this. The ASW usually accompanies the patient and delivers the application papers in person. They are responsible for securing the premises. The ASW informs the patient and nearest relative of the decision.

If no ASW is involved, liaise with the receiving hospital about arrangements for the patient's admission, transport to hospital and the patient's need for care during removal, including medical and nursing escorts if required. Ensure the premises are secured and inform the patient of the decision. The nearest relative may accompany the patient and deliver the application papers.

The patient must be admitted to hospital within two days from the date on which the medical recommendation was signed; otherwise, the authority to detain them expires.

If the patient is not admitted

When the patient is not admitted to hospital, a package of follow-up care needs to be agreed with the patient and nearest relative, if appropriate. Arrangements may need to be made to contact mental health or social work teams during working hours to inform them of the assessment and/or to make a referral.

This is not intended to be a comprehensive guide to the Mental Health Order. Consultation of the Code of Practice, the Guide and the Mental Health Order is recommended.

The Children Act 1989

The Children Act 1989 is the relevant statute that relates to the welfare of children. Its key elements are as follows:

- **The paramountcy principle:** This states that the welfare of children is at all times paramount and overrides all other considerations.

- **The welfare checklist:** This refers to a list of factors that are used to ensure that any decision made by the statutory agencies is done so with the child's best interests in mind. These factors include:
  - the child's physical, emotional and educational needs
  - the perceived effect (positive or otherwise) of changing their environment
  - the child's wishes and views wherever possible
  - the capability of the child's parents to meet their needs.

- **The no delay/no order principle:** No delay should occur in making decisions about a child's future and courts should not make an order unless it is absolutely in the child's best interests to do so.

Implications for GPs

- Although GPs provide care for people of all ages, their primary responsibility lies with the child.
- GPs who encounter children in need of protection should discuss their concerns either with social services or with named paediatricians who have a special interest in child protection.
- Sharing of information is a focal point of the child protection process. The Child Protection Case Conference represents the principle venue whereby this happens. Although attendance at conferences might not always be possible, it is important that the views of GPs are represented at conferences by means of a written report.
- All health professionals who have concerns regarding the welfare of children must maintain accurate and contemporaneous clinical notes.
- GPs are uniquely placed to provide continuing support for vulnerable families.