

Use of the Mental Health Act (England and Wales) 1983: a basic guide for general practitioners working in prisons

Relevant sections of the Mental Health Act

The Mental Health Act (England and Wales) 1983 currently provides the legal framework for compulsory admission and treatment of patients suffering from mental disorder. The sections of the Act most relevant to general practitioners and medical officers working in a prison setting are the following.

- **Section 48:** transferring an unsentenced prisoner (including civil prisoners and those detained under the Immigration Act 1971) from prison to hospital. A civil prisoner is one detained for non-criminal acts, eg non-payment of debt.
- **Section 47:** transferring a sentenced prisoner who has become mentally disordered after entering prison or whose mental disorder was not identified before sentence to an NHS hospital.
- **Section 37:** this is a hospital order (a sentence of the court) imposed as an alternative to sentencing that individual to prison. The prisoner may remain in the prison for 28 days while awaiting a bed in hospital.

Less frequently, a general practitioner or medical officer in prison may be involved in arranging assessments under the following:

- **Section 35,** where a court remands an individual to hospital rather than to prison for psychiatric assessment and report.
- **Section 36,** where a crown court remands a defendant to hospital for psychiatric assessment and report. Psychiatric treatment can be given.
- **Section 38,** which is an interim hospital order where a court orders a convicted person to be detained in hospital temporarily to test if a hospital order is appropriate.

Principles of treatment under the Mental Health Act

The Mental Health Act code of practice stresses the following:

- Mentally disordered people who are subject to criminal proceedings have the same right to psychiatric assessment, treatment and care as anyone else.
- Anyone in prison who needs medical treatment that can only satisfactorily be given in a hospital should be admitted to an NHS hospital or appropriate registered mental nursing home. Prison 'hospitals'/healthcare centres do not qualify as hospitals under the Act, so compulsory treatment under it may not be given in them.
- If it is essential to give medication without the patient's consent, this can only be administered under common law and where the patient lacks 'capacity' (see **Emergency treatment under common law**, page 168).

General points about the Mental Health Act

In the Act, mental illness is not defined and is a matter for clinical judgement. Decisions about whether to seek to transfer a prisoner under the Act require that the statutory criteria are met.

Sections 47 and 48 are used to transfer to hospital a patient in need of hospital treatment without the involvement of a court. The Home Secretary's consent is rarely refused if it can be demonstrated that the level of security at the receiving hospital is adequate. If in doubt, refer.

If a defendant on remand is mentally disordered but does not require urgent transfer to hospital under Section 48, refer the defendant for psychiatric assessment and, with patient consent, notify his/her solicitor that you have done so. This may prompt the court to consider a hospital order. Never rely on notice of a mental disorder coming to the court by other means.

Criteria for the use of the Mental Health Act, Sections 48, 47 and 37

- **Section 48:** applications to the Home Secretary to direct the transfer of an unsentenced, civil or Immigration Act prisoner can only be made when:
 - the person is suffering from mental illness or severe mental impairment
 - the nature and/or degree of the mental disorder makes it appropriate for the person to be detained in a psychiatric hospital for treatment and
 - the person is in urgent need of such treatment.A sentenced civil prisoner is someone not convicted under criminal law, eg someone imprisoned for debt.
- **Section 47:** applications to the Home Secretary to direct the transfer of a sentenced prisoner can only be made when:

- the prisoner is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment
- the nature and/or degree of the mental disorder necessitates detention in a psychiatric hospital for treatment and
- in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate the condition or prevent further deterioration.
- **Section 37:** magistrates and crown courts can impose a hospital order on a person convicted of an imprisonable offence other than murder, if they are satisfied that:
 - the same criteria governing use of Section 47 are met (see above) and
 - a hospital order is the most appropriate way to deal with the case.

How to arrange a Mental Health Act assessment for Sections 47 or 48

The medical officer/senior medical officer, in consultation with the prison governor, is responsible for making the arrangements. For a transfer application to be successful, the following are required.

- Two doctors, one Section 12-approved (usually a psychiatrist) and one who, wherever possible, has prior knowledge of the individual (often the medical officer), complete a form (No 218 or 218a), recommending to the Secretary of State that the patient is suffering from one of the appropriate categories of mental disorder. The doctors must state if a special hospital would be appropriate.
- Home Secretary agrees.
- Hospital has accepted the patient (this may occur after the order is made)
- Transfer is enacted within 14 days of the assessment. Otherwise, a further transfer direction must be sought.

Refer to the catchment area mental-health service for assessment. Indicate that use of Sections 47 or 48 is likely.

Discuss with the psychiatrist or hospital manager the availability of a bed and the level of security required at a suitable hospital. Ideally, a psychiatrist with beds at this hospital should be one of the assessing doctors.

Write to the Home Office Mental Health Unit as soon as possible after referral to the catchment area psychiatric service indicating what action has been taken and what is planned. Discuss the level of security required with the Mental Health Unit.

In the case of a remand prisoner, notify the court in relation to fitness to plead.

Following the assessment, write again to the Home Office Mental Health Unit, enclosing the medical reports. These must specify the form of disorder that the person is suffering from and the hospital to which the person will be transferred.

To ensure that transfer occurs within 14 days of the assessment, maintain close contact with the Home Office Mental Health Unit to make sure that a bed becomes available. If problems or delays are experienced, telephone the unit for help (for more information, see **How to refer urgently**, page 153)

Arrangements for a Mental Health Act assessment for Section 37

Hospital orders are made by the court.

Refer to the catchment area mental-health service for assessment under Section 37.

Discuss with the psychiatrist or Care Programme Approach (CPA) key-worker the availability of a bed at a suitable hospital. A psychiatrist employed at this hospital should be one of the assessing doctors.

The individual may be admitted to a 'place of safety' (usually the remand prison) for 28 days pending admission to hospital. Inform the court of any difficulties in admitting the patient within this period or if the hospital subsequently withdraws its undertaking to admit the individual. During these 28 days, even though the individual has been placed under a hospital order, he/she cannot be treated against their will in the prison except under Common Law (see page 155).

If the transfer arrangements break down, contact the individual's Health Authority and ask it to find another hospital within the 28 days. If this is not possible, the individual must be returned to court within the 28 days and resentenced.

Before the assessment

Information is a very important part of the assessment. Ensure that the information already gathered with the patient's permission is available: old psychiatric notes, general practice notes, care programme approach key-worker, family or close friend, solicitor. This will speed the assessment and allow a better decision to be made about what sort of treatment is needed and where it is best provided (see 'Assessment' in **Managing the interface with the NHS and other agencies**, page 137).

Assessment

A multidisciplinary assessment is preferred if possible. For possible admission to hospital, the presence of a doctor and nurse is usual. If psychological treatment is a prominent issue, the presence of a psychologist is valuable. Make sure that the gate lodge staff know who to expect and that escorts are available. Ensure that the patient is available. Ensure that any staff member who knows the patient is available to speak to the visiting assessment team. If the doctor who made the referral is not on-site at the time of the assessment, ensure that he/she is readily available for discussion by telephone.

If the patient is not accepted for admission

The fact that a patient is not accepted does not mean that he/she is not seriously mentally ill. In most cases, on-going psychiatric treatment will be required with possible re-referral in the future.

If the decision is felt to be reasonable, request advice on the following, as appropriate.

- How to manage the patient in the short and longer term within the prison.
- Risk management.
- Arrangements for liaison before release.
- Clear guidelines on when to re-refer if the situation changes.

Ensure that the provision of such advice in all assessments forms part of any service agreements drawn up by the prison and local mental health services.

If it is felt that the non-acceptance is unreasonable, do the following:

- Communicate this in a doctor-to-doctor telephone conversation.
- Follow-up the telephone conversation with a letter.
- Ask for a second opinion, preferably a local one.
- Notify the patient's solicitor, with patient consent, of all actions taken. The solicitor may help in arranging a second opinion.
- For more actions to take, see **How to make an urgent referral** (page 153).

If the criminal proceedings are discontinued

Refer to 'Unplanned release' in **Managing the interface with the NHS and other agencies** (page 149).

On admission to hospital

The following information must be sent to the hospital at the time of transfer (if it has not already been sent).

- An up-to-date medical report sent by the medical officer to the patient's responsible medical officer (RMO).
- Any relevant social inquiry reports prepared by the Probation Service (addressed to the principal hospital social worker).
- Patient's inmate medical record (IMR) (hospital staff may copy relevant parts of the IMR and return it to the prison).
- Any relevant risk information from the health or security records.

In addition, for patients transferred under Sections 47 or 48, it is important to do the following:

- Identify by name the psychiatrist and key-worker who will be responsible for the care of the prisoner while in hospital.
- Write their contact details on the prisoner's file.
- Make personal contact (by telephone) with the psychiatrist and/or key-worker. Ask them to let you know when possible transfer back to the prison is being considered and (at that time) any information about treatment, the recommended follow support and the risk assessment.

If the individual is returned to prison from hospital

Someone who has been transferred to a secure hospital under Sections 47 or 48 may be returned to prison. Such patients, and any others who have previously been in hospital under sections of the Mental Health Act, eg Sections 3 and 37), **are entitled to aftercare under Section 117 of the Act**. This section imposes on Primary Care Trusts and Local Authorities the duty to provide aftercare for persons treated under the Act in hospital and then discharged. Before transfer of the patient from hospital to prison, prison healthcare staff should expect the following:

- To be invited to a case conference along with in-house or sessional mental-health services if available, or the appropriate Health Trust and local social services to agree Section 117 needs and arrange suitable CPA and aftercare services. This may not be possible in the case of emergency transfers.
- To receive a copy of a discharge plan that includes risk factors for relapse, a crisis plan and what to do if the patient relapses after transfer to prison.
- If the patient is to be returned as 'untreatable' to receive the results of assessments and advice on how the person's behaviour should be managed.

If this does not happen.

- Ask for a discharge plan to be sent, covering the areas outlined above.
- Consider arranging a case conference at the prison. Invite staff from the secure hospital and in-house or sessional mental-health services, if available, or request a visit from Catchment Area Services and local social services. Inform the hospital and the catchment area services and Local Authority that the individual is entitled to aftercare under Section 117 of the Act. Consider including staff from other areas of the prison who will be involved in the patient's care (see **Confidentiality**, page 304).

This is not intended to be a comprehensive guide to the Mental Health Act. Consultation of the most recent Code of Practice and with Home Office and Department of Health guidance relating to mentally disordered offenders, including Home Office Circular 12/95, is recommended.

Treatment for mental illness without consent under common law

Use of compulsory powers under the Mental Health Act 1983 is not allowed in prison. This applies equally to patients in prison awaiting transfer to a psychiatric hospital for assessment or treatment under the compulsory powers of the Act. Treatment without consent for mental illness may be provided in prison under common law under certain circumstances.

In what circumstances may treatment for mental illness without consent under common law in England and Wales be considered?

If a patient is refusing treatment and you have done all you can to transfer him/her to a mental hospital, you can provide treatment without consent for mental illness under common law if the following conditions are met.

(1) Patient has a mental illness and treatment is 'in their best interests'

Key principles are the following.

- Treatment without consent is for treatment of an illness and not for control of aggressive behaviour in the absence of mental illness (for advice on managing aggressive prisoners, including criteria for use of medication for that indication, see **Managing aggression and violence**, page 282).
- Patient's best interests are not confined to what is in his/her best medical interests. Case law has established that other factors that may be taken into account include the patient's values and preferences when competent, their psychological health, well-being, quality of life, relationships with family or other carers, spiritual and religious welfare and their own financial interests.
- A doctor has a duty of care under common law to provide treatment in the patient's best interests where the patient lacks a capacity to consent to or refuse treatment and there is no valid advance statement.

and

(2) Treatment is in accordance with a practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question

This is why it is essential to obtain an opinion from a specialist.

and

(3) Patient lacks 'capacity' to accept or refuse treatment

To have capacity, the patient must:

- understand what in broad terms is the nature of the treatment and that somebody has said that he/she needs it and why the treatment is being proposed
- understand its principal benefits, risks and alternatives
- understand what will be the consequences of not receiving the proposed treatment and
- retain the information for long enough to make an effective decision.

For more details, see **Consent and capacity** (page 300).

In what circumstances may treatment for mental illness without consent under common law *in prisons* be considered?

The criteria set out under (1) above must be met in all places in which compulsory treatment for mental illness under common law is given. Meeting those criteria is an essential legal requirement. There are **in addition** important considerations that arise because of the nature of prisons and of prison healthcare facilities. These are outlined below.

Whenever possible, prison healthcare centres are advised to restrict themselves to treatment that addresses only those medical needs which most urgently need to be met

In a prison context, it is important for the healthcare team to distinguish between the following:

- Treatment that might be needed urgently in the incompetent patient's best interests.
- Treatment in the patient's best interests that can wait until he/she has been transferred to a mental hospital.

Usually treatment needed urgently that cannot wait until the patient has been transferred to a mental hospital will be where:

- the patient's life is endangered
- serious harm or distress may otherwise come to the patient or others and
- a failure to treat would result in an irreversible deterioration in the patient's condition.

In any emergency, the doctor should not exceed the treatments needed to sustain life and health. Other, less urgent, treatments considered to be in the patient's best interests should be clearly specified in the patient's care plan. The care plan should also specify which member of the healthcare team is taking action to arrange for these remaining healthcare needs to be met.

Emergency treatment under common law should only be provided if the appropriate equipment and trained staff are available

Administering emergency treatment without consent is usually dangerous. For example, aggression and hyperexcitability may increase the risk of sudden death and injury.

Staff competencies required

Staff need to be competent in the following:

- Assessment of the risks and benefits involved in intervening with patients who may be highly aroused, have been using illicit drugs or are physically ill.
- Identification of the likely complications of these interventions.
- Resuscitation and the regular monitoring of such patients (Airways, Breathing and Circulation — ABC).

Equipment required

Appropriate resuscitation and patient monitoring equipment must be available (manual ventilation, cardiac resuscitation, pulse oximeter). Emergency medication and equipment should be checked regularly to ensure it is maintained and in date.

Protocols and care pathways required

Protocols required by Prison Health Care Standards on treatment without consent, emergency treatment, restraint, seclusion and transfer of prisoners to a treatment facility should be known, accessible, up to date and regularly reviewed.

Local Trusts will have a protocol on emergency treatment. The *Bethlem and Maudsley Prescribing Guidelines* contain a regularly updated section on rapid tranquillisation and may be a useful resource.¹

Important action to take before giving compulsory treatment under common law

If you are contemplating treatment without consent, you should, if time allows, do the following:

- Urgently refer for an assessment for possible transfer to a psychiatric hospital under the Mental Health Act. Nearly all patients likely to require emergency treatment under common law should be transferred as soon as possible to an appropriate psychiatric hospital. Mental-health services should work towards meeting a standard of assessing and, where appropriate, admitting such patients within 24 hours.
- Obtain a specialist opinion from a consultant psychiatrist not connected with the case.
- Hold a multidisciplinary meeting involving the doctor, nursing and/or other healthcare staff and the duty governor. The meeting should be recorded in the inmate medical record and the care plan.
- Reconsider the diagnosis. The cause of what appears to be a psychosis may be alcohol-induced hallucinosis, post-epileptic confusion, infectious or febrile illness or other physical disease (for other possible physical causes, see **Delirium — F05**, page 41). These possibilities should be considered before, during and after treatment.

Before giving repeat treatments without consent, you should follow the same procedure as above. It is not acceptable to give recurrent top-up medications without holding a case conference, where viable and possible, for each top-up dose. Care should be taken to avoid an overdose by repeating treatments without consent. If there is fever, rigidity and/or labile blood pressure, stop antipsychotic medication and refer immediately to the on-call physician for investigation for neuroleptic malignant syndrome.

How to administer treatment without consent in an emergency

See the local guidelines. The following does not give full details of medications, dosages and routes of administration (see **Acute psychosis**, page 11).

- Document the clinical state and discuss it with colleagues.
- Explain the situation to the patient.
- Try talking down, distraction.
- Move spectators away to avoid audiences and ensure privacy and dignity.
- Obtain a drug history (types and amounts given in the previous 24 hours) and a history of the effective treatment in the past. Carry out a physical examination, including an electrocardiogram (ECG) if possible.
- Use doses at the lower end of the recommended range unless you are certain that the patient is currently taking psychotropic drugs. Do not exceed the *BNF* limits in any 24 hours. The senior prison doctor present should administer the medication.
- Try oral therapy. Benzodiazepines are safer than antipsychotics, but beware of accumulation.
- Use benzodiazepines alone if there is any cardiac disease.
- Low potency antipsychotics such as chlorpromazine or sulphiride are preferred.
- Never give Clopixol Acuphase to a struggling patient or to those who have not built up some tolerance to antipsychotics.
- Procyclidine IV/IM must be available. Consider its use as prophylaxis.
- If IM therapy is required, give the injection deeply into either the middle third of the outer aspect of the thigh or the upper outer quadrant of the buttocks. The patient may need to be restrained using approved techniques. Restraint should be done under health supervision and by staff currently trained in control and restraint techniques.
- Monitor the patient's vital signs every 5 minutes until peak concentrations have been reached (up to 2 hours, or longer in the elderly or physically ill). Give flumazenil if the respiratory rate drops below 10 per minute. After 2 hours, continue to monitor less frequently in case of adverse reaction.
- Consider converting to oral medication soon.
- A record of treatment, dosage and procedure should be made and signed by the senior prison doctor in the drug chart and the inmate medical record.

Action to take after the incident

- It is good practice to debrief those involved after emergency treatment.
- There should be on-going regular reviews of the patient's condition and treatment:
 - Review the patient's competence as this may fluctuate.
 - Review the extent to which any of the unmet needs start to become more urgent.
 - Arrange for newly urgent needs to be treated in the prison if the patient is still not competent.
 - Arrange for consent to treatment for all remaining healthcare needs to be discussed with the patient if he/she becomes competent.
 - Pursue proactively the referral to hospital if unacceptable delays are occurring.
- Incident should be recorded in the inmate medical record (IMR) and also in a document separate to the IMR.
- Significant event audit should take place. The policies, relationships and management may need reviewing. Questions to consider include the following:
 - Could the incident have been avoided and, if so, how?
 - Was the treatment appropriate and effective?
 - Were staffing levels and skills appropriate?
 - Was the treatment given with as much consideration of the patient's dignity and privacy as possible?Consider with the relevant NHS service what occurred, the severity of the situation and how it might support the prison in avoiding a repetition on future occasions.
- All significant event records should be collated and reviewed from time to time.

¹ The Bethlem & Maudsley NHS Trust. *2001 Prescribing Guidelines*, 6th edn. London: Martin Dunitz, 2000. 224 pages, ISBN 1-85317-963-9. Telephone orders can be made with credit cards on 020 7482 2202.