The Mental Health Act in Practice: Detention, Treatment, Rights and the 2025 Reforms

THE TALKING THERAPIES UK PRACTITIONER SERIES



The Mental Health Act in Practice: Detention, Treatment, Rights and the 2025 Reforms

A premium, in-depth programme on the Mental Health Act 1983 as it stands in October 2026, the Mental Health Act 2025 and the therapist's role

Advanced level · 30 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

Copyright © 2026 Talking Therapies UK. All rights reserved.

The moral right of the author has been asserted. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the publisher, except for brief quotations in a review, and except that a purchaser of the accompanying course may print a single copy for their own study.

First edition, 2026.

This manual accompanies the The Mental Health Act in Practice: Detention, Treatment, Rights and the 2025 Reforms course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 3. This printing was set on 2 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

Contents

How to use this manual 1

Part 1 Foundations: purpose, principles and the shape of the Act 5

1. Liberty, protection and the history of compulsory care 6
2. The architecture of the 1983 Act: definitions, roles and pathways 17

How to use this manual

This premium programme is a comprehensive, practice-focused course on the Mental Health Act 1983 as it operates in England and Wales in October 2026. It is written for psychological therapists, counsellors, psychologists, social workers and allied practitioners who work with people who may be, or have been, detained or treated under the Act, and who need a secure, accurate understanding of the law and of their own part in it.

The course is current to the Mental Health Act 2025, which received Royal Assent on 18 December 2025. It identifies exactly which provisions of the 2025 Act are already in force, including the power to conditionally discharge restricted patients subject to deprivation of liberty conditions and the extension of the Human Rights Act to private providers of NHS-funded in-patient care from 6 April 2026, and which reforms, such as the nominated person, statutory care and treatment plans, advance choice documents and the new detention criteria, are still to come. It also explains how the Supreme Court's judgment of 2 June 2026 on deprivation of liberty affects the choice between the Mental Health Act and the Mental Capacity Act.

Across six modules and thirty lessons you will study the purpose, structure and principles of the Act and its human rights framework; compulsory admission under sections 2, 3, 4, 5, 135 and 136, the AMHP assessment and the nearest relative; consent to treatment under Part 4, including the statutory consultee role that therapists often fill; restrictive practices and the Mental Health Units (Use of Force) Act 2018; leave, absence, discharge, community treatment orders, guardianship and section 117 after-care; Part 3 and therapy with forensic and restricted patients; information, advocacy, tribunals, children and young people, race equality and accountability; and the interfaces with the Mental Capacity Act, confidentiality, advance choice and supervision-level ethics.

Every lesson contains a worked clinical example, the common pitfalls in practice and a reflective question, together with key points, a practice task for the week, study activities and further reading drawn from a verified reference list. The course closes with an extended case study and a

25-question assessment with a pass mark of 80 per cent, leading to a certificate for 30 CPD hours. Access lasts twelve months.

The course is designed for practitioners who are not usually statutory decision-makers. It is clear throughout about what the law requires of whom, and about the therapist's own contribution and limits. It is educational material and does not constitute legal advice: for decisions about individual cases, follow your organisation's policies and seek legal advice where needed.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 30 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Explain the structure, definitions and guiding principles of the Mental Health Act 1983 and the human rights framework within which it operates.
- Distinguish the criteria, duration and safeguards of sections 2, 3, 4, 5, 135 and 136, and describe the roles of the AMHP and the nearest relative.
- Apply the Part 4 consent to treatment rules, including the second opinion process and the statutory consultee role, to practice situations.

- Evaluate restrictive practices against the Mental Health Units (Use of Force) Act 2018, national guidance and the evidence on harm.
- Describe the routes to discharge, community treatment orders, guardianship and section 117 after-care, and support clients to use their rights.
- Explain the Part 3 powers for people in the criminal justice system, including the 2025 Act provisions in force since 18 February 2026.
- Identify inequalities in the use of the Act and describe the actions required by the Patient and Carer Race Equality Framework.
- Choose appropriately between the Mental Health Act and the Mental Capacity Act, taking account of the Supreme Court's 2026 judgment on deprivation of liberty.
- State accurately which provisions of the Mental Health Act 2025 are in force and which are pending, and locate authoritative sources on commencement.
- Apply ethical reasoning and supervision to the dilemmas of therapeutic practice within a system of compulsion.

PART 1

Foundations: purpose, principles and the shape of the Act

Why compulsion exists, how the 1983 Act is organised, the principles and human rights framework that govern its use, and the distinctive position of psychological practitioners who are not statutory decision-makers.

CHAPTER 1

Liberty, protection and the history of compulsory care

A client who has been detained in hospital will sooner or later ask some version of the same question: how can it be lawful to confine a person who has committed no offence, and then to treat them after they have said no? Practitioners without a clear answer tend to fall back on one of two scripts, one presenting detention as rescue and the other as oppression. Neither reflects the law or helps the client. English law permits compulsion because it accepts two justifications at once: that a person may need protection from the consequences of their own mental disorder, and that other people may need protection from the person. Every statute since the eighteenth century has had to decide how far those justifications reach and what independent check should follow a decision to rely on them. This lesson traces that history to explain the shape of the current law. The operative framework in England and Wales remains the Mental Health Act 1983, as amended chiefly by the Mental Health Act 2007. The Mental Health Act 2025 received Royal Assent on 18 December 2025, but most of it is not yet in force.

In general medicine an adult with capacity may refuse treatment, even treatment needed to save their life, and the Mental Capacity Act 2005 allows decisions to be made for a person only when they lack capacity to make the decision themselves. The Mental Health Act 1983 contains no capacity test. A person who understands what is proposed and refuses it can still be detained and, subject to the consent to treatment safeguards, treated for mental disorder if the statutory criteria are met. Those criteria combine the presence of mental disorder with a judgement that detention is needed for the person's health or safety or for the protection of others. Supporters argue that serious mental illness can distort judgement without removing formal capacity, so a capacity test would leave some very unwell people without help. Critics reply that the Act singles out one group of patients for treatment that would be unlawful if imposed on anyone else.

The earliest statutes regulated confinement rather than treatment. Licensing and inspection of private madhouses began in 1774. Counties were

permitted to build public asylums from 1808 and required to do so from 1845, when the Commissioners in Lunacy became a permanent national inspectorate. As asylum populations grew, public anxiety settled on one fear in particular: that sane people, often inconvenient relatives, were being confined for private reasons. The Lunacy Act of 1890 answered that fear with legal procedure. Most admissions required an order from a judicial authority, usually a justice of the peace, and the scheme was designed to prevent wrongful detention rather than to secure early treatment. The cost was that people could rarely reach asylum care without being certified, a status that carried lasting stigma. The Mental Deficiency Act of 1913, which provided for the segregation of people then labelled mentally defective, reflected eugenic thinking that now looks indefensible.

The twentieth century moved in the opposite direction. The Mental Treatment Act of 1930 allowed people to enter mental hospitals as voluntary patients. After the creation of the National Health Service, a Royal Commission chaired by Lord Percy reported in 1957, and its recommendations shaped the Mental Health Act of 1959. That Act made informal admission the normal route into hospital, removed the magistrate from compulsory admission and placed the decision with doctors, on an application usually made by a relative or a local authority mental welfare officer. It also created Mental Health Review Tribunals so that detained patients could seek independent review. Bartlett and Sandland (2014) discuss the long contest in English mental health law between legalism, which trusts procedure and judicial oversight, and professional discretion, which trusts clinical expertise. The 1959 Act is generally regarded as the high point of trust in clinical judgement.

The 1983 Act, which consolidated amendments made in 1982, reflected renewed concern with patients' rights, sometimes called a new legalism. It created the approved social worker, a specially trained professional who would make applications and bring a social perspective to them. It introduced the consent to treatment safeguards, including independent second opinions for certain treatments, set up a Mental Health Act Commission to visit detained patients, widened access to tribunals and imposed a duty to provide after-care for some patients leaving hospital. Its central choices, including the absence of a capacity test and the breadth of professional discretion, were contested at the time and remain so.

Reform returned to the agenda in the late 1990s, shaped partly by a small number of high-profile homicides and by a political focus on public protection. Two draft Bills met sustained opposition from professional and service user organisations, and the eventual result was not a new Act but the Mental Health Act 2007, which amended the 1983 Act. It replaced four legal categories of mental disorder with a single broad definition and replaced the old treatability test with a requirement that appropriate medical treatment be available. It opened the roles of approved mental health professional and approved clinician to professions beyond social work and medicine, including psychology, and introduced community treatment orders, independent mental health advocates and stronger safeguards for electroconvulsive therapy. It also inserted the Deprivation of Liberty Safeguards into the Mental Capacity Act 2005, in force from April 2009, in response to HL v United Kingdom (2005) 40 EHRR 32, in which the European Court of Human Rights held that a compliant man who lacked capacity had been detained in hospital informally without the procedural safeguards that Article 5 requires.

By the middle of the 2010s, detentions had risen substantially over the preceding decade, Black people were detained at markedly higher rates than white people (Barnett et al., 2019), and many service users reported being excluded from decisions about their own care. In 2017 the government commissioned an independent review, chaired by Professor Sir Simon Wessely, which reported in 2018 (DHSC, 2018). It recommended four principles to shape the law and its use: choice and autonomy, least restriction, therapeutic benefit, and the person as an individual. Its proposals included tighter detention criteria, a nominated person chosen by the patient in place of the nearest relative, statutory care and treatment plans, advance choice documents and wider access to advocacy. A White Paper followed (DHSC and Ministry of Justice, 2021), then a draft Bill that underwent pre-legislative scrutiny, and finally the Mental Health Act 2025.

The 2025 Act amends the 1983 Act rather than replacing it, and very little of it is yet in force. As at October 2026 the provisions in force are technical provisions commenced on Royal Assent, a group concerning restricted patients and transfers to hospital from custody commenced on 18 February 2026, and two provisions commenced on 6 April 2026 by the first commencement regulations (SI 2026/385), one of which extends human rights duties to some private providers (lesson 1.4). Lesson 6.3 sets these

out in detail. The principles, the new detention criteria, the nominated person, statutory care and treatment plans, advance choice documents, opt-out advocacy and the changes for people with autism or a learning disability are not yet in force. The government has said that full implementation may take around ten years, with a new Code of Practice and the first major phase of reform expected from 2027, subject to workforce readiness. Commencement happens by statutory instrument, so check legislation.gov.uk and the DHSC implementation pages before telling a client that any reform applies to them.

History has not resolved the tension between autonomy and protection; each settlement has moved the point of balance. On capacity, the 2025 reforms, which are not yet in force, will tighten the criteria and give more weight to the person's wishes, but they do not make incapacity a condition of detention, so the Act will still be able to override a capable refusal. On risk, the criteria require professionals to judge the likelihood of harm, yet predicting uncommon events for an individual is inherently imprecise, so any law built on risk will detain some people who would not have come to harm and miss some who will. The revised criteria in the 2025 Act, which will require that serious harm may be caused to the health or safety of the patient or of another person, having regard to the nature, degree and likelihood of the harm, are not yet in force; they make the risk judgement more explicit without making it more certain.

The strongest challenge to this structure comes from disability rights law. The Convention on the Rights of Persons with Disabilities, the CRPD (United Nations, 2006), which the United Kingdom has ratified but not incorporated into domestic law, provides that disability alone can never justify depriving a person of their liberty and that disabled people enjoy legal capacity on an equal basis with others. The committee that monitors the CRPD reads these provisions as prohibiting detention and involuntary treatment based on actual or perceived impairment, even where risk is also present, and has urged states parties to replace substituted decision-making with supported decision-making. The European Convention on Human Rights takes a different position: Article 5 expressly permits the lawful detention of persons of unsound mind, subject to safeguards (Council of Europe, 1950), and it is the European Convention, given effect by the Human Rights Act 1998, that English courts apply. Szmukler, Daw and Callard (2014) accept much of the discrimination critique but argue that a more defensible response than

abolishing involuntary intervention is a generic law, applying to everyone whatever their diagnosis, that permits intervention only where decision-making ability is impaired and that gives the person's will and preferences central weight. The 2025 Act does not take that step, so the CRPD critique will still apply once its reforms are in force.

For therapists, some of the most useful evidence concerns what compulsion is like to live through. Akther et al. (2019) synthesised qualitative studies of people's experiences of assessment and detention under mental health legislation. Recurring themes included fear and powerlessness, feeling poorly informed about what was happening and about their rights, and feeling excluded from decisions. Relationships with staff made a considerable difference: being listened to and treated with respect could make detention feel like care, whereas dismissive or coercive contact could make it feel like punishment. Some people later described detention as having kept them safe. These findings do not settle whether compulsion is justified. They describe what a client brings into the therapy room afterwards, and they help explain why the same lawful admission can leave one person grateful and another traumatised.

This history should make practitioners wary of assuming that reform follows evidence. Several major changes were prompted by scandal or by the politics of public protection rather than by research, and evidence that compulsion improves outcomes compared with intensive voluntary care is limited, partly because detention cannot ethically be allocated at random. Safeguards and access also trade against each other: the 1890 Act protected people from wrongful confinement but delayed treatment, while the 1959 Act eased access to care but left patients more exposed to professional discretion, with tribunals as the main check. No reform has yet removed the ethnic disparities that the independent review treated as a central concern. Whether the 2025 Act reduces detention will depend less on its text than on the community services, workforce and alternatives to admission available when its provisions are commenced.

Worked clinical example. Imran Qureshi, a 41-year-old accountant, had seen Catriona Bell, an integrative psychotherapist in private practice, weekly for eighteen months for recurrent depression after his father's death. Over a fortnight in the spring he became elated, slept two or three hours a night, spent heavily and told colleagues he had been chosen to transform the firm.

His wife contacted their GP, a crisis team visited, and after an assessment at home he was detained under section 2 of the Mental Health Act 1983, the power for assessment explained in lesson 2.2, and admitted to a ward twenty miles away. He was discharged three weeks later with a diagnosis of bipolar disorder and asked to resume therapy. Before the first session Catriona took the case to supervision. Her notes from three weeks before the admission recorded that he had seemed unusually energised, and she had not explored it. Her supervisor helped her separate an honest review of what she could learn from a wish to be reassured, and they agreed that the first sessions would be given to understanding what had happened rather than to relapse prevention.

Imran's account came in fragments: police officers in his hallway, the ambulance, being held by staff for an injection on his second night. He felt humiliated, furious with his wife for calling the GP and ashamed of things he had said, and, more quietly, admitted that his own thoughts had frightened him before the admission. Catriona neither told him the detention had been for the best nor agreed that it had been an outrage. She reflected both experiences back to him and asked how he was now; he described nightmares about the night of the injection and avoidance of the road where the ambulance had parked, so she noted possible trauma symptoms for structured review. He did not know which power had been used or what his rights had been. She explained in general terms that he had been detained for assessment under a time-limited power and that the hospital managers must give detained patients information about their rights, and they drafted questions for his care coordinator and a request for his records. When he said she should have seen it coming, she acknowledged that she had noticed a change and had not asked enough about it. Over the next three sessions they wrote a one-page plan naming his early signs (reduced sleep, rapid speech, sudden spending and irritability at work), what he wanted her to do if they appeared (raise them directly, then contact his GP and his wife if they persisted for more than a few days) and what he did not want (any contact with his employer). With his consent the plan went to his GP; lesson 6.4 considers how such plans can become advance statements. Her records noted his account in his own words, the possible trauma symptoms, the supervision discussion, the plan and the exact scope of his consent to contact others.

Common pitfalls. The first is taking a side on the detention. Telling a client

that the section was clearly necessary closes down anger that needs to be heard, while agreeing that it was an abuse can entrench a grievance and weaken engagement with help the client may need again; the therapist's task is to help the person make sense of what happened, and questions of lawfulness belong with advocates, complaints processes and lawyers. The second is overstating reform. Clients see headlines about the Mental Health Act 2025 and may assume that the nominated person, advance choice documents or the new detention criteria already apply to them. They are not yet in force, and a therapist who repeats the error can give false reassurance, so check the commencement position before discussing reform. The third is moving too quickly to relapse prevention. A plan written before the person has told their story tends to be compliant rather than owned, and it can miss trauma responses to restraint, conveyance or seclusion that need assessment in their own right. The fourth is acting out the therapist's own reaction. Guilt about missed signs can produce excessive apology or defensiveness, and either distorts the work; take the reaction to supervision and decide deliberately what, if anything, to acknowledge to the client.

Reflective question. Where do you personally draw the line between respecting a person's refusal of care and protecting them from serious harm, and how did you arrive at that position? Consider how it might shape the way you hear a client's account of being detained, including which parts of the story you find easy to accept and which you are inclined to explain away.

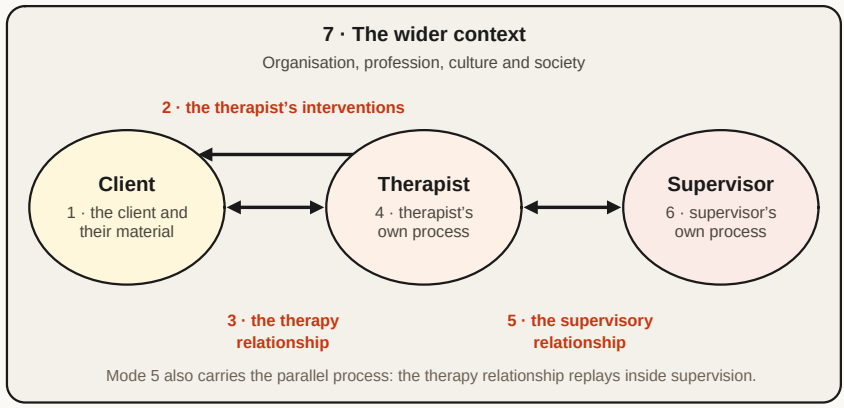


FIGURE 1.1 The seven-eyed model of supervision

Hawkins and Shohet's seven modes give supervision its lenses: the client and their material, the therapist's interventions, the therapy relationship, the therapist's own process, the supervisory relationship itself (including parallel process), the supervisor's process, and the wider organisational and social context around all of it.

Points worth keeping

- English mental health law justifies compulsion on two grounds, the person's own health or safety and the protection of others, and each statute has balanced them differently.
- The Lunacy Act of 1890 relied on judicial orders to prevent wrongful confinement, whereas the 1959 Act made informal admission normal and gave compulsory admission decisions to doctors.
- The Mental Health Act 1983, amended chiefly by the Mental Health Act 2007, remains the operative framework for compulsory assessment and treatment in England and Wales.
- Unlike the Mental Capacity Act 2005, the 1983 Act contains no capacity test, so a capable person who refuses treatment can still be detained if the criteria are met.
- The 2018 independent review recommended four principles: choice and autonomy, least restriction, therapeutic benefit, and the person as an individual.
- The Mental Health Act 2025 received Royal Assent on 18 December 2025, but its principles, revised detention criteria and nominated person

are not yet in force.

- The CRPD challenges detention based on impairment, whereas Article 5 of the European Convention permits the lawful detention of persons of unsound mind subject to safeguards.
- People describe detention as frightening and disempowering, and respectful relationships with staff strongly influence whether it is later experienced as care or as punishment.

PRACTICE TASK

This week: Reread the contract or information sheet you give new clients and find what it says about what you will do if a client becomes acutely unwell or at serious risk. Many documents say very little. Draft a revised paragraph of no more than 200 words, in plain English, explaining when you might share concerns, with whom (for example the client's GP or a crisis team), how you would involve the client first wherever possible, and that you have no power yourself to admit anyone to hospital. Avoid any suggestion that reforms in the Mental Health Act 2025 already apply. Take the draft to supervision, agree any changes, and record the date from which the revised wording will be used with new clients.

Study activities: The reflective-practice activity helps you examine your own stance on compulsion. Write about 400 words on a time when you witnessed or heard about a compulsory admission, describing what you felt, which of the two justifications for compulsion you instinctively gave more weight to, and how the CRPD critique and the findings of Akther et al. (2019) challenge that stance, then end with one question about your stance to take to supervision; allow about 25 minutes. The skills-practice activity builds your ability to explain the law simply. Prepare a three-minute spoken explanation, for an imagined client who has just been discharged, of why English law permits detention, how the 1983 Act came about and what the 2025 Act will change once it is in force. Record yourself, listen back, and remove any jargon, any claim that reforms are already in force and any statement that takes a side on the client's own detention. If a colleague is willing, play them the final version and ask which point they found hardest to follow. Allow about 30 minutes.

Further reading:

DHSC (2018) Modernising the Mental Health Act: increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. London: DHSC.
Akther et al. (2019) Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. BJPsych Open, 5(3), e37.
Szmukler, Daw and Callard (2014) Mental health law and the UN Convention on the Rights of Persons with Disabilities. International Journal of Law and Psychiatry, 37(3).
Bartlett and Sandland (2014) Mental Health Law: Policy and Practice. 4th

edn. Oxford: Oxford University Press.

CHAPTER 2

The architecture of the 1983 Act: definitions, roles and pathways

When someone is detained, a family's first questions are rarely about criteria. They ask who decided, who is in charge now, whether anyone can stop it and what happens next. Each question has a precise answer in the Mental Health Act 1983, but the answers are spread across a statute that has been amended many times and that distributes power among people with unfamiliar titles. A therapist who can map that structure accurately can reduce fear without overstepping their role. This lesson provides the map: how the Act is organised, the definitions on which every power depends, the people who hold those powers, and the routes by which a person moves into, through and out of compulsory care. The detailed criteria for each power are taught in Modules 2 to 4.

The Act is divided into Parts. Part 1 consists of section 1, which defines mental disorder. Part 2, sections 2 to 34, contains the civil powers: admission for assessment and for treatment, emergency admission, the holding powers for people already in hospital, leave of absence, community treatment orders, guardianship, the nearest relative provisions and the main discharge powers. Part 3, sections 35 to 55, governs people concerned in criminal proceedings or serving sentences, including hospital orders, restriction orders and transfers from prison. Part 4, sections 56 to 64, sets out when treatment for mental disorder may be given without consent and the safeguards that then apply, and Part 4A adds rules for community patients who have not been recalled to hospital. Part 5, sections 65 to 79, deals with tribunals. Several provisions that therapists meet often sit in the later Parts: the after-care duty in section 117, the Code of Practice in section 118, independent mental health advocacy in sections 130A to 130D (with separate provision for Wales), informal admission in section 131, information for detained patients in section 132, the police powers in sections 135 and 136, and the interpretation section, section 145. The Code of Practice for England (Department of Health, 2015) and the separate Code for Wales (Welsh Government, 2016) explain how the powers should be used; lesson 1.3 considers their legal status.

Every power depends on the definition in section 1. Mental disorder means any disorder or disability of the mind, a deliberately broad formula that covers mental illnesses, personality disorders, autism, dementia and learning disabilities. Two qualifications narrow it. A learning disability, defined as "a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning", counts for detention under section 3 and for several other powers only if it is associated with abnormally aggressive or seriously irresponsible conduct; the qualification does not apply to detention for assessment under section 2. Dependence on alcohol or drugs is not by itself a mental disorder, although a disorder that coexists with or results from substance use, such as a psychotic illness, can be. The 2007 amendments removed older exclusions relating to promiscuity, immoral conduct and sexual deviancy, and abolished the four legal categories that had previously determined who could be detained for treatment. The Mental Health Act 2025 will change the position for people with autism or a learning disability, who will not be detainable for treatment under section 3 unless they also have a co-occurring psychiatric disorder that warrants it, while section 2 will remain available with safeguards and commissioners will take on new duties, including keeping dynamic support registers. These provisions are not yet in force.

Detention for treatment under section 3 also requires that appropriate medical treatment is available: medical treatment which is appropriate in the person's case, taking into account the nature and degree of the mental disorder and all other circumstances of the case. Section 145(1) defines medical treatment to include nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care, and section 145(4) requires its purpose to be to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations. Two consequences follow for therapists. First, psychological intervention is medical treatment in law, so the availability of therapy can form part of the treatment that makes a detention lawful, which places an ethical weight on the therapist that lesson 1.5 considers. Secondly, treatment for mental disorder has been read broadly enough to include treating a condition that is a consequence or symptom of the disorder: in B v Croydon Health Authority [1995] Fam 133, feeding a patient with borderline personality disorder was held to be treatment for her mental disorder (lesson 3.1). Section 8 of the Mental Health Act 2025 will add a requirement of a reasonable prospect of

therapeutic benefit to the meaning of appropriate medical treatment; it is not yet in force.

The people who hold powers under the Act are best understood by what each can decide. The approved mental health professional (AMHP) is approved by a local authority and may be a social worker, nurse, occupational therapist or psychologist, but not a doctor. The AMHP coordinates the assessment and decides, independently of the doctors and of the family, whether to apply for detention, after interviewing the person and considering the views of relatives and the alternatives to admission; the nearest relative can also apply, although this is rare. Applications under sections 2 and 3 need two medical recommendations, at least one from a doctor approved under section 12 as having special experience in the diagnosis or treatment of mental disorder. An approved clinician is a professional approved to take responsibility for treatment under the Act; doctors, psychologists, nurses, occupational therapists and social workers can all hold that approval. The responsible clinician is the approved clinician with overall responsibility for a particular patient's case and is the person who can, among other things, renew detention, grant leave of absence under section 17 and discharge the patient. The responsible clinician need not be a psychiatrist, so families should ask for the person by name and role rather than assume that a consultant is in charge.

The nearest relative is a statutory role and is not the same as next of kin. Section 26 sets a hierarchy: husband, wife or civil partner; son or daughter; father or mother; brother or sister; grandparent; grandchild; uncle or aunt; nephew or niece. A relative who lives with or cares for the patient is preferred, and a cohabitant of at least six months is treated as a spouse. The AMHP must inform the nearest relative about a section 2 application and must consult them before a section 3 application unless consultation is not reasonably practicable or would involve unreasonable delay; a nearest relative's objection prevents a section 3 application. In TW v Enfield London Borough Council [2014] EWCA Civ 362 the Court of Appeal held that the AMHP must weigh the patient's Article 8 rights when deciding whether consultation is reasonably practicable, which matters where the patient fears, or has been harmed by, the relative concerned. The nearest relative can order the patient's discharge on 72 hours' notice, which the responsible clinician may bar by reporting that the patient would be likely to act in a manner dangerous to themselves or others. A nearest relative can be

displaced only by the county court under section 29.

Several bodies complete the picture. The hospital managers are the organisation responsible for the hospital, whether an NHS trust or a registered independent provider; once a valid application is made it is the managers who are authorised to detain, and they must give detained patients information about their rights under section 132, refer patients to the tribunal under section 68 when they have not applied, and can themselves discharge. Independent mental health advocates (IMHAs) help qualifying patients to understand and use their rights, independently of the treating team. The tribunal, which is the First-tier Tribunal (Mental Health) in England and the Mental Health Review Tribunal for Wales, is the independent judicial check on detention and can order discharge. The Care Quality Commission monitors the use of the Act in England, visits detained patients and appoints the second opinion doctors who certify certain treatments; Healthcare Inspectorate Wales performs the monitoring role in Wales.

With the roles in place, the pathways become clear. Many people enter hospital informally under section 131, without any compulsory power being used. Compulsory civil admission is under section 2 (assessment, up to 28 days and not renewable), section 3 (treatment, up to six months, renewable for six months and then yearly) or, in cases of urgent necessity, section 4 (up to 72 hours on one medical recommendation), and an in-patient can be held briefly under section 5(2) or section 5(4). The police powers bring people to a place of safety: section 135 by warrant and section 136 from anywhere except a private dwelling. The courts and the prison system use Part 3. Within hospital, Part 4 governs treatment and section 17 governs leave. People leave detention through discharge by the responsible clinician, the hospital managers, the nearest relative or the tribunal, sometimes onto a community treatment order under section 17A or, for restricted patients, by conditional discharge, and guardianship under sections 7 and 8 offers a separate community route. After-care under section 117 is a free, joint duty of the integrated care board (in England) and the local authority for people who have been detained under sections 3, 37, 45A, 47 or 48; detention under section 2 alone does not create it.

The architecture has well-known weaknesses. The breadth of the definition means that the other criteria do almost all of the limiting work. The 2007 changes, and especially the replacement of the treatability test, were

intended in part to make it easier to detain people with personality disorders who had been regarded as untreatable, and critics argue that they widened the Act's reach (Bartlett and Sandland, 2014). Because autism is a mental disorder without the conduct qualification, autistic people without a learning disability can be detained for treatment, and some people with autism or learning disabilities have spent long periods in hospital for want of suitable community support; the reform intended to address this is not yet in force. The nearest relative is assigned by a hierarchy rather than chosen, so the person holding these powers may be estranged from the patient or may have harmed them, and displacement requires court proceedings. The independent review recommended replacing the role with a nominated person chosen by the patient (DHSC, 2018), a reform contained in the 2025 Act but not yet in force. Finally, the number of roles and the speed of events leave many patients and families confused, which fits the reports of poor information in Akther et al. (2019) and marks the point at which a therapist's explanation can be most useful.

Worked clinical example. Kieran Doyle, 24, had seen Hannah Lewis, a clinical psychologist in an early intervention in psychosis team, for six sessions. He lives with his mother, Bernadette, and his sister, Aoife, who is 19; his parents separated years ago and his father lives in Cardiff. Over a week his paranoid beliefs intensified, he barricaded his bedroom and stopped eating, and after an assessment at home he was detained under section 2 and admitted to an acute ward. The next morning Bernadette telephoned Hannah in tears. A social worker had told her that she was the nearest relative, Aoife insisted that their father was next of kin, and both wanted to know whether Kieran could be forced to take medication and whether he now had a criminal record. Hannah first rang the ward and spoke to Kieran, who agreed that she could explain the process to his family but asked her not to discuss anything he had said in therapy. She recorded his consent and its limits.

With Bernadette and Aoife in her office that afternoon, Hannah drew the map on a single sheet. At the centre she wrote Kieran's name and the power used: section 2, detention for assessment for up to 28 days, which cannot be renewed. On the left she showed how he came to be there: the AMHP who interviewed him and made the application, and the two doctors who gave medical recommendations, one approved under section 12. She explained that Bernadette was the nearest relative because section 26 places parents above siblings and prefers a relative who lives with the patient, so their

father, though above Aoife in the list, was not the nearest relative, and that next of kin has no status under the Act. On the right she showed who could act now: the responsible clinician on the ward, whose name they should ask for; the hospital managers, who must give Kieran information about his rights; an IMHA, whom Kieran could ask to see; and the tribunal, to which Kieran could apply within the first 14 days. She then explained Bernadette's own position. Bernadette had been entitled to be informed of the application; she could give 72 hours' notice to discharge Kieran, which the responsible clinician could bar by reporting that he would be likely to act in a manner dangerous to himself or others; and if the team later considered section 3, the AMHP would have to consult her, and her objection would prevent the application unless the county court displaced her. Asked about medication, Hannah said that Part 4 allows some treatment for mental disorder to be given without consent, subject to safeguards, and that the ward team was the right source for what was planned. She confirmed that detention under the Act is not a criminal conviction, and she declined to predict how long Kieran would stay. Her note recorded the scope of Kieran's consent, the information given, the fact that no therapy content was disclosed and Bernadette's request for the responsible clinician to call her.

Common pitfalls. The commonest error is treating the nearest relative as next of kin, so that the wrong person is told they hold powers or the right person is never told. Work the section 26 hierarchy through, including the preference for a relative who lives with or cares for the patient and the rule on cohabitants, and say plainly that next of kin has no status under the Act. A second is assuming that the responsible clinician must be a consultant psychiatrist. Any approved clinician can hold the role, and families who ask for the wrong person lose time; encourage them to ask the ward who the responsible clinician is. A third is misdescribing section 2 as either trivial or open-ended. It is a time-limited power that cannot be renewed, but treatment for mental disorder can still be given without consent under Part 4, and the period can end in discharge, informal admission or an application under section 3. A fourth is promising after-care. Families often assume that any detention brings section 117 support, yet only detention under sections 3, 37, 45A, 47 or 48 does, so describe the duty accurately and leave the discharge plan to the team that will deliver it.

Reflective question. If a frightened relative asked you today who decided on a detention and who could end it, could you answer accurately for the setting

in which you work, including who the nearest relative would be and what that person can and cannot do? Which part of this map are you least sure about, and what will you do to close that gap before you next need it?

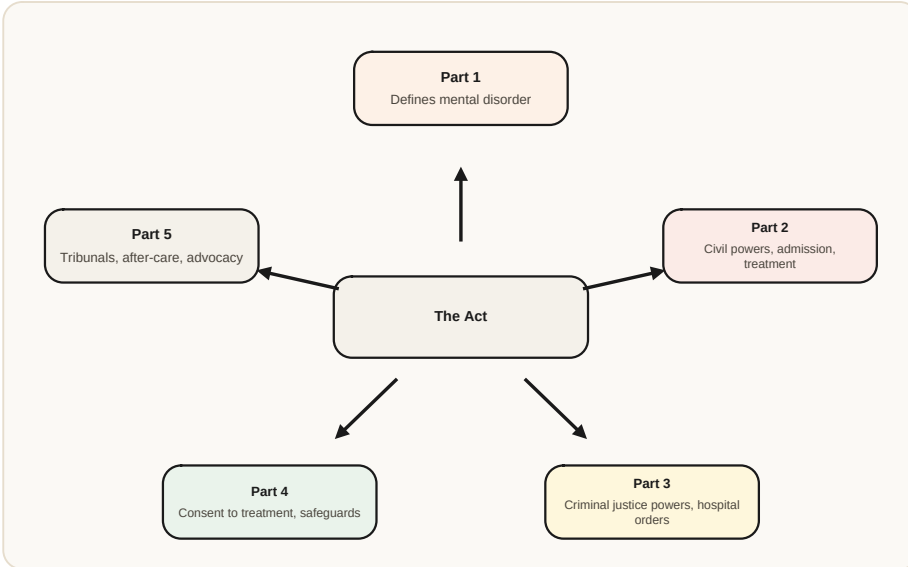


FIGURE 2.1 MHA 1983 Structure

The Mental Health Act 1983 is organised into parts with specific roles and pathways. This figure maps the central structure of the Act, highlighting key definitions, roles, and routes into and out of compulsory care.

Points worth keeping

- Part 2 of the Mental Health Act 1983 contains the civil powers, Part 3 the criminal justice powers, Part 4 consent to treatment and Part 5 the tribunals.
- Section 1 defines mental disorder as any disorder or disability of the mind, and dependence on alcohol or drugs is not by itself a mental disorder.
- For section 3 and several other powers, a learning disability counts only if associated with abnormally aggressive or seriously irresponsible conduct; the qualification does not apply to section 2.
- Section 145 includes psychological intervention within medical treatment, so the availability of therapy can form part of the appropriate medical treatment that section 3 requires.

- The AMHP, who may be a social worker, nurse, occupational therapist or psychologist but not a doctor, decides independently whether to apply for detention.
- The responsible clinician is the approved clinician with overall responsibility for the patient's case, can renew detention, grant leave and discharge, and need not be a doctor.
- The nearest relative is fixed by the section 26 hierarchy, is not the same as next of kin, and can be displaced only by the county court under section 29.
- After-care under section 117 follows detention under sections 3, 37, 45A, 47 or 48, but not detention under section 2 alone.

PRACTICE TASK

This week: Build a one-page map of the people and powers around a compulsory admission in your own area. Find out how the local AMHP service is contacted, which hospital would usually admit your clients, how detained patients there are put in touch with an IMHA, and how a family can contact the hospital managers or raise a concern. Add the section 26 hierarchy in plain words and a line on how a patient applies to the tribunal. Keep the map free of any client information. Check it with your supervisor or a colleague in secondary care, correct any errors, and store it where you can find it quickly in a crisis.

Study activities: The reflective-practice activity examines how families experience the structure of the Act. Recall or imagine a relative who has just learned that someone they love has been detained, write down the five questions they are likely to ask first, and note beside each whether you could answer it accurately, which role under the Act holds the answer and what you would need to check; allow about 20 minutes. The skills-practice activity rehearses identifying the nearest relative. Work out who the nearest relative would be under section 26 in three fictional situations: a woman who has lived with her unmarried partner for eight months and whose mother lives nearby; a man with no partner or children whose sister lives with and cares for him while his father lives elsewhere; and a man with no partner or children whose parents live apart, one of them with him. Then explain each answer aloud in under two minutes, as if to the family, without using the phrase next of kin. Allow about 30 minutes.

Further reading:

Mental Health Act 1983, c. 20. Available at: https://www.legislation.gov.uk/ukpga/1983/20 (Accessed: 6 October 2026).
Mental Health Act 1983: Code of Practice (Department of Health, 2015).
Mental Health Act 1983: Code of Practice for Wales, Review 2016 (Welsh Government, 2016).