Mental Health Act (MHA) – an aide memoire for medical, nursing and pharmacy staff

This is only a brief guide. For more in-depth guidance see:

www.cqc.org.uk/content/mental-health-act

Glossary of terms

Community Treatment Order (CTO): Treatment of patients in the community. A patient can be become subject to a CTO if they were subject to a treatment section during admission. Patients can be recalled to hospital and the section revoked by the responsible clinician (RC).

Responsible clinician (RC)

The professional responsible for the patient’s care – this applies to patients subject to the Mental Health Act both in hospital and in the community. Usually the patient’s consultant psychiatrist, but does not have to be and occasionally may not be a doctor.

Second Opinion Approved Doctor (SOAD)

Appointed by the Care Quality Commission (CQC) a SOAD will decide whether patient consent is able to be given and whether or not the treatment should be given. They will complete a T3 form. The RC provides details of the treatment plan and the SOAD will interview the patient. They also discuss treatment with a nurse and another professional (often a pharmacist) involved with the patient’s care about the appropriateness of treatment.

Consent to Treat (CTT)

Must be completed after three months of detention. It lists all the psychiatric medication that can be given either on a form T2 (patient consents) or on form T3 (no consent), which the SOAD completes. A CTO has slightly different rules (can have 1 month extra) so double check if a CTT is required on recall. The three months after detention start from the first section i.e. from the date of the start of the section 2, if it changes to a section 3.

T3 forms don’t expire but remain valid at the discretion of the CQC although they recommend review no longer than two years. T2 forms also don’t expire but good practice is to review regularly. T2 forms become invalid if patient loses capacity or if they withdraw consent and then a second opinion should be sought.

Important sections of the MHA

Section 2 is for unknown patients or new presentation of a MH condition. It lasts for up to 28 days, for inpatient assessment and treatment. The section cannot be extended.

Section 3 is up to six months for inpatient treatment. It is used for patients well known to the mental health services or following admission under section 2. The section can be extended for a further six months, then annually if necessary.

Section 37/41 is used by the criminal court for patients to be treated in hospital instead of prison for 6 months. Section 37 can be extended by 6/12 month periods. Section 41 is the discharge restriction order, if patient is at risk to the public, and has no time limit.
Section 136 allows the police to admit mentally disordered persons to a “place of safety” – e.g. s136 suite of a mental health unit or a police station. Duration of detention under this section should not usually exceed 24 hours, but can be extended to 36 hours in exceptional circumstances.

Section 5(2) is used to temporarily hold an informal or voluntary patient on a mental health unit in order to allow a Mental Health Act assessment to take place. It is applied by a doctor and lasts up to 72 hours.

Section 5(4) is applied by a registered mental health nurse to temporarily hold a patient on a mental health unit if they feel their mental health condition renders them too unwell to leave. It lasts for only 6 hours, which should be long enough to arrange an assessment by a doctor where necessary.

Section 62 – urgent treatment to save life, prevent injury to the patient or others, prevent serious deterioration of psychiatric condition or to alleviate serious suffering

The RC can write a section 62(1) form for urgent medication needing CTT (so after three months detention) where either SOAD is required to assess, patient no longer agrees to T2 or a medication not on T3 form. Also consider CTO recall, as medication often has changes from the community treatment plan (T3). This section also covers emergency ECT, (up to two sessions).

Section 63 – capacity assessment

Form A is completed by the admitting doctor or nurse for all patients on admission. Section 63 (for detailed patients) is then completed by the RC at first ward round. Form B is completed for all informal patients when assessing capacity to consent to treatment. These forms will list all psychiatric medications. Medication can be prescribed and given if not on the section 63 form, but it must be deemed necessary and a decision to prescribe it cannot wait until the RC can review the patient. This must be documented in the patient’s care notes as to why it is necessary. The section 63 form must be changed at the earliest opportunity by the RC.

Correct way to fill out MHA forms

Record the class of drug and route of administration, but rather than noting particular sections, should either:

1. **State that the dose (when calculated together with frequency) is within BNF guidelines as to advisory maximum dose limits for that route, or state a maximum dose limit referenced to BNF guidelines such as, for example, 50% or 120%.**

   OR

2. **State a named drug and its route & dose maximum.**

In some circumstances it may be useful, indeed necessary, to specify a named drug and also its purpose, especially when it is being used for a non-licensed indication, e.g. clonazepam when used for agitation.

Example extracts from a Form T3 might therefore read as follows:

1) **One oral antidepressant drug within BNF advisory maximum dose limits.**

2) **Olanzapine, oral antipsychotic, maximum 15mg daily.**
3) *Clonazepam 1mg orally as required, maximum 4mg daily, for adjunct management of agitation.*

NB: The Care Quality Commission (CQC) removed the requirement to include or exclude clozapine on all forms that include antipsychotics, so there still may be some forms in circulation which are still valid until renewal. There may however be reasons to exclude a specific drug e.g. due a previous ADR and this can be stated on the form.

**Responsibilities of medical, nursing and pharmacy in relation to the MHA**

1. Check the front of medication chart is filled out with details of when CTT is due or NA if not applicable.

2. Check T2/3 or section 62(1) forms attached to drug chart.

3. Before prescribing or administration check T2/3 or section 62(1) forms are correct and match the prescription. If a psychiatric medication is not on these forms it CANNOT and MUST NOT be given. RC can write a section 62(1) if deemed emergency treatment. In an emergency out of hours, then the doctor in charge of the patient’s treatment may complete a section 62(1) urgent treatment form to authorise treatment.

4. If a medication is given outside the T2/3 or section 62(1) an incident form must be completed by the medic who prescribed it or the nurse who administered it.

5. Check capacity forms attached to drug chart and if incorrect inform staff so that it can be reviewed by the RC with the patient at the earliest opportunity. Medication can be given if deemed necessary.

6. Only discuss a patient’s treatment with SOAD if you have been directly involved with their care. Document all discussions with the SOAD in Care notes.

7. The RC is required to complete a “Result of SOAD” form (provided by the MHA office), following a SOAD visit. The completed “Result of SOAD” form must be returned to the MHA office.

8. Remote prescribing for detained patients
   
a. If the patient is detained under section and the prescriber remotely prescribes a new medication that is not covered on the existing section 62(1), T2 or T3 form, the on-call consultant will need to authorise this by email, or by making an entry in Care notes. The on-call Responsible Clinician logging into Care notes is as effective as a signature. The following day a section 62(1) form will need to be written by the ward consultant to reflect the new medication until the T2 or T3 can be updated.

   b. For patients detained for less than 3 months, the section 63 form will need to be updated at the earliest opportunity.