TRAINING MANUAL

The Mental Health Act, the Inpatient System and the Restricted Patient System

A rights-based guide for practitioners, advocates and neurodivergent communities in England and Wales

NeuroHub Connect CIC

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Law stated as at 5 November 2026

About this manual

This manual supports NeuroHub Connect training on the Mental Health Act 1983, the mental health inpatient system and the restricted patient system in England and Wales. It is written for advocates, peer supporters, social care and health practitioners, families and neurodivergent people who want to understand how compulsory mental health care works, and how to uphold rights within it.

It is organised in three parts:

- **Part A: The Mental Health Act** sets out the legal framework, the civil sections, police powers, consent to treatment, rights and safeguards, and the reforms made by the Mental Health Act 2025.
- **Part B: The Inpatient System** follows a person through admission, ward life, leave and discharge, with a focus on restrictive practices and on autistic people and people with a learning disability.
- **Part C: The Restricted Patient System** explains how the Secretary of State for Justice oversees patients subject to restrictions, from the routes into hospital through leave, discharge, conditions and recall.

How to use this manual

Each section combines plain-language explanation with boxed features. You can work through the manual in order, or use it as a reference alongside live training.

Box	What it is for
Key point	Learning outcomes and the essentials to take away
In practice	Practical guidance for advocates and practitioners
Rights lens	A rights-based, neurodiversity-affirming reading of the law and practice
Law in transition	Changes made by the Mental Health Act 2025, and whether they are in force
From the MHCS	What the Ministry of Justice Mental Health Casework Section has said about its own practice
Reflect	Questions for individual reflection or group discussion

Sources and currency

The law is stated as at 5 November 2026. Part C draws on the HMPPS Mental Health Casework Section's webinar *An Introduction to the Restricted Patient System* (5 November 2026), its guidance *Conditionally Discharged Patients: Supervision and Reporting* (October 2025) and the Ministry of Justice's *Restricted Patients Statistics, England and Wales 2025* (April 2026). A full list of sources is at Appendix D.

> **LAW IN TRANSITION** **Important**
>
> This manual is a training resource, not legal advice. Mental health law is changing: most of the Mental Health Act 2025 is not yet in force, and a new Code of Practice is being prepared. Always check current legislation, the Code of Practice and local policy, and seek specialist legal advice about individual cases.

Language and position

We use identity-first language (autistic people, rather than "people with autism"), because many autistic people prefer it. We use "learning disability" because it is the term used in law and services. We use "patient" where the law does, while recognising that many people subject to the Act reject that label.

We write from a rights-based, neurodiversity-affirming position. Compulsion is something that must always be justified, minimised and scrutinised; it is never simply assumed to be care. Where systems confine people in the name of care, we call this carcerative care, and we name it so that it can be questioned.

Contents

PART A The Mental Health Act

1 Foundations
2 Civil detention: Part 2 of the Act
3 Police powers and places of safety
4 Key people and roles
5 Consent to treatment: Part 4 of the Act
6 Rights and safeguards
7 The Mental Health Act 2025

PART B The Inpatient System

8 The inpatient landscape
9 The inpatient journey
10 Restrictive practices
11 Autistic people and people with a learning disability in hospital
12 Inequality and the Act

PART C The Restricted Patient System

13 Introducing restricted patients
14 Routes into the restricted system
15 The Secretary of State's role for detained patients
16 Risk, victims and public protection
17 Tribunals for restricted patients
18 Discharge
19 Conditions of discharge
20 Supervision in the community
21 Recall
22 Working with the Mental Health Casework Section
23 A rights-based lens on the restricted system

Appendix A Glossary
Appendix B Quick reference to sections
Appendix C Knowledge check
Appendix D Sources and further reading

About NeuroHub Connect

PART A

The Mental Health Act

The legal framework for assessment, detention and compulsory treatment in England and Wales, and the reforms now under way.

IN THIS PART

1 Foundations
2 Civil detention: Part 2 of the Act
3 Police powers and places of safety
4 Key people and roles
5 Consent to treatment: Part 4 of the Act
6 Rights and safeguards
7 The Mental Health Act 2025

1 Foundations

KEY POINT **Learning outcomes for Part A**

By the end of Part A you should be able to:

- describe the purpose and structure of the Mental Health Act 1983 and how it relates to human rights and mental capacity law;
- distinguish the main civil sections and police powers, and their time limits;
- explain the consent to treatment rules and the main safeguards available to detained people;
- summarise the Mental Health Act 2025 reforms and say which of them are in force.

1.1 What the Mental Health Act does

The Mental Health Act 1983 ("the Act") is the law in England and Wales that allows people to be assessed, detained in hospital and treated for mental disorder without their consent, and in some cases supervised in the community under compulsory powers. It was significantly amended in 2007, and the Mental Health Act 2025 amends it again. The 1983 Act remains the source law: the 2025 Act changes its wording rather than replacing it. Scotland and Northern Ireland have their own, separate mental health legislation.

The Act is organised into Parts. The ones you will meet most often are:

Part	What it covers
Part 1	Definitions, including "mental disorder"
Part 2	Civil detention, guardianship and community treatment orders
Part 3	People involved in criminal proceedings or under sentence (the "forensic" sections), including restricted patients
Part 4	Consent to treatment for detained patients
Part 4A	Treatment of community patients who have not been recalled to hospital
Part 5	Mental Health Tribunals
Part 8	Functions of local authorities and others, including approved mental health professionals and section 117 aftercare
Part 10	Miscellaneous provisions, including information for patients, advocacy and police powers (sections 135 and 136)

1.2 Key definitions

Mental disorder means "any disorder or disability of the mind" (section 1). The definition is deliberately broad. Dependence on alcohol or drugs is not, on its own, a mental disorder for the purposes of the Act.

Learning disability means "a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning". For most longer-term powers (section 3, guardianship, community treatment orders and hospital orders), a learning disability only counts if it is "associated with abnormally aggressive or seriously irresponsible conduct".

Autism is currently treated as a mental disorder in its own right. Unlike learning disability, it carries no extra conduct requirement, so autism alone can currently ground detention for treatment under section 3. This is one of the most significant things the Mental Health Act 2025 will change (see 7.4).

Appropriate medical treatment must be available before a person can be detained under section 3 and most Part 3 sections. "Medical treatment" is broad: it includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. Its purpose must be to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms (section 145).

> RIGHTS LENS **Why definitions matter**
>
> The breadth of "mental disorder" and "medical treatment" has allowed autistic people and people with a learning disability to be detained for long periods in places that offer little that is genuinely therapeutic. Advocates can usefully ask three questions. What is the disorder said to be? What treatment is actually being provided? How is it expected to help this person?

1.3 The Code of Practice and guiding principles

The Act is supported by statutory Codes of Practice: the *Mental Health Act 1983: Code of Practice* (England, 2015) and the *Mental Health Act 1983: Code of Practice for Wales* (2016). Professionals must have regard to the Code, and should only depart from it for cogent reasons, which they should record (*R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58).

The English Code sets out five guiding principles: least restrictive option and maximising independence; empowerment and involvement; respect and dignity; purpose and effectiveness; and efficiency and equity.

> LAW IN TRANSITION **New statutory principles**
>
> The Mental Health Act 2025 will replace these with four principles: choice and autonomy; least restriction; therapeutic benefit; and the person as an individual. A new Code of Practice is being prepared to reflect the reforms. Until it is published and the relevant provisions commenced, the current Codes continue to apply.

1.4 Human rights, capacity and equality

The Act operates within a wider legal framework.

- **Human Rights Act 1998.** Public authorities must act compatibly with the European Convention on Human Rights, especially Article 2 (right to life), Article 3 (freedom from torture and inhuman or degrading treatment), Article 5 (liberty), Article 8 (private and family life) and Article 14 (discrimination). Since 6 April 2026, private providers delivering NHS-arranged inpatient mental health care or section 117 aftercare are also bound by the Human Rights Act when doing so.
- **Mental Capacity Act 2005.** This governs decisions for people aged 16 and over who lack capacity to make a particular decision. A deprivation of liberty in a hospital or care home for someone lacking capacity, outside the Mental Health Act, is authorised under the Deprivation of Liberty Safeguards (DoLS) or by the Court of Protection. The planned Liberty Protection Safeguards have not been implemented.
- **What counts as a deprivation of liberty.** On 2 June 2026, in *A Reference by the Attorney General for Northern Ireland* [2026] UKSC 16 ("AGNI"), the Supreme Court overruled the *Cheshire West* "acid test" (continuous supervision and control, and not free to leave), replacing it with a multifactorial approach. Interim government guidance has been issued, and practice is still settling.

- **Equality Act 2010.** Services must make reasonable adjustments for disabled people, including autistic people and people with a learning disability, and must not discriminate.

> **IN PRACTICE** **Mental Health Act or Mental Capacity Act?**
>
> Where a person needs to be in hospital for treatment of mental disorder and objects, or meets the criteria for detention, the Mental Health Act is usually the relevant framework. The interface between the two Acts is complex, and the English Code of Practice (chapter 13) gives guidance. A useful starting question is always: which legal authority is being relied on to restrict this person, and has it been properly applied?

2 Civil detention: Part 2 of the Act

2.1 Assessment for detention

An application for detention under Part 2 is usually made by an **approved mental health professional (AMHP)**, supported by medical recommendations. The nearest relative can make an application, but this is rare and the Code of Practice discourages it. AMHPs are often social workers; nurses, occupational therapists and psychologists can also train as AMHPs, but doctors cannot.

The AMHP must interview the person "in a suitable manner", consider all the circumstances, and be satisfied that detention in hospital is the most appropriate way of providing the care and treatment the person needs. They must consider less restrictive alternatives, such as home treatment or crisis services. The AMHP brings an independent, social perspective and is not obliged to apply just because doctors have recommended detention.

At least one of the medical recommendations must come from a doctor approved under **section 12** as having special experience in the diagnosis or treatment of mental disorder. Where practicable, one should come from a doctor who already knows the person.

> **IN PRACTICE** **Reasonable adjustments in Mental Health Act assessments**
>
> Assessments are frightening and sensory-heavy. Adjustments might include:
>
> - allowing a trusted person to be present;
> - using the person's preferred communication method, including AAC, text or written questions;
> - reducing the number of people in the room, and the noise and light;
> - giving processing time, and explaining what is happening and why;
> - recognising that autistic distress, shutdown or meltdown is not, in itself, evidence of mental illness.

2.2 The main civil sections

Section	Purpose	Maximum length	How it is made	Tribunal application
2	Admission for assessment (and treatment)	28 days; cannot be renewed	AMHP application plus two medical recommendations	Once, within the first 14 days
3	Admission for treatment	6 months; renewable for 6 months, then 12 months at a time	AMHP application plus two medical recommendations; appropriate medical treatment must be available; nearest relative can object	Once in each period of detention

Section	Purpose	Maximum length	How it is made	Tribunal application
4	Emergency admission for assessment	72 hours	AMHP application plus one medical recommendation, in cases of urgent necessity	Can apply, though it usually ends or converts first
5(2)	Holding power for an informal inpatient	72 hours	Report by the doctor or approved clinician in charge of treatment, or their nominee	No
5(4)	Nurse's holding power for an informal inpatient	6 hours	A registered mental health or learning disability nurse	No
7	Guardianship in the community	6 months; renewable	AMHP application plus two medical recommendations; the guardian is the local authority or an approved person	Once in each period
17A	Community treatment order (CTO)	6 months; renewable for 6 months, then 12 months at a time	Responsible clinician, with AMHP agreement, for people detained under section 3 or an unrestricted hospital order	Once in each period

2.3 Section 2

Section 2 allows a person to be detained for up to 28 days for assessment, or for assessment followed by treatment. The criteria are that the person is suffering from mental disorder of a nature or degree that warrants detention in hospital for assessment for at least a limited period, and that they ought to be detained in the interests of their own health or safety, or to protect other people. Section 2 cannot be renewed. If further detention is thought necessary, a section 3 assessment must take place.

2.4 Section 3

Section 3 authorises detention for treatment for up to six months, renewable. The criteria are that:

- the person is suffering from mental disorder of a nature or degree that makes treatment in hospital appropriate;
- treatment is necessary for their health or safety or for the protection of others, and cannot be provided unless they are detained; and
- appropriate medical treatment is available.

The AMHP must consult the nearest relative where practicable. The nearest relative can block a section 3 application by objecting, although the AMHP can apply to the county court to displace them. To renew detention, the responsible clinician must examine the person in the last two months of the period and, with the agreement of another professional involved in their treatment, confirm the criteria are still met (section 20).

People detained under section 3, and certain Part 3 sections, are entitled to free **section 117 aftercare** when they leave hospital (see 6.6).

2.5 Holding powers

Sections 5(2) and 5(4) allow a person who is already an inpatient to be held while an assessment is arranged. They are not treatment sections and do not authorise compulsory treatment under Part 4. They cannot be used for someone in an emergency department who has not been admitted to a ward.

2.6 Leave, absence and transfer

- **Section 17 leave** allows a detained patient to be away from hospital lawfully, with or without an escort, for a set period or indefinitely, and with conditions. Only the responsible clinician can grant it. For restricted patients, the Secretary of State for Justice must also consent (see Part C).
- **Section 18** allows a patient who is absent without leave (AWOL), or who does not return from leave, to be taken into custody and returned.
- **Section 19** allows transfer between hospitals, and between hospital and guardianship.

2.7 Community treatment orders

A CTO allows a person who has been detained under section 3 (or an unrestricted hospital order) to leave hospital subject to conditions and to recall. The responsible clinician can recall the person to hospital for up to 72 hours (section 17E) and, with an AMHP's agreement, revoke the CTO, returning them to detention (section 17F). CTOs are used disproportionately for Black people (see 12.1). People on CTOs are not restricted patients.

2.8 Ending detention

Detention can be ended by:

- the responsible clinician, at any time (section 23);
- the hospital managers, usually through a panel of associate hospital managers;
- the nearest relative, for section 2 and section 3 patients, by giving 72 hours' written notice, unless the responsible clinician issues a barring report saying the person would be likely to act in a manner dangerous to themselves or others (section 25);
- the Tribunal (see 6.3).

3 Police powers and places of safety

3.1 Section 135

- **Section 135(1).** On an AMHP's application, a magistrate can issue a warrant allowing police to enter premises, by force if necessary, and remove a person believed to have a mental disorder, who is being ill-treated or neglected or is unable to care for themselves, to a place of safety for assessment.
- **Section 135(2).** A magistrate can issue a warrant allowing police to enter premises to take or retake a patient who is liable to be taken into custody, such as someone who is AWOL. Police need this warrant to force entry to a private dwelling, including when executing a restricted patient's recall warrant (see 21.3).

3.2 Section 136

Section 136 allows a police officer to remove a person who appears to be suffering from mental disorder and to be in immediate need of care or control to a place of safety, from anywhere other than a private dwelling. Before using it, the officer must, where practicable, consult a registered health professional. The person can be held for up to 24 hours (extendable by up to 12 hours by a doctor in limited circumstances) so that they can be assessed by a doctor and an AMHP.

3.3 Places of safety

A place of safety should usually be a health-based place of safety, often called a "section 136 suite". Since reforms introduced by the Policing and Crime Act 2017, a police station can never be used as a place of safety for anyone under 18, and can only be used for adults in exceptional circumstances.

LAW IN TRANSITION **Police stations and prisons**

When commenced, the Mental Health Act 2025 will remove police stations and prisons as places of safety altogether, and end the courts' power to remand a person to prison for their own protection where the concern is solely their mental health.

RIGHTS LENS **Policing, race and the Act**

Black people are far more likely than White people to be subject to police powers under the Act, as well as to detention and CTOs (see 12.1). Scrutiny of how section 136 is used locally, and who it is used on, is part of the Patient and Carer Race Equality Framework.

4 Key people and roles

Role	Who they are	What they do
Approved mental health professional (AMHP)	A social worker, nurse, occupational therapist or psychologist approved by a local authority	Coordinates Mental Health Act assessments, makes applications, considers alternatives, agrees CTOs
Responsible clinician (RC)	The approved clinician with overall responsibility for the person's case; often a consultant psychiatrist, but can be a psychologist, nurse, occupational therapist or social worker	Renews detention, grants leave, discharges, makes CTOs
Approved clinician (AC)	A professional approved to act as a responsible clinician	Makes treatment decisions under Part 4
Section 12 doctor	A doctor approved as having special experience in mental disorder	Gives medical recommendations for detention
Nearest relative (NR)	A relative identified by the statutory list in section 26; not chosen by the person	Rights to information and consultation, to object to section 3, to apply, and to order discharge
Independent mental health advocate (IMHA)	A specialist independent advocate	Helps qualifying patients understand and exercise their rights
Second opinion appointed doctor (SOAD)	An independent doctor appointed by the Care Quality Commission (England) or Healthcare Inspectorate Wales	Certifies certain treatments under Part 4
Hospital managers	The organisation detaining the person, often acting through panels of associate managers	Duties on information and reviews; can discharge
The Tribunal	First-tier Tribunal (Mental Health) in England; Mental Health Review Tribunal for Wales	Independent judicial review of detention

Role	Who they are	What they do
Regulators	Care Quality Commission (England); Healthcare Inspectorate Wales	Monitor use of the Act, visit wards, appoint SOADs, consider complaints

4.1 The nearest relative

The nearest relative is identified by a fixed hierarchy in section 26: spouse or civil partner (including a partner who has lived with the person for six months or more); 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 person takes priority, and within each category, the elder takes priority. A non-relative who has lived with the person for five years or more can also qualify.

The person cannot choose their nearest relative. They, or others, can apply to the county court to displace an unsuitable nearest relative (section 29).

> **LAW IN TRANSITION** **The nominated person**
>
> The Mental Health Act 2025 will replace the nearest relative with a **nominated person** chosen by the patient (see 7.5). Until this is commenced, the nearest relative rules continue to apply.

5 Consent to treatment: Part 4 of the Act

5.1 What Part 4 covers

Part 4 allows certain treatment for mental disorder to be given to detained patients without their consent, subject to safeguards. It does not authorise treatment for physical health conditions unrelated to the mental disorder; those are governed by consent or the Mental Capacity Act.

Part 4 does not apply to people held under sections 4, 5(2), 5(4), 35, 135 or 136, or to conditionally discharged restricted patients. They keep the same right as anyone else to refuse treatment.

5.2 The safeguards

Section	Treatment	Rule
57	Neurosurgery for mental disorder; surgical implantation of hormones to reduce male sex drive	Needs the person's consent **and** a SOAD certificate. Applies to informal patients too.
58	Medication for mental disorder, after three months from first administration during the period of detention	Needs either the person's valid consent, certified by the approved clinician or a SOAD, or a SOAD certificate that the treatment is appropriate
58A	Electroconvulsive therapy (ECT)	A refusal by a person with capacity must be respected, except for urgent treatment under section 62. For a person lacking capacity, a SOAD must certify, and ECT cannot conflict with a valid advance decision, a decision of an attorney or deputy, or a Court of Protection order. Applies to under-18s even if informal.
62	Urgent treatment	Allows treatment that would otherwise need a certificate in an emergency, within strict limits

Section	Treatment	Rule
63	Other treatment for mental disorder	Treatment not covered above (eg; medication in the first three months, nursing, psychological therapy) can be given without consent by, or under the direction of, the approved clinician

LAW IN TRANSITION **Treatment safeguards under the 2025 Act**

When commenced, the 2025 Act will: shorten the three-month medication period to two months; strengthen safeguards where a person with capacity refuses treatment, or where treatment conflicts with their advance wishes, including faster access to a second opinion; tighten the rules on urgent treatment; allow some assessments to take place remotely; and introduce statutory care and treatment plans.

6 Rights and safeguards

6.1 The right to information

Hospital managers must take practicable steps to make sure a detained person understands, as soon as practicable, the section they are held under, what it means, and their rights, including the right to apply to the Tribunal and to have an IMHA (section 132). Information must be given both orally and in writing, should be in an accessible format, and should be repeated. The nearest relative must usually be given a copy unless the person objects.

6.2 Independent mental health advocates

IMHAs (sections 130A to 130D) are available to "qualifying patients". These are people detained under the Act (except under sections 4, 5(2), 5(4), 135 and 136), on a CTO, in guardianship, or conditionally discharged restricted patients. Informal patients being considered for section 57 treatment, and under-18s being considered for ECT, also qualify.

An IMHA can visit and interview the person in private, see relevant records (with consent, or where appropriate if the person lacks capacity), and meet the professionals involved. In Wales, the Mental Health (Wales) Measure 2010 extends IMHA access to informal inpatients.

RIGHTS LENS **Advocacy is a right, not a favour**

IMHA access is a legal entitlement, and staff have a duty to tell qualifying patients about it. The 2025 Act will move towards an opt-out model, with advocacy offered automatically and extended to informal patients in England. Advocates working with autistic people should check that information about rights has actually been understood, not just delivered.

6.3 The Tribunal

The Tribunal is an independent judicial body: in England, the First-tier Tribunal (Mental Health); in Wales, the Mental Health Review Tribunal for Wales. A panel usually includes a judge, a medical member and a specialist lay member. People are entitled to free legal representation through legal aid, which is not means-tested for Tribunal proceedings. The Tribunal must discharge if it is not satisfied that the criteria for detention are met.

Automatic references (section 68) mean that people who do not apply are still reviewed. Hospital managers must refer a person detained under section 3 if they have not had a Tribunal hearing within the first six months, and then whenever three years pass without one (one year for under-18s). They must also refer when a CTO is revoked.

> **LAW IN TRANSITION** **More frequent Tribunal review**
>
> When commenced, the 2025 Act will extend the section 2 application window from 14 to 21 days, shorten detention periods so that people can apply more often, increase the frequency of automatic references, and give Tribunals power to make recommendations about aftercare and treatment.

6.4 Hospital managers' reviews

Hospital managers can discharge most detained patients, and must review detention when it is renewed. Their hearings are less formal than the Tribunal. They cannot discharge a restricted patient without the Secretary of State's consent.

6.5 Complaints and monitoring

Complaints should usually go to the provider first. Detained people and their representatives can also complain to the Care Quality Commission (England) or Healthcare Inspectorate Wales about how Mental Health Act powers have been used. Unresolved NHS complaints can go to the Parliamentary and Health Service Ombudsman in England, or the Public Services Ombudsman for Wales.

6.6 Section 117 aftercare

Section 117 places a joint duty on the integrated care board (in Wales, the local health board) and the local authority to provide aftercare to people who have been detained under section 3, 37, 45A, 47 or 48, including when they leave hospital on a CTO or are conditionally discharged. Aftercare must be free of charge. It must meet a need arising from or related to the person's mental disorder, and aim to reduce the risk of deterioration and readmission. The duty continues until both bodies are satisfied the person no longer needs the services. It should not be withdrawn simply because the person is doing well, and it cannot end while they are on a CTO.

> **IN PRACTICE** **Check section 117 eligibility early**
>
> Many people do not know they are entitled to section 117 aftercare, or are wrongly charged for care that should be free. Ask at admission and before discharge: is this person eligible, who are the responsible bodies, and what is in the aftercare plan?

7 The Mental Health Act 2025

7.1 Why reform?

The Independent Review of the Mental Health Act, chaired by Sir Simon Wessely, reported in December 2018. It found rising detentions, stark racial inequalities, the inappropriate detention of autistic people and people with a learning disability, and too little say for people over their own care. The Mental Health Act 2025 received Royal Assent on 18 December 2025. It amends the 1983 Act, and most of its provisions will be brought into force in stages over around ten years, depending on workforce, funding and the new Code of Practice.

7.2 What is in force now

Change	Status at 5 November 2026
Conditional discharge of restricted patients with conditions amounting to a deprivation of liberty ("supervised discharge"), with mandatory Tribunal references	**In force** from 18 February 2026
Wider powers to transfer people from immigration detention and youth detention accommodation to hospital (section 48)	**In force** from 18 February 2026
Human Rights Act applies to private providers of NHS-arranged inpatient mental health care and section 117 aftercare	**In force** from 6 April 2026
Review of when the CQC is notified of children admitted to hospital for mental disorder	**In force** from 6 April 2026
Statutory 28-day time limit for transfers from prison and immigration detention to hospital	Not yet in force
New detention criteria (serious harm and therapeutic benefit)	Not yet in force
Four statutory principles	Not yet in force
Nominated person replacing the nearest relative	Not yet in force
Advance choice documents and statutory care and treatment plans	Not yet in force
Opt-out advocacy and IMHA access for informal patients	Not yet in force
Shorter detention periods and more frequent Tribunal access	Not yet in force
Removal of police stations and prisons as places of safety	Not yet in force
Ending section 3 detention on the basis of autism or learning disability alone	Not yet in force; dependent on adequate community provision

LAW IN TRANSITION **Check before you rely on it**

Provisions are being commenced in stages through regulations. Before relying on any part of the 2025 Act, check legislation.gov.uk for the latest commencement regulations, and look out for the new Code of Practice.

7.3 New detention criteria

When commenced, detention under sections 2 and 3 (and the nurse's holding power) will require that **serious harm** may be caused to the health or safety of the person or another person unless they are detained, taking into account the nature, degree and likelihood of the harm. For section 3, there must also be a **reasonable prospect of therapeutic benefit**: "appropriate medical treatment" will be redefined so that it must have a reasonable prospect of alleviating, or preventing deterioration in, the disorder or its symptoms. The Tribunal's discharge criteria will mirror the new tests.

7.4 Autism and learning disability

The 2025 Act introduces separate definitions of "autism", "learning disability" and "psychiatric disorder" (meaning a mental disorder other than autism or learning disability). When commenced:

- autism or a learning disability alone will no longer be grounds for detention for treatment under section 3, or for a CTO; a co-occurring psychiatric disorder will be required;
- section 2 detention for assessment will remain available;

- people in the criminal justice system can still be detained under Part 3 on the basis of autism or a learning disability;
- integrated care boards and local authorities in England will have duties to keep registers of autistic people and people with a learning disability who are at risk of admission, building on existing dynamic support registers, and to take them into account in commissioning;
- care (education) and treatment reviews will be placed on a statutory footing for autistic people and people with a learning disability who are detained.

The government has said the section 3 change will only be commenced once there is sufficient community provision to support people safely.

> **RIGHTS LENS** **Unintended consequences**
>
> Rights organisations and autistic advocates have warned that, without real investment in community support, the reform could push people into other routes: the Mental Capacity Act; repeated section 2 admissions; diversion into the criminal justice system; or "diagnostic substitution", where autistic distress is relabelled as a psychiatric disorder so that detention remains lawful. Advocates should scrutinise any new psychiatric diagnosis made during an admission, and ask what evidence supports it.

7.5 The nominated person

The nominated person will replace the nearest relative. A person with capacity (or, for a child, competence) will choose who they want, subject to suitability. If they cannot or have not chosen, an AMHP can appoint an interim nominated person. The nominated person will be consulted about detention, treatment and discharge, receive key information, be able to object to certain applications and to order discharge (subject to barring), and can be displaced by the court if unsuitable.

7.6 A stronger voice for the person

- **Advance choice documents** will allow people to record their wishes about care and treatment ahead of a crisis. Clinicians must have regard to them, and integrated care boards (local health boards in Wales) will have duties to make arrangements so that people know about them and can make them.
- **Care and treatment plans** will become a statutory requirement for detained patients, setting out the purpose of each treatment and how it is expected to help.
- **Advocacy** will move to an opt-out model for detained patients and be extended to informal inpatients.
- **Prison transfers** will be subject to a statutory 28-day time limit.

> **REFLECT**
>
> Which of the 2025 Act reforms do you think will make the biggest difference to the people you support, and what would need to be in place locally for that difference to be real?

PART B

The Inpatient System

How mental health inpatient services are organised, what happens during an admission, and how to protect rights on the ward.

IN THIS PART

8 The inpatient landscape
9 The inpatient journey
10 Restrictive practices
11 Autistic people and people with a learning disability in hospital
12 Inequality and the Act

8 The inpatient landscape

KEY POINT **Learning outcomes for Part B**

By the end of Part B you should be able to:

- describe the main types of mental health inpatient service, including secure services;
- follow the stages of an admission, from arrival to discharge and aftercare;
- explain the legal framework for restrictive practices, and how to challenge their misuse;
- identify the particular risks facing autistic people and people with a learning disability in hospital, and practical ways to reduce them.

8.1 Types of inpatient service

Service	Who it is for	Notes
Acute adult wards	Adults in mental health crisis	Most admissions, informal and detained. Bed pressures lead to out-of-area placements.
Psychiatric intensive care units (PICUs)	People who cannot be safely cared for on an open acute ward	Higher staffing and locked; stays are intended to be short
Children and young people's inpatient units	Under-18s	Hospital managers must ensure an age-appropriate environment (section 131A); children should only be placed on adult wards in exceptional circumstances
Specialist units	eg; eating disorders, perinatal (mother and baby), older adults	Often regional, so may be far from home
Learning disability and autism inpatient units	Autistic people and people with a learning disability	Including "assessment and treatment units". The subject of repeated abuse scandals; national policy aims to reduce reliance on them.
Rehabilitation units	People with complex, longer-term needs	Includes "locked rehabilitation", much of it in the independent sector
Secure (forensic) services	People who are considered to pose a risk to others, often admitted through the criminal justice system	Low, medium and high security (see 8.2)

8.2 Secure services

Level	Typical setting	Notes
Low secure	Locked wards with enhanced physical and relational security	Often a step down from medium secure, or a diversion from prison
Medium secure	Regional units with higher perimeter security	Many restricted patients spend time here

Level	Typical setting	Notes
High secure	Ashworth (Merseyside), Broadmoor (Berkshire) and Rampton (Nottinghamshire)	For people who require treatment under conditions of high security because of their dangerous, violent or criminal propensities. The national women's high secure service is at Rampton. Wales has no high secure hospital; Welsh patients who need high security are cared for in England.

Security is usually described in three dimensions: **physical** (walls, airlocks, locks); **procedural** (searches, rules, item restrictions); and **relational** (the quality of relationships and how well staff know each person). Relational security is the dimension most open to improvement through neurodiversity-affirming practice, and the one most damaged by high staff turnover.

8.3 Informal and detained admission

Many inpatients are informal, often called "voluntary". Informal status should mean genuine freedom: the right to leave, to refuse treatment and to have visitors. In practice, informal patients can face locked doors, pressure to stay, or the implied threat of detention ("if you try to leave, we will section you"). The Code of Practice is clear that informal patients should be told they can leave, and that coercion undermines informal status.

A person who lacks capacity to consent to admission cannot genuinely be an informal patient. If they are being kept in hospital, the Mental Health Act or the Mental Capacity Act must be considered.

> **IN PRACTICE** **Checking informal status**
>
> If you support an informal inpatient, ask: have they been told, in a way they understand, that they can leave? Is the ward door locked, and if so, how do they get out? Have they ever been told they will be detained if they try to leave? If the answers suggest they are not free, raise it with the ward manager and consider whether their legal status needs to be reviewed.

8.4 Out-of-area placements and the independent sector

A significant proportion of inpatient care, especially secure, rehabilitation, and learning disability and autism services, is provided by independent providers commissioned by the NHS. Out-of-area placements separate people from family, friends, community and local services, and are associated with longer stays and harder discharges. Since 6 April 2026, independent providers delivering NHS-arranged inpatient care must act compatibly with the Human Rights Act.

9 The inpatient journey

9.1 Admission

On admission, staff should:

- explain the person's legal status and rights (section 132), and repeat this later;
- carry out a physical health check;
- complete an initial risk assessment and care plan with the person;
- identify communication needs, sensory needs and reasonable adjustments;
- involve family and carers, with the person's consent;
- tell the person about advocacy, and refer to the IMHA service where appropriate.

Restrictions on personal belongings, including mobile phones, should be individual, justified and reviewed, not applied to everyone by default.

9.2 Care planning and ward life

Care should be planned with the person, not for them. In England, the Care Programme Approach is being replaced by personalised care planning under the Community Mental Health Framework. In Wales, the Mental Health (Wales) Measure 2010 gives people a statutory right to a care and treatment plan.

Key decisions are often made at ward rounds or multidisciplinary reviews. The person has the right to attend and to be supported.

> **IN PRACTICE** **Making ward rounds accessible**
>
> Ward rounds can be overwhelming: a room of professionals, little notice and rapid decisions. Ask for:
>
> - the date and time in advance;
> - the chance to submit questions or views in writing beforehand;
> - a smaller group, or a meeting with the responsible clinician alone;
> - an advocate or supporter to be present;
> - written outcomes afterwards, in plain language;
> - time to think and respond.

9.3 Observation and engagement

Observation levels range from general observation to continuous observation within eyesight or arm's length. Observation should be a form of therapeutic engagement, not surveillance, and should be reviewed regularly. For autistic people, constant close observation can be a significant sensory and social stressor in its own right, and may escalate the distress it is meant to manage.

9.4 Leave

Section 17 leave is often the first step towards discharge. Leave should be individual and graduated. Cancelled leave, often because of staffing, is a common and serious grievance: it can set back recovery and feel punitive. Leave should never be withheld as a sanction.

9.5 Discharge and aftercare

Good discharge planning starts at admission. It should cover accommodation, support, finances, medication, a crisis plan and section 117 entitlements. NHS England expects people discharged from inpatient mental health care to be followed up within 72 hours. Delayed discharge, where someone stays in hospital because there is nowhere suitable for them to go, undermines the least restrictive principle in practice and should always be escalated.

10 Restrictive practices

10.1 What counts as a restrictive practice

Restrictive practices are actions that restrict a person's movement, liberty or freedom to act independently. They include:

- **physical restraint**: holding a person to restrict their movement; prone (face-down) restraint carries a particular risk of death and should be avoided;

- **mechanical restraint**: belts, cuffs or other devices;
- **chemical restraint**: medication used to control behaviour, including rapid tranquillisation;
- **seclusion**: supervised confinement in a room, which may be locked, to contain severely disturbed behaviour likely to cause harm to others;
- **long-term segregation**: keeping a person apart from others on the ward for a prolonged period;
- **blanket restrictions**: rules applied to everyone regardless of individual risk, eg; fixed bedtimes, no phones, locked kitchens;
- **coercion**: the threat of restraint, detention or loss of privileges.

10.2 The legal framework

- The Code of Practice (England, chapter 26) sets standards for restraint, seclusion and long-term segregation, including review requirements. Seclusion must never be used as a punishment or threat, or because of staff shortages.
- The **Mental Health Units (Use of Force) Act 2018**, known as Seni's Law after Olaseni Lewis, who died after prolonged restraint in 2010, applies in England. It requires every mental health unit to appoint a responsible person, publish a policy on reducing the use of force, give patients information about their rights in relation to force, train staff, record every use of force, and have regard to national guidance on investigating deaths. Police attending mental health units must wear body cameras where reasonably practicable.
- Articles 3, 5, 8 and 14 of the European Convention on Human Rights all apply. Unjustified or excessive restraint or seclusion can amount to inhuman or degrading treatment.

10.3 Reducing restrictive practice

Approaches that reduce restriction include trauma-informed care; proactive, person-centred support planning; the Restraint Reduction Network Training Standards; the HOPE(S) model for working with people in long-term segregation; sensory-informed environments; and debriefs that genuinely involve the person.

> RIGHTS LENS **The NeuroHub position**
>
> We do not accept restraint, seclusion and segregation as forms of care. They are failures of support that cause lasting trauma, particularly for autistic people, whose distress is frequently misread as aggression. Every use should be treated as an incident requiring review, and every person subject to a restrictive practice should have access to independent advocacy and a clear route to challenge it.

10.4 Questions an advocate can ask

- What legal authority is being relied on for this restriction?
- Is it individual, proportionate and time-limited? When will it next be reviewed, and by whom?
- What less restrictive alternatives were tried first?
- Has the person, and their nearest relative, been told how to challenge it?
- Is each use of force recorded, and has the person had a debrief?
- Does the care plan address the causes of distress, including sensory and communication needs?

11 Autistic people and people with a learning disability in hospital

11.1 The numbers

At the end of July 2026, 2,115 autistic people and people with a learning disability were in mental health inpatient care in England, including 215 children and young people under 18. Nearly half (49%) had a total length of stay of more than two years, and 315 had been in hospital for more than ten years (NHS England, Learning Disability Services Statistics).

11.2 A history of harm

Year	What happened
2011	**Winterbourne View.** A BBC Panorama investigation exposed abuse at a private hospital near Bristol, leading to the Transforming Care programme.
2015	**Building the Right Support.** A national plan to close inpatient beds and develop community services.
2019	**Whorlton Hall.** Panorama revealed abuse at a hospital in County Durham.
2020	**Out of sight: who cares?** The CQC's review of restraint, seclusion and segregation found people held in segregation for years in poor conditions.
2022	**Edenfield Centre.** Panorama exposed abuse at an NHS mental health unit in Greater Manchester, showing the problem is not confined to independent providers or specialist learning disability services.
2023	**"My heart breaks".** Baroness Hollins' final report on people with a learning disability and autistic people in long-term segregation found that solitary confinement in hospital has no therapeutic benefit, and called for urgent action.

National targets to reduce the number of autistic people and people with a learning disability in hospital have repeatedly been missed.

11.3 Why hospital so often harms autistic people

- **The sensory environment.** Noise, alarms, fluorescent lighting, smells, crowding and a lack of retreat space can cause severe and sustained distress.
- **Unpredictability.** Changing staff, cancelled leave and unexplained decisions remove the predictability many autistic people rely on.
- **Diagnostic overshadowing.** Physical pain, trauma or sensory overload are misread as "behaviour" or as "part of their autism", and genuine mental health needs are missed.
- **Misinterpretation of distress.** Meltdowns, shutdowns and self-protective responses are treated as aggression or non-compliance, leading to restraint.
- **Communication barriers.** Information about rights is given verbally at a time of overwhelm, and services rely on spoken language.
- **Escalating restriction.** Restriction causes distress; distress is recorded as risk; risk is used to justify further restriction. This cycle can trap people in hospital for years.

IN PRACTICE **Practical adjustments on the ward**

- Ask for, and use, a communication profile or hospital passport.
- Agree a sensory plan: quiet space, lighting, ear defenders, weighted items, and access to preferred objects and activities.
- Give information in advance, in writing or visually, and allow processing time.
- Keep routines and staff consistent where possible, and give warning of changes.
- Involve the people who know the person best.
- Use autistic-led, neurodiversity-affirming training. The Health and Care Act 2022 requires CQC-registered providers to ensure staff receive training on learning disability and autism appropriate to their role; the Oliver McGowan Mandatory Training is the government's recommended package.

11.4 Safeguards specific to this group

- **Care (education) and treatment reviews (C(E)TRs).** Independent reviews, including an expert by experience, of whether a person needs to be in hospital and what is needed for them to leave. They should take place before admission where possible (community reviews) and regularly during an admission.
- **Dynamic support registers.** Local registers of people at risk of admission, intended to trigger early, preventative support.
- **Independent advocacy.** Including IMHAs and, where relevant, Care Act advocacy.
- **LeDeR.** The Learning from Lives and Deaths programme reviews the deaths of people with a learning disability and autistic people.

The 2025 Act will place registers and C(E)TRs on a statutory footing in England (see 7.4).

12 Inequality and the Act

12.1 Race

In 2024-25, Black or Black British people in England were detained under the Act at nearly four times the rate of White people (262.4 compared with 65.8 detentions per 100,000 population), and were made subject to CTOs at around eight times the rate (NHS England, Mental Health Act Statistics, Annual Figures 2024-25). Black people are also over-represented among restricted patients: at the end of 2025, about 19% of restricted patients were Black, compared with around 4% of the population of England and Wales at the 2021 Census.

The **Patient and Carer Race Equality Framework (PCREF)**, introduced by NHS England in 2023, requires mental health providers to work with racialised communities to understand and act on these inequalities.

12.2 Intersecting inequalities

Detention rates are also markedly higher in more deprived areas. Inequalities rarely act alone: an autistic Black man, for example, may face both diagnostic overshadowing and racialised perceptions of risk, compounding the likelihood of restriction and extending the time he spends in hospital.

REFLECT

Think about a recent case or experience. Where might race, class, neurotype or gender have shaped how a person's distress was interpreted, and how their risk was assessed? What would have helped?

PART C

The Restricted Patient System

How the Secretary of State for Justice oversees patients detained in hospital through the criminal justice system, from admission to absolute discharge.

IN THIS PART

13 Introducing restricted patients
14 Routes into the restricted system
15 The Secretary of State's role for detained patients
16 Risk, victims and public protection
17 Tribunals for restricted patients
18 Discharge
19 Conditions of discharge
20 Supervision in the community
21 Recall
22 Working with the Mental Health Casework Section
23 A rights-based lens on the restricted system

13 Introducing restricted patients

KEY POINT **Learning outcomes for Part C**

By the end of Part C you should be able to:

- explain who restricted patients are and how people become subject to restrictions;
- describe the role of the Mental Health Casework Section (MHCS) and the decisions it takes for the Secretary of State for Justice;
- understand how leave, transfer, discharge, conditions and recall work for restricted patients;
- support a person through applications, Tribunals and community supervision with confidence.

FROM THE MHCS **About this part**

Part C uses the HMPPS Mental Health Casework Section's webinar *An Introduction to the Restricted Patient System* (5 November 2026) as its guide, together with MHCS published guidance and the Ministry of Justice's *Restricted Patients Statistics, England and Wales 2025*. Where we report MHCS practice, targets or views, these are as the MHCS described them. Always check current MHCS guidance on GOV.UK (search for "working with restricted patients").

13.1 Who are restricted patients?

Restricted patients are people detained in hospital for treatment under Part 3 of the Mental Health Act who are also subject to special controls by the Secretary of State for Justice, because of the risk of serious harm they are considered to pose to the public. The legislation describes them as "mentally disordered offenders", although not all have been convicted: some are on remand, and some are immigration detainees.

Restrictions mean that key decisions which, for other detained patients, the responsible clinician could make alone, need the Secretary of State's consent. These include section 17 leave, transfer to another hospital, and discharge. Day-to-day care and treatment remain the responsibility of the responsible clinician and the treating team.

13.2 The numbers

Measure (England and Wales, 2025)	Figure
Restricted patients at 31 December 2025	7,998 (up 1% on 2024, and 13% since 2015)
Detained in hospital	4,674
Living in the community on conditional discharge	3,324
Admissions in 2025 (new admissions and recalls)	1,733
Admissions that were transfers from prison	65%
Admissions that were new hospital orders with restrictions	12%
Admissions that were recalls from conditional discharge	17%
Discharges in 2025	614 (of conditional discharges, 58% were by the Tribunal and 42% by the Secretary of State)

Measure (England and Wales, 2025)	Figure
Other disposals in 2025 (eg; remission to prison, sentencing)	1,028
Absolute discharges in 2025	84
Proportion who are male	About 88%
Proportion who are Black	About 19%

The restricted patient population is small compared with the hospital and prison populations, but it has grown slowly, year on year, for more than a decade, with only a brief pause around the COVID-19 pandemic. The conditionally discharged population in particular continues to rise.

13.3 The Mental Health Casework Section

The **Mental Health Casework Section (MHCS)** is a headquarters team within His Majesty's Prison and Probation Service (HMPPS), an executive agency of the Ministry of Justice. Its team of around 64 people takes decisions under delegated authority from the Secretary of State for Justice.

Its core function is public protection: making decisions, after robust risk assessment, at key points in a patient's journey, especially as the person gains increasing access to the community. It also has functions for restricted patients living in the community. MHCS covers England and Wales only; Scotland and Northern Ireland have separate arrangements.

14 Routes into the restricted system

14.1 Hospital order with a restriction order (sections 37 and 41)

At sentencing, a court can divert a convicted person away from custody and into hospital for treatment under a **hospital order** (section 37), on the evidence of two doctors. Only the Crown Court can add a **restriction order** (section 41), and only where it considers this necessary to protect the public from serious harm, having regard to the nature of the offence, the person's antecedents and the risk of further offending. At least one of the doctors must give evidence in person. A magistrates' court can commit a case to the Crown Court so that a restriction order can be considered (section 43).

The combination is usually called a "37/41". It is made **without limit of time**: the person remains restricted until they are absolutely discharged, or the restrictions are lifted. A 37/41 is a diversion from custody, not a punishment. However, because there is no fixed end date, people can spend far longer in hospital than they would have spent in prison for the same offence.

14.2 Hospital and limitation direction (section 45A)

Often called a "hybrid order", section 45A allows the Crown Court to impose a prison sentence and, at the same time, direct that the person goes straight to hospital for treatment, with a limitation direction that works in the same way as restrictions. If the person no longer needs treatment in hospital before their sentence ends, they can be remitted to prison to continue serving it.

14.3 Transfer of sentenced prisoners (sections 47 and 49)

A serving prisoner who becomes so unwell that they need detention in hospital can be transferred by the Secretary of State under a **transfer direction** (section 47), on the reports of two doctors. A

restriction direction (section 49), which gives the Secretary of State their powers, is almost always added. When the person is well enough, they are remitted to prison.

14.4 Transfer of unsentenced prisoners and others (sections 48 and 49)

People on remand, civil prisoners and immigration detainees can be transferred under section 48 where they are suffering from mental disorder of a nature or degree that makes hospital treatment appropriate, and they are **in urgent need** of that treatment. Since 18 February 2026, section 48 also covers people in youth detention accommodation and a wider range of immigration detainees. Restrictions under section 49 are normally applied, and are mandatory for people on remand.

14.5 When restrictions end for transferred prisoners

Restriction directions (section 49) and limitation directions (section 45A) end on the person's release date, meaning the date they would have been released from prison. If they still need hospital treatment at that point, they remain detained as an unrestricted "notional section 37" patient, and the Secretary of State's role ends. Sentence recalculations can change this date. The MHCS noted that a small number of detained patients have had their sentences recalculated following recent changes to sentencing legislation, and that each has been written to individually.

14.6 Who is not a restricted patient

- People on a hospital order without restrictions (section 37 alone), who are managed in a similar way to section 3 patients.
- People on community treatment orders. The MHCS has no involvement in CTOs unless a separate restriction is in place.
- People on pre-sentence sections, such as remand to hospital for a report (section 35) or for treatment (section 36), or an interim hospital order (section 38). These are Part 3 patients, but they are not restricted.
- "Notional section 37" patients after their release date.

14.7 Summary of routes

Section	Made by	Who	Restrictions	How it usually ends
37/41	Crown Court, at sentence	A convicted person diverted from custody	Restriction order (s41), without limit of time	Absolute discharge, or restrictions lifted
45A	Crown Court, at sentence	A convicted person given a prison sentence	Limitation direction	Remission to prison, or release date (then notional s37 if still detained)
47/49	Secretary of State	A sentenced prisoner	Restriction direction (s49)	Remission to prison, or release date (then notional s37)
48/49	Secretary of State	A remand or civil prisoner, immigration detainee or young person in youth detention, in urgent need of treatment	Restriction direction (s49)	Return to prison or court, conclusion of the case, or end of the detention

REFLECT

A 37/41 has no end date. What might "without limit of time" feel like to the person living under it, and how might that shape their relationship with the people deciding their progress?

15 The Secretary of State's role for detained patients

15.1 Key decisions

The MHCS takes the following decisions on behalf of the Secretary of State:

- issuing **warrants** to transfer prisoners to hospital (sections 47 and 48);
- **remission** back to prison when hospital treatment is no longer needed;
- **section 17 leave**, including escorted, unescorted and overnight community leave, and compassionate and medical leave;
- **transfers between hospitals**, including lateral moves, moves to lower security and moves to higher security;
- **discharge**, conditional or absolute (section 42), and lifting restrictions;
- **recall** of conditionally discharged patients to hospital.

Applications usually come from the responsible clinician and treating team, using the MHCS template forms published on GOV.UK.

15.2 Prison transfers

FROM THE MHCS **"Not to assess, but to ensure"**

The MHCS described its role in prison transfers as not to assess the person clinically, but to review the documentation, ensure the criteria under the Act are met, and consider any public protection issues about the hospital being proposed.

The MHCS target is to decide within five days of receiving all the necessary paperwork, once assessments have taken place; it reported that it routinely decides within one day. The whole process, from first identifying need in prison to arrival in hospital, often takes much longer. The 2025 Act will introduce a statutory 28-day time limit for transfers from prison to hospital; this is not yet in force.

15.3 Leave

Leave usually progresses in stages: escorted community leave, then unescorted leave, then overnight leave, often as preparation for transfer or discharge. The MHCS considers each request against the risk factors in section 16.1.

Medical leave. Restricted patients keep the right to physical healthcare. Admission letters usually state whether the responsible clinician has general authority to grant leave for medical treatment; if so, no separate application is needed. For patients designated **high profile**, an application is required. In a genuine emergency, the MHCS will not prevent necessary treatment: call the casework team in hours (or the out-of-hours line, if you are concerned), make sure appropriate escort arrangements are in place, and notify the MHCS at the earliest opportunity.

15.4 Transfers between hospitals

Transfers can be lateral (eg; so that a person can access a particular therapy), downward (to lower security as the person progresses) or upward (where risk has increased and higher security is needed). All need the Secretary of State's consent.

15.5 Remission to prison

When a transferred prisoner no longer needs treatment in hospital, the MHCS manages remission back to prison. The MHCS described a new model for sentenced men: rather than returning to the nearest local or reception prison, which serves the courts and often leads to a quick onward move, they will be remitted directly to a resettlement prison in their home area. This should reduce onward moves and support section 117 planning. It does not apply to long-term high secure patients, women or young people, who have other pathways. Updated policy frameworks are expected.

15.6 Decision timeframes

Decision	MHCS target, as described in the webinar
Prison transfer warrant	5 days from receipt of the complete paperwork (routinely 1 day)
Escorted, unescorted and overnight leave	Longer targets, in the region of four to five weeks
Conditional discharge	28 days; decided by an experienced senior manager
Absolute discharge	A senior "three pairs of eyes" decision, which occasionally takes longer than target

All timeframes run from receipt of a **complete** application. Incomplete applications may be returned for updating before they are considered. The MHCS reported that, for the last couple of years, it has routinely met its targets.

16 Risk, victims and public protection

16.1 How the MHCS assesses risk

Every decision is taken case by case. The MHCS balances protecting the public from harm against the person's right to treatment and progression. The MHCS described itself as not bound by the least restrictive principle in the same way as clinicians are. The factors it considers include:

- the person's mental disorder, how they are responding to and engaging with treatment, and their current stability;
- their behaviour in hospital, including any subversion of hospital rules and any risk of absconding or escape;
- their offending history, the index offence and the likelihood of reoffending;
- relapse indicators, and how they relate to past offending;
- the work done during detention to address risk factors;
- how the person has progressed on leave, and the control measures in place;
- victims' requests, including exclusion zones;
- the views of MAPPA, offender managers and others involved.

Sources include the application itself, previous convictions, Tribunal reports and structured professional judgement tools such as the HCR-20. There is no tick-box checklist; the factors are guides, not an exhaustive list.

FROM THE MHCS **The clinical picture matters**

The responsible clinician's assessment, and how well it is represented in the application, forms a substantive part of the MHCS's consideration, alongside other sources of information.

16.2 Victims

Victims of restricted patients have statutory rights. If eligible, and if they opt in to the **Victim Contact Scheme**, they are allocated a **victim liaison officer (VLO)** in the Probation Service. Through the VLO, victims can:

- receive information at key points, such as leave and discharge;
- make representations, eg; about conditions such as exclusion zones and non-contact;
- make a **victim personal statement** when the Secretary of State is considering discharge;
- in certain circumstances, provide a statement to the Tribunal, under provisions in the Victims and Prisoners Act 2024.

The MHCS also emphasised wider confidence in the system: each decision is an individual assessment of risk, but the system as a whole must work for patients and be trusted by the public.

IN PRACTICE **Engage the VLO early**

The MHCS recommends early contact with the VLO, before an application is made, so that victims' likely requests can be built into planning rather than delaying a decision. If you do not know whether a VLO is involved, the MHCS can check and put you in touch.

16.3 MAPPA, offender managers and extremism

- Most restricted patients are eligible for **Multi-Agency Public Protection Arrangements (MAPPA)** because of the seriousness of their offences. The statutory MAPPA guidance, and the GOV.UK guidance on restricted patients and MAPPA, set out responsibilities and lead agency arrangements. The MAPPA coordinator can confirm the level at which a person is managed.
- People transferred from prison may have a probation **offender manager**, especially as they approach their sentence end date. A 37/41 patient with no prior contact with probation is unlikely to have one. The MHCS can confirm if you are unsure.
- The MHCS has a process to identify restricted patients with an extremist or terrorist risk profile, so that information is shared effectively between agencies and clinical teams, and a dedicated Head of Extremism Casework.

16.4 High-profile patients

Some patients are designated high profile, and their treating teams are told. For these patients, applications are needed for decisions that would otherwise fall within general authority, such as medical leave.

17 Tribunals for restricted patients

17.1 Applying to the Tribunal

Restricted patients have the same right as other patients to an independent review of their detention by the Tribunal, and to free legal representation.

Patient	When they can apply
37/41 or 45A	Not in the first six months; once in the second six months; then once every 12 months
47/49 or 48/49	Once in the first six months; once in the second six months; then once every 12 months
Conditionally discharged (not recalled)	Not in the first 12 months after discharge; once in the second 12 months; then once every two years
Recalled from conditional discharge	As for a 37/41, counted from the date of return to hospital

17.2 Automatic references by the Secretary of State

- The Secretary of State must refer a detained restricted patient whose case has not been considered by a Tribunal in the previous **three years** (section 71(2)).
- After a **recall**, the Secretary of State must refer the case to the Tribunal within one month of the person's return to hospital (section 75(1)). The MHCS aims to make this referral within **two weeks** of confirming the person is physically back in hospital, not merely of issuing the warrant.
- People conditionally discharged with **deprivation of liberty conditions** must be referred 12 months after those conditions begin, and then every two years (in force since 18 February 2026).

> **LAW IN TRANSITION** **More regular review for conditionally discharged patients**
>
> The 2025 Act contains provisions for more regular Tribunal review of conditionally discharged patients. The MHCS indicated these will not be commenced until Tribunals and other services are able to deliver them.

17.3 What the Tribunal can do

For **restriction order** patients (37/41), the Tribunal must discharge if it is not satisfied that the detention criteria are met (section 73). It then decides between:

- **absolute discharge**, if it is satisfied that it is not appropriate for the person to remain liable to recall; and
- **conditional discharge**, with conditions. The Tribunal can **defer** a conditional discharge until arrangements, such as accommodation, are in place.

For **restriction direction** patients (45A, 47/49 and 48/49), the Tribunal cannot discharge directly (section 74). It notifies the Secretary of State whether the person would be entitled to absolute or conditional discharge. If so, the Secretary of State has 90 days to agree; if they do not, the person is remitted to prison, unless the Tribunal has recommended (where conditional discharge would be appropriate) that they remain in hospital. For people on remand, the outcome is a return to custody or court rather than discharge.

The Secretary of State is a party to restricted patient Tribunals, and the MHCS provides a statement setting out the Secretary of State's view.

18 Discharge

18.1 Who can discharge?

Both the Secretary of State (section 42) and the Tribunal can discharge a restricted patient, either conditionally or absolutely. The responsible clinician and the hospital managers cannot discharge without the Secretary of State's consent. The Secretary of State can also lift restrictions altogether (section 42(1)), leaving the person as an unrestricted hospital order patient.

The usual route is conditional discharge, followed, often years later, by absolute discharge. Conditional discharge is not a legal requirement before absolute discharge, but requests for absolute discharge directly from hospital are relatively rare.

18.2 Conditional discharge

Conditional discharge means the person no longer needs to be detained in hospital. They may still need treatment, but it can be provided in the community. A conditionally discharged person:

- lives in the community with conditions intended to support their transition and help manage risk;
- is supervised by a **clinical supervisor** (usually a consultant psychiatrist) and a **social supervisor** (usually a social worker or community mental health nurse);
- is the subject of regular joint reports to the MHCS;
- remains liable to recall to hospital, however long they have been discharged, until absolutely discharged.

Conditionally discharged patients are not subject to compulsory treatment under Part 4. They can refuse medication, although refusal may be relevant to risk and to recall.

18.3 Supervised discharge: conditions amounting to a deprivation of liberty

In *Secretary of State for Justice v MM* [2018] UKSC 60, the Supreme Court held that neither the Secretary of State nor the Tribunal could impose conditions of discharge that amounted to a deprivation of liberty, even with the person's consent. In practice, a small number of people who lacked capacity were conditionally discharged with a separate DoLS authorisation in place, which the conditional discharge itself did not mention.

The Mental Health Act 2025 reversed this position. Since 18 February 2026, the Secretary of State and the Tribunal can grant a conditional discharge with conditions that amount to a deprivation of liberty, known as **supervised discharge**. It is not a separate type of discharge but a subset of conditional discharge. Conditions typically involve supervision when the person is outside their accommodation and, for some, within it. (The Tribunal uses slightly different terminology for the same arrangement.)

- The Secretary of State may impose such conditions where necessary to protect the public from serious harm.
- The Tribunal may do so only if the conditions are necessary to protect another person from serious harm, and discharge on those terms would be no less beneficial to the person's mental health than remaining in hospital.
- Mandatory Tribunal references apply (see 17.2).

Supervised discharge was always intended for a very small number of people, and its use attracted close parliamentary scrutiny. The MHCS has committed to providing information about its use in future published statistics.

LAW IN TRANSITION **After AGNI**

The Supreme Court's June 2026 decision in *AGNI* [2026] UKSC 16, overruling the *Cheshire West* "acid test", changes the analysis of when restrictions amount to a deprivation of liberty. The MHCS has issued information on what this means for restricted patients, and the Department of Health and Social Care has published interim guidance.

RIGHTS LENS **A new form of community detention**

Supervised discharge allows a person to be deprived of their liberty in the community, indefinitely, under a regime designed for public protection. It may enable some people to leave hospital who otherwise could not. It also extends carcerative control beyond the hospital walls. Advocates should check exactly what the person is prevented from doing; whether each condition is necessary and proportionate; how and when it will be reviewed; and whether the person understands their right to Tribunal review.

18.4 Absolute discharge

Absolute discharge ends all detention authority, all conditions and all liability to recall. Both the Secretary of State and the Tribunal can grant it. It remains relatively rare for the Secretary of State, who regards it as the highest-risk decision, because all of the Secretary of State's powers fall away. The MHCS therefore uses a "three pairs of eyes" process. Requests may arise, for example, on compassionate grounds or when someone is near the end of life. The MHCS guidance on section 42 discharge, on GOV.UK, describes the factors considered. Section 117 aftercare continues for as long as it is needed.

18.5 "Deferred discharge"

"Deferred conditional discharge" is Tribunal language: the Tribunal decides the person should be conditionally discharged, but defers the discharge until something, often accommodation, is in place. The Secretary of State does not defer: it either approves or refuses an application for conditional discharge. A refusal may invite a fresh application in, for example, six or twelve months, once particular factors have been addressed.

19 Conditions of discharge

19.1 Purpose and legal status

Conditions can be attached to leave and to discharge. They must be proportionate to the risk the person presents, so they differ from person to person.

KEY POINT **Conditions are not licence conditions**

Unlike the licence conditions of someone released from prison, conditions of discharge are **not statutory** and have no separate legal force. A breach does not automatically lead to recall.

Conditions still matter. They set clear expectations about what the person can and cannot do in relation to their risks; they support proactive conversations with the community team; and a pattern of non-adherence may be an early sign that the person is struggling or relapsing. The MHCS can issue **warning letters**, and a breach may contribute to recall where it reflects increased risk.

19.2 Common conditions

Condition	What it usually involves
Residence	Living at an agreed address. The MHCS does not decide where a person lives; that is part of discharge planning with the local authority and providers. The MHCS asks to be notified 14 days before any change of accommodation.
Supervision and treatment	Engaging with the clinical and social supervisors and the treating team, and attending appointments with the responsible clinician.
Substance use	Conditions on alcohol or drug use, sometimes with testing, where these are linked to risk.
Exclusion zones	Not entering a defined area, often at a victim's request.
Non-contact	No contact with named people, often victims or their families.
Relationships	Disclosing intimate and personal relationships to the care team as they develop.
Bespoke conditions	Conditions specific to the person's history, eg; relating to knives where there is a history of weapons offences, where reasonable, proportionate and necessary.

19.3 Changing conditions

Conditions can be varied, and changes are routinely considered. They may be requested by the community team, prompted by a victim's request or by MAPPA, or proposed in a conditional discharge report. The MHCS considers the risks of any change and the community team's recommendations. Over years of stable community living, conditions often reduce.

> **IN PRACTICE** **Making conditions accessible**
>
> Conditions are often written in dense legal language. Make sure the person has an accessible version, understands what each condition means in daily life, and knows what to do if they cannot comply (eg; if their accommodation breaks down). For autistic people, ambiguous conditions such as "maintain contact as directed" can be a source of anxiety and of unintended breaches.

20 Supervision in the community

20.1 Roles

- The **clinical supervisor** oversees treatment and medication, and reports on mental state, interventions, physical health and risk.
- The **social supervisor** oversees accommodation, relationships, finances, activities and employment, and reports on the frequency of contact.
- They work jointly, and submit joint **conditional discharge reports (CDRs)** to the MHCS.

The MHCS treats clinical and social supervision as an essential part of section 117 aftercare. A failure to provide supervision will be escalated to the chief executives of the responsible bodies.

20.2 Reporting and contact

The MHCS guidance *Conditionally Discharged Patients: Supervision and Reporting* (October 2025) sets a baseline:

- the first CDR is due one month after discharge, then quarterly; a reduced frequency can be requested where reports have been consistently positive, and the webinar noted that some long-term stable patients have moved to six-monthly reporting;
- contact should be weekly for the first month, then fortnightly for around six months, and only then, at the earliest, monthly; any reduction should reflect the person's circumstances, not simply the passage of time;
- contact should be mainly face to face, including at the person's home;
- extra contact is expected at times of change, such as a move or a bereavement.

Check which reporting schedule applies to each person you support.

> **FROM THE MHCS** **"Not for us to dictate"**
>
> Asked how often a social supervisor should visit long-term stable patients, the MHCS explained that it does not specify visiting frequency, because day-to-day supervision is a matter of professional judgement for those who know the person. When taking on new cases, supervisors may reasonably visit more often while they get to know the person, their risks and their protective factors. If a change of reporting frequency seems appropriate, ask in the conditional discharge report.

20.3 Professional curiosity

The MHCS revised its guidance for community supervisors after prevention of future deaths reports in which the Ministry of Justice was named. In a small number of cases, people who had lived in the community apparently successfully for ten or fifteen years went on to commit very serious offences. The guidance therefore emphasises **professional curiosity**: not assuming that long-term stability means risk has reduced; triangulating information; staying alert to disguised compliance; and using unannounced visits where appropriate.

20.4 Telling the MHCS

Contact the MHCS:

- **by phone, immediately**, if risk appears to be increasing; do not wait for the next report;
- by email at the point of any psychiatric admission;
- before any change of supervisor, with the new supervisors' details;
- about any absence from home of more than one full calendar week;
- if the person enters an exclusion zone;
- about planned changes of accommodation (the webinar asked for 14 days' notice).

20.5 Travel abroad and moves

There is no blanket policy on overseas travel for conditionally discharged patients: it is not prohibited, but it is not always advisable, and each case is considered individually with the treating team. The MHCS guidance generally opposes trips longer than about four weeks, does not accept telephone supervision while the person is abroad, and requires advance agreement for moves to Scotland, Northern Ireland, the Isle of Man or the Channel Islands. Talk to the MHCS early.

20.6 Informal admission or section 2 for a conditionally discharged patient

Sometimes a conditionally discharged person needs a hospital admission. An informal admission, or detention under a civil section, may be appropriate, case by case, depending on what the admission is intended to achieve and whether the person agrees. The MHCS asks to be called first. It may agree that recall is not needed, but an admission that lasts longer than planned may lead to recall. Detention under Part 2 with no clear end point will be considered for recall.

21 Recall

21.1 When recall is considered

The MHCS takes recall very seriously, because it deprives a person of their liberty again. Recall is a last resort, used mainly where there is a change in mental state with a proportionate change in risk, or where risk of harm is imminent. Indicators include:

- deterioration in mental state;
- not taking medication, eg; missed depot injections, or concerns about whether self-administered medication is being taken;
- further offending, assessed against the person's history;
- other factors linked to the risk of harm.

21.2 How recall works

- **Call the MHCS.** Phone lines are staffed from 9am to 5pm, Monday to Friday, with an out-of-hours service for emergencies every day of the year. The MHCS encourages early conversations: discussing concerns with social supervisors and others can identify alternatives to recall.
- **The decision.** A senior member of the team decides. Recall can be for urgent assessment or for treatment.
- **The warrant.** If recall is agreed, the MHCS issues a warrant by email, including out of hours. Recall may be agreed in principle while a bed is found. When you call back, recap the earlier conversation, because the person you are speaking to, who will issue the warrant, is the decision maker at that point.
- **The return.** The person is taken to the hospital named in the warrant.

Every conditionally discharged patient remains liable to recall, regardless of how long they have been in the community.

21.3 Unlawfully at large and police powers

Once a recall warrant is issued, the person is unlawfully at large until they are returned to hospital. Police can take them into custody, but to enter a private dwelling to execute the warrant, a **section 135(2) warrant** from a magistrate is still required.

21.4 After recall

The Secretary of State must refer the case to the Tribunal within one month of the person's return to hospital, and the MHCS aims to do so within two weeks. The person also has a fresh right to apply (see 17.1). This is a vital safeguard: recall is a further deprivation of liberty, and the Tribunal provides an independent check that continued detention is lawful.

> RIGHTS LENS **Recall and autistic people**
>
> Changes that look like deterioration can sometimes be autistic burnout, sensory overload, a response to a loss of routine, or distress at a breakdown in support. Before recall, it is worth asking whether the change reflects mental illness and increased risk, or unmet needs that could be addressed in the community.

22 Working with the Mental Health Casework Section

22.1 Tips for applications

The MHCS asks for a lot of information because it needs a rich, up-to-date picture of the person's progress and risk factors. Its forms are developed in collaboration with professionals who work with patients day to day. To avoid delay:

- use the current MHCS template from GOV.UK and complete every section;
- be honest and accurate about progress, setbacks and risk;
- describe the interventions the person has undertaken to address their risk;
- consult MAPPA where the person is MAPPA-eligible, and include their view;
- include the offender manager's view, where there is one;
- include VLO details and any victim requests, and engage the VLO early;
- include the person's own view where the form allows, if they wish to give it;
- respond promptly to follow-up questions from caseworkers, and phone if you are unsure.

If an application has been refused, contact the MHCS to understand what the person would need to show for a future application to succeed.

> **RIGHTS LENS** **The person's own voice**
>
> The MHCS gives patients the opportunity to give their own view on certain decisions. Advocates can help people prepare this in their own words, with accessible information about what the decision involves and how it will be made.

22.2 Recent and upcoming developments

Development	What it means
Revised community supervision guidance	Stronger emphasis on professional curiosity, following prevention of future deaths reports; most recent version October 2025
Reporting frequency	Some long-term stable conditionally discharged patients have moved from quarterly to six-monthly reporting
Supervised discharge	Conditional discharge with deprivation of liberty conditions, in force since 18 February 2026
Remission pathway	Sentenced men to be remitted to a resettlement prison in their home area, rather than a local reception prison
Extremism casework	A process to identify restricted patients with an extremist or terrorist risk profile, led by a Head of Extremism Casework
28-day transfer time limit	A statutory limit on prison-to-hospital transfers under the 2025 Act; among the first provisions due to be commenced, but not yet in force
Code of Practice	The Department of Health and Social Care is leading work on a new Code of Practice reflecting the 2025 Act

22.3 Contacts

Purpose	Contact
General casework queries	020 7820 5900
Urgent recall requests (office hours)	020 8253 4725
Out-of-hours emergencies	0300 303 2079
Ministry of Justice switchboard, if you cannot get through	020 3334 3555
General mailbox (enquiries, conditional discharge reports, emails for named staff)	mhcsmailbox@justice.gov.uk
Tribunal reports	MHCS.TribunalCorrespondence@justice.gov.uk
Prison transfers	prison.transfers@justice.gov.uk
Training, open sessions and bulk transfers (CPST)	mhcscpst@justice.gov.uk
Hospital orders	MHCSCorrespondence@justice.gov.uk
Public enquiries	public_enquiry.mhu@justice.gov.uk

These details are taken from the HMPPS Mental Health Casework Section contact list on GOV.UK; check for updates before use. The MHCS also provides quarterly updates to stakeholders on request, publishes statistics annually, and offers bespoke training on the management of restricted patients.

23 A rights-based lens on the restricted system

23.1 Neurodivergent people in forensic services

Studies have found autistic people in secure hospitals at higher rates than in the general population, often undiagnosed before admission. Many of the features of the restricted system weigh especially heavily on autistic people and people with a learning disability.

- **Without limit of time.** A 37/41 has no end date, so the length of detention depends on progress through a system built around neurotypical expectations of insight, engagement and group therapy.
- **Communication read as risk.** Autistic communication, such as flat affect, literal answers or difficulty with hypothetical questions, can be misread as a lack of remorse or insight, raising perceived risk.
- **Unadapted interventions.** Offending behaviour programmes and group therapies are often not adapted for autistic people, leaving no realistic route to demonstrate reduced risk.
- **Part 3 is untouched.** The 2025 reforms do not remove Part 3 detention on the basis of autism or learning disability, so the restricted system remains a route by which people can be detained indefinitely on the basis of neurodivergence combined with offending.
- **Conditions that set people up to fail.** Ambiguous or rigidly applied conditions, and recall triggered by unmet needs, can turn community life into a series of tests.

23.2 What good support looks like

- Make sure the person's diagnosis and communication profile are known to the MHCS, the Tribunal and the care team, and are reflected in applications.

- Ask for adapted psychological interventions, and for evidence of how they have been adapted.
- Help the person prepare their own view for applications and Tribunals.
- Challenge risk narratives that rest on autistic traits rather than evidence of harm.
- Push for the least restrictive, community-based options, including well-planned conditional discharge with the right support in place.
- Use the Tribunal: restricted patients have the same right to apply, and to free legal representation, as anyone else.

REFLECT

A restricted patient tells you they "have to say the right things" in their MHCS application to get leave. How would you support them to give an honest account in their own words, while helping them understand how their account will be read?

Appendix A Glossary

Term	Meaning
Absolute discharge	Discharge of a restricted patient that ends all detention authority, conditions and liability to recall
Approved clinician (AC)	A professional approved to act as a responsible clinician and to make treatment decisions under Part 4
Approved mental health professional (AMHP)	A professional approved by a local authority to coordinate Mental Health Act assessments and make applications
AWOL	Absent without leave from hospital (section 18)
C(E)TR	Care (education) and treatment review, for autistic people and people with a learning disability
CDR	Conditional discharge report: the joint report from clinical and social supervisors to the MHCS
Clinical supervisor	The psychiatrist responsible for a conditionally discharged patient's treatment in the community
Conditional discharge	Discharge of a restricted patient into the community, subject to conditions and liability to recall
CTO	Community treatment order (section 17A)
Deprivation of liberty	Confinement that engages Article 5 ECHR and must be lawfully authorised
DoLS	Deprivation of Liberty Safeguards under the Mental Capacity Act 2005
HMPPS	His Majesty's Prison and Probation Service, an executive agency of the Ministry of Justice
Hospital order	A court order for a convicted person to be detained in hospital for treatment (section 37)
IMHA	Independent mental health advocate
Index offence	The offence that led to the person's current order or sentence
Limitation direction	The restriction attached to a hospital direction under section 45A
MAPPA	Multi-Agency Public Protection Arrangements
MHCS	Mental Health Casework Section, the HMPPS team that takes decisions on restricted patients for the Secretary of State for Justice
Nearest relative	The relative identified under section 26 with rights under the Act; to be replaced by the nominated person
Nominated person	The person a patient chooses to represent them, replacing the nearest relative once the 2025 Act is commenced
Notional section 37	An unrestricted status that applies when a transferred prisoner's restrictions end at their release date while they remain in hospital
Part 2 / Part 3	Civil sections / sections relating to criminal proceedings and sentences
PICU	Psychiatric intensive care unit
Recall	The return of a conditionally discharged patient (or CTO patient) to hospital

Term	Meaning
Remission	The return of a transferred prisoner from hospital to prison
Responsible clinician (RC)	The approved clinician with overall responsibility for a patient's case
Restriction direction	The restriction attached by the Secretary of State to a prison transfer (section 49)
Restriction order	The restriction attached by the Crown Court to a hospital order (section 41)
Section 12 doctor	A doctor approved as having special experience in the diagnosis or treatment of mental disorder
SOAD	Second opinion appointed doctor
Social supervisor	The professional responsible for social supervision of a conditionally discharged patient
Supervised discharge	Conditional discharge with conditions amounting to a deprivation of liberty, available since 18 February 2026
Tribunal	First-tier Tribunal (Mental Health) in England; Mental Health Review Tribunal for Wales
Unlawfully at large	The status of a recalled patient who has not yet been returned to hospital
Victim Contact Scheme / VLO	The statutory scheme for victims, and the victim liaison officer who supports them

Appendix B Quick reference to sections

Section	Summary	Duration
2	Admission for assessment	Up to 28 days; not renewable
3	Admission for treatment	Up to 6 months; renewable for 6 months, then 12 months
4	Emergency admission for assessment	Up to 72 hours
5(2)	Doctor's or approved clinician's holding power	Up to 72 hours
5(4)	Nurse's holding power	Up to 6 hours
7	Guardianship	Up to 6 months; renewable
17	Leave of absence	As granted
17A	Community treatment order	6 months; renewable for 6 months, then 12 months
35	Remand to hospital for a report	28 days, renewable to a maximum of 12 weeks
36	Remand to hospital for treatment (Crown Court)	28 days, renewable to a maximum of 12 weeks
37	Hospital order	6 months; renewable as for section 3
38	Interim hospital order	Up to 12 weeks, renewable to a maximum of 12 months

Section	Summary	Duration
41	Restriction order (Crown Court)	Without limit of time
42	Secretary of State's powers, including discharge and recall	Not applicable
45A	Hospital and limitation direction	Until remission or release date
47	Transfer of sentenced prisoners to hospital	Until remission or release date
48	Transfer of other prisoners and detainees in urgent need	Until remission or conclusion of the case or detention
49	Restriction direction	Until release date
73 / 74	Tribunal powers for restriction order / restriction direction patients	Not applicable
75	Tribunal applications and references for conditionally discharged patients	Not applicable
117	Aftercare	Until no longer needed
135	Warrants to enter premises	Up to 24 hours in a place of safety (extendable by 12 hours)
136	Police removal to a place of safety	Up to 24 hours (extendable by 12 hours)

Appendix C Knowledge check

Use these questions to check your learning, individually or in a group. Suggested answers follow.

1. What is the maximum length of a section 2 detention, and can it be renewed?

2. Which provisions of the Mental Health Act 2025 were in force by November 2026?

3. Which court can add a restriction order to a hospital order, and what is the test?

4. Are people on community treatment orders restricted patients?

5. What happens to a 47/49 patient who is still in hospital on their release date?

6. Does a breach of a condition of discharge automatically lead to recall?

7. When must the Secretary of State refer a recalled patient to the Tribunal?

8. What is supervised discharge, and what does the Tribunal have to be satisfied of before imposing it?

9. Can police force entry to a private home to execute a recall warrant without a further warrant?

10. What should you do before arranging an informal admission for a conditionally discharged patient?

11. What test did the Supreme Court overrule in June 2026, and in which case?

12. Name three ways in which hospital environments can harm autistic people.

Suggested answers

- **1.** Up to 28 days. It cannot be renewed; if further detention is thought necessary, a section 3 assessment is needed.
- **2.** Supervised discharge and the section 48 transfer changes (18 February 2026); the application of the Human Rights Act to private providers, and the review of CQC notification of child admissions (6 April 2026).

- **3.** Only the Crown Court, where it is necessary to protect the public from serious harm, having regard to the nature of the offence, the person's antecedents and the risk of further offending.
- **4.** No. The MHCS has no involvement in CTOs unless a separate restriction is in place.
- **5.** The restriction direction ends; the person remains detained as an unrestricted "notional section 37" patient.
- **6.** No. Conditions are not statutory, but a breach may prompt a warning letter, a review of risk and, where risk has increased, recall.
- **7.** Within one month of the person's return to hospital; the MHCS aims to do so within two weeks.
- **8.** Conditional discharge with conditions amounting to a deprivation of liberty. The Tribunal must be satisfied that the conditions are necessary to protect another person from serious harm, and that discharge on those terms would be no less beneficial to the person's mental health than remaining in hospital.
- **9.** No. A section 135(2) warrant from a magistrate is required to enter a private dwelling.
- **10.** Phone the MHCS to discuss the most appropriate route.
- **11.** The *Cheshire West* "acid test" for deprivation of liberty, in *A Reference by the Attorney General for Northern Ireland* [2026] UKSC 16.
- **12.** Any three of: the sensory environment; unpredictability; diagnostic overshadowing; misinterpretation of distress as aggression; communication barriers; cycles of escalating restriction.

Appendix D Sources and further reading

Legislation and case law

- Mental Health Act 1983 (as amended): legislation.gov.uk/ukpga/1983/20
- Mental Health Act 2025: legislation.gov.uk/ukpga/2025/33
- The Mental Health Act 2025 (Commencement No. 1) Regulations 2026 (SI 2026/385)
- Mental Health Units (Use of Force) Act 2018
- *Secretary of State for Justice v MM* [2018] UKSC 60
- *A Reference by the Attorney General for Northern Ireland* [2026] UKSC 16

Guidance

- Department of Health (2015) *Mental Health Act 1983: Code of Practice*
- Welsh Government (2016) *Mental Health Act 1983: Code of Practice for Wales*
- HMPPS Mental Health Casework Section (2025) *Conditionally Discharged Patients: Supervision and Reporting*, October 2025
- HMPPS Mental Health Casework Section, *Contact list*, GOV.UK
- GOV.UK, *Working with restricted patients* (MHCS guidance and application forms)
- Department of Health and Social Care (2026) *UK Supreme Court 2026 judgment on what constitutes a deprivation of liberty*

Training and evidence

- HMPPS Mental Health Casework Section (2026) *An Introduction to the Restricted Patient System* [webinar], 5 November 2026
- Ministry of Justice (2026) *Restricted Patients Statistics, England and Wales 2025*, 30 April 2026
- NHS England (2025) *Mental Health Act Statistics, Annual Figures 2024-25*
- NHS England (2026) *Statistics on people with a learning disability and autistic people in mental health hospitals*, at July 2026
- Independent Review of the Mental Health Act (2018) *Modernising the Mental Health Act*
- Care Quality Commission (2020) *Out of sight: who cares?*

- Mental Health Law Online: mentalhealthlaw.co.uk

About NeuroHub Connect

NeuroHub Connect CIC is a UK-based neurodiversity training, consultancy and community organisation. Our training is neurodivergent-led, rights-based and grounded in lived experience, and our work spans autism, mental health, substance use, and restraint and seclusion.

This manual is part of our training on mental health law and carcerative care. We welcome feedback, corrections and suggestions from the people who use it.

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