BRADFORD VTS TEACHING AIDS
July 2026

The Mental Health Act in General Practice

Five case scenarios for small-group teaching — with a plain-English legal primer, a decision flowchart, and trainer's notes updated to the law as it stands in 2026. Written for GP trainees and international medical graduates working in England and Wales.

◎ HOW TO USE THIS TEACHING AID

This is a **workshop resource**, not a lecture. Pages 2–4 give the whole group a shared foundation: who does what, which section does what, and the pathway a GP actually follows. Read them together first — about ten minutes. Then work through the five scenarios. Each scenario has a story, discussion questions, and a **trainer's crib** of key teaching points. Learners should attempt the questions *before* the crib is revealed: retrieving an answer from memory, even a wrong one, fixes learning far better than reading the answer first.

▲ WHAT'S CHANGED FROM THE ORIGINAL (2018) VERSION

- **The Mental Health Act 2025.** A new Act received Royal Assent on 18 December 2025. It *amends* — it does not replace — the Mental Health Act 1983. Almost none of it is in force yet: implementation is phased over several years, starting with a new Code of Practice. **The MHA 1983 (as amended in 2007) remains the law you use today.** The horizon changes are flagged on the final page.
- **"Form 4" no longer exists.** The old numbered forms were replaced in 2008. The GP-relevant forms are now **A3/A4** (section 2), **A7/A8** (section 3) and **A11** (section 4). Scenario 2 has been updated accordingly.
- **Roles renamed.** The Approved Social Worker became the **Approved Mental Health Professional (AMHP)**; the Responsible Medical Officer became the **Responsible Clinician**.
- **Scenario 1 reframed.** A confused care-home resident is usually a **Mental Capacity Act** problem, not a Mental Health Act one. The crib now teaches that distinction explicitly — including the June 2026 Supreme Court ruling that has changed the legal test for deprivation of liberty.
- **Trainer's cribs added.** The original posed questions without answers. Each scenario now carries verified teaching points so any trainer can facilitate with confidence.

First, meet the cast

A compulsory admission is a team event, and the law names each player precisely. Learn these five roles and every scenario in this pack becomes easier.

THE COORDINATOR

Approved Mental Health Professional (AMHP)

A specially trained professional — most often a social worker, sometimes a mental health nurse, occupational therapist or psychologist — approved by the local authority. The AMHP **coordinates the assessment and makes the application** for detention. Think of the AMHP as the conductor: the doctors play their parts, but the AMHP brings the whole thing together and decides whether detention is truly the least restrictive option.

THE SPECIALIST

Section 12 approved doctor

A doctor approved under section 12(2) as having special expertise in mental disorder — usually a psychiatrist, occasionally a GP with a special interest. **At least one of the two medical recommendations must come from a section 12 doctor.**

USUALLY YOU

The doctor with "previous acquaintance"

Where practicable, the second doctor should already know the patient — and in the community that is nearly always **the GP**. This is not a courtesy; it is a deliberate safeguard. Your longitudinal knowledge of the patient is exactly what the law wants in the room.

THE FAMILY VOICE

Nearest relative

Defined by a strict legal hierarchy in section 26 — **the patient does not choose them**. The AMHP must inform the nearest relative of a section 2 application, and must consult them for section 3, which they can object to. (When the 2025 Act reforms take effect, this role will be replaced by a patient-chosen **"nominated person"**.)

AFTER ADMISSION

Responsible Clinician (RC)

The approved clinician in overall charge of the patient's care once detained. The RC grants leave (s17), renews detention and discharges the section.

THE SAFEGUARD

Independent Mental Health Advocate (IMHA)

Detained patients have a statutory right to an IMHA — an independent advocate who helps them understand and exercise their rights, including appealing to the Mental Health Tribunal.

◆ **TWO DIFFERENT KEYS: MHA VS MCA**

Think of the **Mental Health Act** and the **Mental Capacity Act** as two different keys that open two different doors. The **MHA** authorises detention in hospital for *assessment or treatment of a mental disorder* — and it can override a capacitous refusal of that treatment. The **MCA** authorises care and treatment given in the *best interests of a person who lacks capacity* for that specific decision — including, through the Deprivation of Liberty Safeguards (DoLS), care arrangements in a care home or hospital that deprive the person of their liberty.

You must not reach for the MHA simply because a patient is confused or refusing care. Ask first: does this person lack capacity for this decision? If so, the MCA is usually the right key — as Scenario 1 will show.

The sections at a glance

These are the parts of the MHA 1983 a GP actually meets. Durations are maximums, and every section demands the **least restrictive option** to have been considered first.

Section	What it does	How long	Who signs	The point to remember
s131	Informal (voluntary) admission	—	Nobody — the patient agrees	Always the starting point. The patient is free to leave.
s2	Admission for **assessment** (± treatment)	28 days, **not renewable**	AMHP application + **2 doctors** (≥1 s12-approved)	Use when the diagnosis or response to treatment is unclear — e.g. a first presentation. Patient may appeal to the Tribunal in the first 14 days.
s3	Admission for **treatment**	6 months; renewable (6 m, then 12 m)	AMHP application + **2 doctors** (≥1 s12-approved)	Diagnosis and treatment plan already known, and appropriate treatment must actually be available. Triggers free s117 aftercare on discharge.
s4	**Emergency** admission for assessment	72 hours	AMHP + **1 doctor** (often the GP)	Only when waiting for a second doctor would cause undesirable delay. Converted to s2 by a second recommendation in hospital. Rarely used.
s5(2)	Doctor's holding power — **inpatients only**	72 hours	Doctor in charge (or deputy)	Stops an informal *inpatient* leaving while a full assessment is arranged. **You must not use it in A&E or the community** — an A&E attender is not an inpatient. No power to treat.
s5(4)	Nurse's holding power	6 hours	Registered mental health / LD nurse	Bridges the gap until a doctor arrives.
s135	Warrant to enter **private premises**	24 h (+12 h) at a place of safety	Magistrate, on AMHP application	The key that opens a locked front door. Police enter with the AMHP and a doctor, and may remove the person to a place of safety.
s136	Police power in a **public place**	24 h (+12 h) at a place of safety	Police officer	No warrant needed — there is no front door in the street. Police stations may be used only exceptionally for adults and **never for under-18s**.
s17A	Community Treatment Order (CTO)	Reviewable	RC + AMHP	Supervised community treatment for some patients leaving s3, with a power of recall to hospital.
s117	Free **aftercare**	Until formally ended	NHS + local authority (joint duty)	Anyone who has been on s3 is entitled to free aftercare — worth knowing when patients are asked to pay for care.

2 to assess • 3 to treat • 4 when you can't wait • 5 to stop them leaving • 135 behind a door • 136 on the street

Six phrases that carry the whole framework. If a section number appears in the SCA or AKT, one of these is almost certainly the answer.

▸ THE PAPERWORK, DECODED

Since 2008 the statutory forms have been lettered, not numbered. As a GP you will meet: **Form A4** — your single medical recommendation for section 2 (**A3** if completed jointly with the other doctor); **Form A8** — your recommendation for section 3 (**A7** jointly); and **Form A11** — the single recommendation for an emergency section 4. Three rules protect the patient and you: the two medical examinations must be **no more than five clear days apart**; the AMHP's application must follow within **14 days** of the later examination; and **you must not act where you have a conflict of interest** (for example, a financial or close personal connection). Forms may now be completed and served electronically — know your local process, and know where the blank forms live before the day you need them.

▲ FIVE TRAPS THAT CATCH GPS

- **Using s5(2) outside a hospital ward.** It applies to admitted inpatients only. **You must not attempt to "hold" a patient in your surgery, in A&E or at home** — no such power exists there.
- **Expecting police to use s136 inside the patient's home.** It applies in public places only. Behind a front door, the route is an AMHP-obtained **s135 warrant**.
- **Signing a recommendation without personally examining the patient that day.** You must examine the patient yourself before signing — a corridor conversation or a relative's account is not an examination, and a defective form can make the whole detention unlawful.
- **Treating under a holding power.** Sections 4, 5, 135 and 136 authorise *holding for assessment* only. Treatment without consent needs s2 or s3 (or, in a capacity-lacking emergency, the Mental Capacity Act).
- **Forgetting that "voluntary" is a real option.** Skipping the offer of informal admission is not just poor practice — the least restrictive principle is a legal requirement of the Code of Practice, and the AMHP will ask what alternatives you considered.

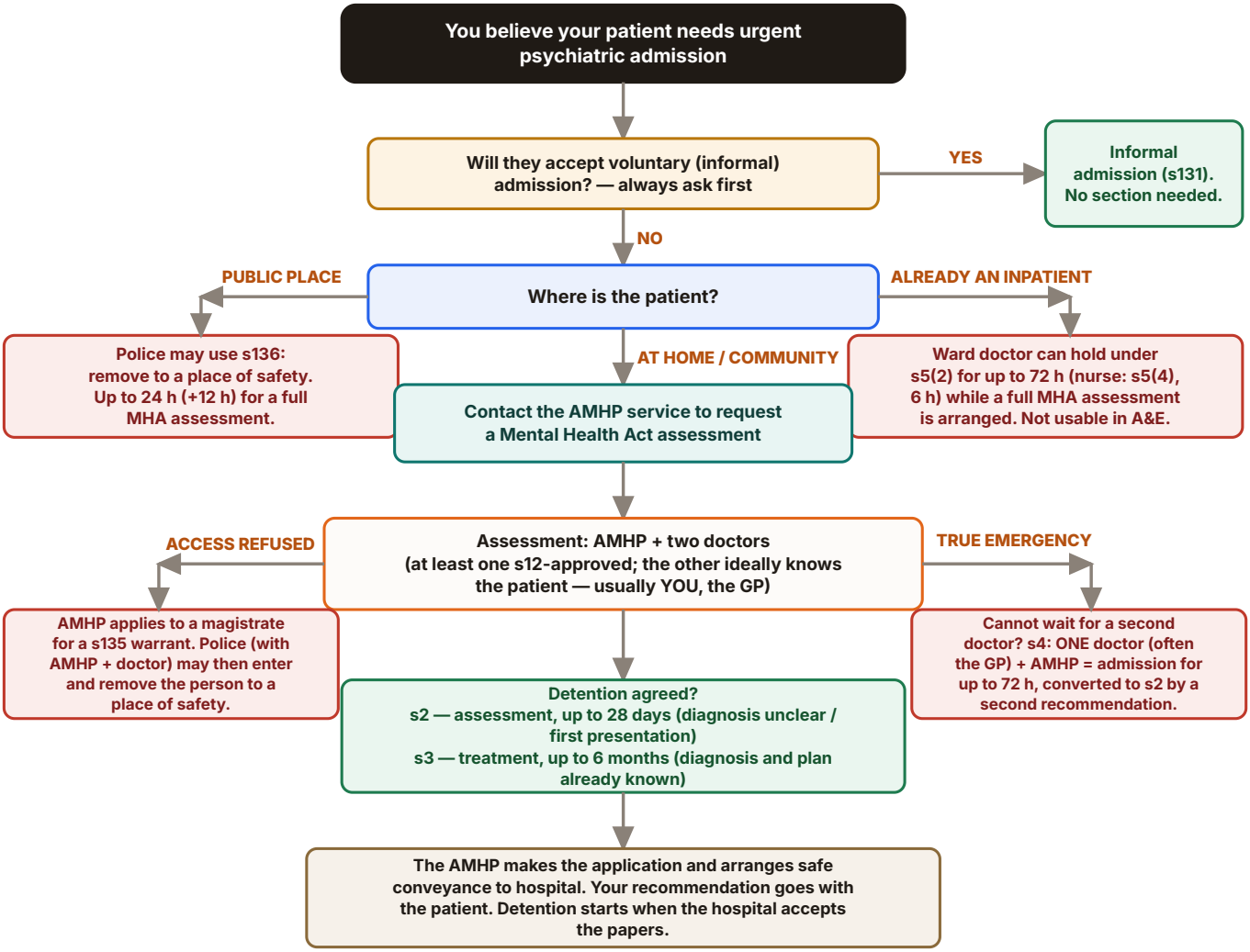
◎ MAKING THE CALL: WHAT THE AMHP SERVICE WILL ASK YOU

When you phone to request a Mental Health Act assessment, have this to hand — it turns a slow referral into a fast one:

- **The person:** demographics, diagnosis and psychiatric history, current mental state as *you* observed it, and when you last examined them.
- **The risk:** risk to self and others, weapons in the house, children or dependants at home, and any history of violence — safety-critical for everyone attending.
- **What has been tried:** was informal admission offered and refused? Is the community team or crisis team already involved?
- **The practicalities:** access to the property, family or nearest-relative contacts, and whether *you* can attend as the second doctor — the assessment is far stronger with you there.

The pathway: what a GP actually does

Trainees often imagine the GP "sectioning" a patient single-handedly. You never do. Your job is to **recognise, refer and recommend** — the AMHP coordinates, and the hospital detains.



The community pathway under the Mental Health Act 1983 (England & Wales). Red boxes are emergency powers; green boxes are destinations.

✓ GOLDEN RULES FOR THE GP

- **You must always consider the least restrictive option first.** Ask about voluntary admission before anyone mentions a section.
- **You must not attempt to force entry, restrain, or transport a resisting patient yourself.** That is what s135 warrants, the police and the ambulance service are for.
- **Detention under s2 or s3 authorises treatment of the mental disorder without consent** (with Part 4 safeguards). Sections 4, 5, 135 and 136 authorise *holding*, not treating.
- **The MHA cannot be used to force treatment of a purely physical illness.** For a patient who lacks capacity, that is Mental Capacity Act territory.
- **Document everything contemporaneously** — your examination, your reasoning against the statutory criteria, and the least-restrictive options you considered.

1 The wandering resident

Capacity, dementia and the limits of the Mental Health Act

THE STORY

An elderly, confused man lives in a nursing home. You are asked to visit to review his medication. He wanders: he recently climbed over the wall and was found five miles away, disorientated, searching for the house he lived in decades ago. He has disturbed other residents — once trying to get into bed with a female resident he believed was his wife. Staff report he refuses his medication because of side-effects; when he does take it, he is sedated and "much less of a management challenge".

Work through

Q1 Is the Mental Health Act the right legal framework here? If not, what is?

Q2 What clinical work must be done before any legal question is even asked?

Q3 What do you make of medication that makes him "less of a management challenge"?

Q4 Which safeguarding issues does this story raise?

✓ TRAINER'S CRIB — KEY TEACHING POINTS

- **This is almost never an MHA case — it is an MCA case.** He does not need detention in a psychiatric hospital; he needs safe care where he already lives. If he lacks capacity to consent to his care arrangements and those arrangements restrict his freedom, the home must follow the Mental Capacity Act 2005 route and seek authorisation under the **Deprivation of Liberty Safeguards (DoLS)** from the local authority.
- **Clinical work comes first.** You must exclude delirium and reversible causes — infection, pain, constipation, dehydration, and the medication itself — before attributing everything to dementia. New wandering or agitation is a symptom to be investigated, not merely managed.
- **Take his complaint of side-effects seriously.** Sedating a resident for the convenience of staff is **chemical restraint**, not treatment. NICE dementia guidance is clear that non-drug approaches come first and that any sedating medication needs a documented best-interests rationale, the lowest effective dose and regular review. A medication review is precisely what you were asked to do — do it properly.
- **Capacity is decision-specific.** Apply the MCA two-stage test to each decision (taking medication, remaining in the home) rather than declaring him globally "incapable".
- **The behaviour towards the female resident is a safeguarding matter for her** as well as a care-planning matter for him. It calls for a risk assessment and supervision plan, not a knee-jerk detention.
- **Law in motion — flag this honestly.** On 2 June 2026 the Supreme Court overruled the 2014 *Cheshire West* "acid test", so the legal definition of when care arrangements amount to a deprivation of liberty is being reworked nationally. DoLS remains the authorisation scheme (its planned replacement, the Liberty Protection Safeguards, is still not in force). **You must follow your local authority's current DoLS process and emerging national guidance** rather than older summaries of the law.
- The MHA would only enter the picture if he needed *hospital* assessment or treatment of his mental disorder that could not be arranged informally or under the MCA. Guardianship (s7) exists but is rarely needed in a settled placement.

2 "Eureka — I've got it!"

A first psychotic episode, a home visit, and the paperwork done properly

THE STORY

The father of a 22-year-old patient, known to your trainer for many years, telephones the practice. His son has been found riding his bicycle naked through the streets shouting *"Eureka — I've got it!"*. He is now at home but refuses to dress, declaring that "nakedness is next to godliness". You arrange to visit after surgery.

◎ RUN THE EXERCISE

Act 1 — the visit. Cast the father, the patient and the GP registrar; nominate a scribe. Play the home visit. **Act 2 — the referral.** The trainer has phoned the duty psychiatrist requesting an assessment with a view to compulsory admission. Discuss: who should attend, and what must happen at that visit? **Act 3 — the paperwork.** Split into two groups (GP and psychiatrist). Assume the assessment supports detention under section 2, and have each group complete a medical recommendation — **Form A4** (or a joint **Form A3**). Compare the forms against the statutory criteria. **Act 4 — the debrief.** Play the feedback conversation between registrar and trainer; the scribe captures learning points and action points.

Work through

Q1 Who should attend the assessment visit, and why does the law want each of them there?

Q2 Which section fits a first presentation like this — and why?

Q3 What must each medical recommendation actually say?

Q4 What happens to the forms next? Who makes the application, and when does detention legally begin?

✓ TRAINER'S CRIB — KEY TEACHING POINTS

- **The picture is a first episode of mania or psychosis** — grandiosity, disinhibition, religiosity. Organic causes and intoxicants belong on the differential, which is itself an argument for assessment in hospital.
- **Who attends: the AMHP, a section 12 approved doctor (usually the duty psychiatrist), and you** — the doctor with previous acquaintance. Plan safety before the visit: park for an easy exit, agree roles, and involve the police only if a specific risk demands it.
- **Least restriction first:** a surprising number of patients in this state will accept informal admission if it is offered warmly and simply. Ask before anyone reaches for a form.
- **Section 2 is the natural fit**: no established diagnosis, unknown response to treatment, 28 days to assess. Section 3 would be premature; section 4 is wrong because a full team can be assembled the same day.
- **Your recommendation must state facts, not conclusions.** Form A4 requires the clinical grounds for believing he has a mental disorder of a nature or degree warranting assessment in hospital, and why detention is necessary for his health or safety or the protection of others — quoting observed behaviour beats adjectives. The two medical examinations must be within **five clear days** of each other.
- **The AMHP makes the application** (Form A2) after interviewing the patient, informs the nearest relative, and arranges conveyance. The recommendations travel with the patient; the hospital scrutinises and formally accepts the papers, and only then is the patient detained. If a form is fundamentally defective, the detention itself can be unlawful — which is why this paperwork exercise is worth the trainees' time.
- **Note for discussion:** had he still been naked in the street when found, police could have used **s136**. At home, s136 is unavailable — a private dwelling needs a s135 warrant if access is refused.

3 The Friday afternoon phone call

A voluntary inpatient who is quietly dying of depression

THE STORY

You are duty doctor one Friday afternoon when a social worker at the local psychiatric hospital calls. Your patient — a 45-year-old woman with recurrent, profound depression — has been on the ward voluntarily for ten days. She lives alone and no one has visited. Her community mental health nurse brought her to outpatients emaciated, virtually mute, rocking and silently crying. She agreed to admission, but on the ward she has refused all solid food and all medication. She says all treatments make her worse and her life is not worth living. The social worker asks you to visit to make a recommendation under the Mental Health Act.

Work through

Q1 Why are *you* — a GP — being asked to attend a psychiatric ward?

Q2 How quickly must you go, and what makes this urgent?

Q3 Which section is most appropriate, and what would you need to be satisfied of?

Q4 Who do you speak to before completing your assessment?

✓ TRAINER'S CRIB — KEY TEACHING POINTS

- **You are the second doctor.** Detention under s2 or s3 needs two recommendations, and where practicable one doctor should have previous acquaintance with the patient. The ward supplies the s12 doctor; you supply the knowledge of the person. This is one of the commonest real-world ways GPs meet the Act.
- **Go the same day.** An emaciated patient refusing food, fluids and medication, expressing that life is not worth living, is at risk of death from suicide *and* from the physical consequences of starvation and dehydration. Friday afternoon is exactly when such patients fall through gaps — do not let the weekend arrive first.
- **Section 3 is usually the better fit here**: the diagnosis (recurrent depressive disorder) is established, the treatment plan is known, and appropriate treatment is available on the ward where she already is. Section 2 would suit genuine diagnostic doubt. Discuss both — the reasoning matters more than the label.
- **Before you sign, speak to and examine the patient yourself**, and speak to the ward team, the responsible psychiatrist, her community nurse and the AMHP; read the notes. For s3 the AMHP must consult the nearest relative — she has no close family, but the AMHP must still take reasonable steps to identify one.
- **If she tries to leave before the assessment is complete,** the ward doctor can hold her under **s5(2)** (72 hours) — a holding power only, with no authority to treat.
- **Stretch point:** severe depression with refusal of food and fluids is one of the situations in which ECT may be considered. Under the Act, ECT has special safeguards (s58A) — it cannot normally be given to a capacitous refusing patient — with a narrow emergency provision (s62). That decision belongs to the specialist team, but the GP should know the safeguards exist.

4 Packing a bag

Serious self-harm, an unwise plan — and the limits of compulsion

THE STORY

A 20-year-old woman with a history of severe self-harm lives in a supported "half-way house" with residential care staff, six weeks after discharge from a detained admission. Before that admission she had swallowed glass, needing a laparotomy; previously she had inserted razor blades into her ears and other body orifices, and had lain down in front of moving traffic several times. Care staff phone you, worried: she is packing a bag, saying she is going travelling with her boyfriend and may not return. She takes no medication but attends weekly one-to-one psychotherapy and an art group.

Work through

Q1 What can you actually advise the care staff to do right now?

Q2 Could she lawfully be detained under the Mental Health Act? Could she *appropriately* be?

Q3 What does "nature or degree" mean, and how does it apply here?

Q4 What would change your answer?

✓ TRAINER'S CRIB — KEY TEACHING POINTS

- **She is an informal resident with, on the information given, capacity.** Adults with capacity are entitled to make decisions others think unwise; a risky lifestyle is not, by itself, grounds for detention. **You must not use the threat of the MHA to control her** — NICE self-harm guidance (NG225) is explicit that coercion and threats of detention harm engagement and outcomes.
- **Could the Act apply in principle? Yes.** Since the 2007 amendments there is a single broad definition of mental disorder, and the old "treatability" test was replaced by the **appropriate medical treatment test** — so a personality disorder can fall within the Act. The legal question is whether her disorder is currently of a *nature or degree* warranting detention, and whether detention is *necessary*. Nothing in the story describes an acute crisis: she is engaging with weekly psychotherapy and making a plan, however worrying.
- **Teach "nature or degree" — it is the exam-and-real-life crux.** *Degree* is how unwell the person is right now; *nature* is the character of the illness over time — a relapsing condition with catastrophic risk when it relapses can justify detention on *nature* even when today's presentation is calm. That is the strongest argument on her side of the scales; the counterweight is her current stability and engagement. Reasonable clinicians can disagree — which is exactly why the decision belongs to a full MHA assessment, not a telephone call.
- **Practical advice to staff:** talk with her rather than obstruct her; staff have no power to detain her. Urgently contact her care coordinator / community mental health team and, if concern escalates, the crisis team; request an urgent review or MHA assessment via the AMHP service if her mental state deteriorates. Encourage a collaborative safety plan and clarify follow-up arrangements if she does travel.
- **What would change the answer:** evidence of acute deterioration — current intent to harm herself, disengagement from therapy, psychotic features, or behaviour like standing in traffic *now*. Then an urgent MHA assessment is required, and if she were in a public place in crisis, police could use s136.

5 Soundproofing the television

A relapsing psychosis, a refused depot and a locked front door

THE STORY

Your practice nurse has given a monthly depot antipsychotic to a 50-year-old man for several years. He has a history of extreme paranoia with ideas of reference from the media and delusions about current affairs. He becomes agitated and verbally aggressive; he has never been violent, though he once answered the door holding a kitchen knife. The nurse tells you he is "not quite right" — she cannot put her finger on it, but he refused his injection, saying it was too soon after the last one. A week later his wife telephones: he will not leave the house, is trying to soundproof the television, and has pulled the plugs from the radio and video players. She wants you to "GET HIM INTO HOSPITAL".

Work through

Q1 What are your options, in order of escalation?

Q2 Who do you involve, and what does each person contribute?

Q3 If he refuses to let anyone in, what then?

Q4 If detention is needed, which section — and why?

✓ TRAINER'S CRIB — KEY TEACHING POINTS

- **Read the early-warning signs.** The nurse's "not quite right" plus a first-ever refusal of the depot *was* the relapse signature — a fortnight's head start that was lost. Teach the practical rule: **a missed or refused depot in a patient with psychosis is never routine. You must act on it the same day** — inform the GP and the community mental health team.
- **Escalate in order:** gather information from the wife (an invaluable informant — and likely the nearest relative); attempt an urgent assessment visit yourself with a planned approach; contact his care coordinator / CMHT and the crisis resolution and home treatment team, who may re-establish treatment at home; if he cannot be assessed or is deteriorating, **request an MHA assessment through the AMHP service**.
- **The locked door:** if he refuses entry, the **AMHP applies to a magistrate for a s135 warrant**. Police then enter with the AMHP and a doctor and may remove him to a place of safety for assessment. **You must not force entry yourself, and you must share the knife history with everyone attending** — risk information is a safety-critical handover, not gossip.
- **Section 3 is usually the answer here**: the diagnosis is long-established, the effective treatment (his depot) is known and available, and the purpose of admission is treatment, not diagnosis. Section 2 would suit a genuinely changed or unclear picture.
- **Manage the wife's expectations honestly.** She cannot simply have him admitted, and neither can you: the decision belongs to a properly constituted assessment. But do not dismiss her — for s3 the AMHP must consult the nearest relative, and her observations are evidence. Safety-net her explicitly: if he becomes threatening or she feels unsafe, she must call 999.
- **Afterwards:** if detained under s3 he is entitled to free s117 aftercare, and the team may consider a Community Treatment Order (s17A) on discharge — supervised community treatment with a power of recall — given that treatment refusal drove this relapse.

On the horizon: the Mental Health Act 2025

The MHA 2025 amends the 1983 Act and will be switched on in phases over several years, beginning with a new Code of Practice and secondary legislation; the first major phase of reforms is expected from around 2027. For GPs, the headlines to watch are:

- A **higher threshold for detention**: under the new criteria for s2 and s3, detention will require that *serious harm* may be caused to the patient or others, with the likelihood of that harm considered.
- The nearest relative replaced by a patient-chosen **nominated person**.
- **Statutory care and treatment plans** for detained patients, and **advance choice documents** that clinicians must consider.
- Tighter limits on detaining **autistic people and people with a learning disability** under s3 without a co-occurring mental disorder.
- **Faster, more frequent Tribunal access** (for example, the s2 appeal window extends from 14 to 21 days when the relevant provision commences), and the removal of police cells and prisons as places of safety.

Until each provision is commenced, you must continue to apply the MHA 1983 as amended — the law in this document.

Sources used to verify this teaching aid (checked July 2026)

- Mental Health Act 1983 (as amended), legislation.gov.uk — ss 1–5, 11–13, 17A, 26, 117, 131, 135–136.
- Mental Health Act 1983: Code of Practice (Department of Health, 2015).
- Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (as amended 2020) and GOV.UK statutory admission forms A1–A11.
- Mental Health Act 2025: GOV.UK Royal Assent announcement (18 December 2025); House of Commons Library briefing CBP-10317; NHS Confederation / NHS Providers explainer (2026); Royal College of Psychiatrists statement (January 2026).
- NHS.uk — the Mental Health Act (sections 135, 136, 5(2), 5(4) and place-of-safety time limits).
- Mental Capacity Act 2005; Deprivation of Liberty Safeguards; SCIE and House of Commons Library DoLS briefings, including the Supreme Court judgment of 2 June 2026 revisiting *Cheshire West*; Care England LPS status update (February 2026).
- NICE NG225 — Self-harm: assessment, management and preventing recurrence (2022).
- NICE NG97 — Dementia: assessment, management and support (managing non-cognitive symptoms).

▲ ENGLAND & WALES ONLY — AND LAW CHANGES

This teaching aid describes the law of **England and Wales**. Scotland (Mental Health (Care and Treatment) (Scotland) Act 2003) and Northern Ireland (Mental Capacity Act (NI) 2016 / Mental Health (NI) Order 1986) use different frameworks. Mental health and capacity law is changing rapidly — the MHA 2025 is being phased in and deprivation-of-liberty case law shifted in June 2026. **You must check the current position and your local policies before acting on any of this in practice.**

◆ DISCLAIMER

This document is provided exclusively for educational and training purposes as a teaching aid. It does not constitute formal clinical or legal guidance. Clinicians must independently verify all medical information, prescribing guidance, procedural protocols and legal requirements against current national guidance, legislation, local policies and relevant regulatory bodies before applying them in practice.

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