Adult Social Care

Section 42(3) Mental Health Act 1983: Recall to Hospital Protocol and Guidance

Version 3

Contents

If you would like to make any comments, amendments, additions etc. please email ASCH.AdultCare.Policy@derbyshire.gov.uk

Introduction

This policy covers the role of staff acting as social supervisors acting under section 42 of the Mental Health Act 1983, relating to the recall of people held under a restriction order, under section 37 and section 41 of the Act.

The following guidance should also be referred to:

- Ministry of Justice (MOJ) Guidance for social supervisors

  The Recall of Conditionally Discharged Restricted Patients
- Contacting the Ministry of Justice Mental Health Casework Section "Out of Hours" Service - Guidance for Professionals Revised Practice

Thresholds for Recall

Any identified risk must result from a mental disorder.

This can be a different mental disorder than led to the initial detention.

A deterioration in the mental disorder does not need to be present, just reason to believe the mental disorder may deteriorate, leading to an increase in risk, e.g., current behaviour such as drug use, may indicate likely deterioration of their illness, and subsequent risk to others.

Consideration should be given to the imminence of risk or severity of any predicted behaviour, or both.

There must be medical evidence that the patient is mentally disordered.

Public protection takes precedence over the therapeutic interests of the patient.

Drug and alcohol use on their own will not be reason for recall (even if it is a breach of conditions). Unless there is a link, or potential link, to deterioration in mental disorder and therefore risk. Non-compliance with medication is not in itself a reason for recall unless it is linked to an increase in risk. But any refusal of medication should be reported to the MOJ.

Hospital Admissions

When admission is informal, recall may still be indicated particularly where any risks to others are considered to be present.

Where there is risk to self, need for recall is less likely.

Where the person meets the criteria for admission under section 2 or 3, in most cases recall will be indicated unless it is a brief admission due to risk of self-harm.

Imprisonment

Consideration should be given to recall at the end of any custodial sentence. Recall should always take place following the end of section 49 restrictions.

Who Can Recall to Hospital

If the social supervisor has concerns, they should discuss these with the MOJ even if the clinical supervisor doesn't share the concerns.

Immediate local action can be taken where appropriate to detain under sections 2, 3, or 4 or to admit voluntarily. If admitted under section, then recall is likely to follow (see above).

The MOJ can override the opinion of the clinical supervisor and the social supervisor.

If one of the supervisors is recommending recall, then the person should be recalled unless there are compelling reasons not to.

Warrant

Recall may sometimes be authorised out of office hours by the Mental Health Casework Section (MHCS) duty officer. In those circumstances, no paper warrant will immediately be available. The police will be invited to accept the same verbal authority as the supervisors, until a warrant can be produced (para.75 Ministry of Justice Guidance for Social Supervisors). The warrant doesn't give powers of entry. Consideration should be given to whether a Section 135(2) warrant is required.

Process of Recall

If the social supervisor is the first to be alerted, they should immediately contact the clinical supervisor. It is suggested that any phone contact with the clinical supervisor is followed up with an email confirming the conversation and actions to be taken.

Even if the clinical supervisor does not share the social supervisors concerns, the social supervisor should inform the MOJ of their concerns.

The relevant contact numbers can be accessed via the mental health casework section contact list or by contacting Tel: 020 3334 3335.

If the clinical and the social supervisor both agree that recall is necessary, the clinical supervisor will contact the MOJ. They will usually be asked to put their concerns in writing (by email).

The clinical supervisor will discuss with the MOJ what level of security is needed and if there are any specific reasons for one hospital above another. The clinical supervisor will then organise the bed and give the address to the MOJ for warrant.

Out of Hours

Callers contact the central switchboard number (0300 303 2079). The operator will ask the caller for the following information:

- name and contact number for caller
- name of patient
- the relevant section of Mental Health Act e.g., 37/41
- the reason for call

- whether the caller needs to speak to the MHCS Duty Officer (YES/NO)

If the caller needs to speak to the duty officer, he or she (who is a senior member of MHCS), is then contacted and asked to call you back. The duty officer will call you, provide advice or consider your urgent request over the telephone and will then provide appropriate written confirmation during the next working day.

Once a recall warrant has been issued the patient must be admitted to the address on the warrant. There is not an option to amend or issue another warrant with a different address.

The direction is by the Secretary of State and a bed should be found immediately. If there is no bed forthcoming the MOJ should be contacted to resolve this issue. The caseworker at the MOJ will then discuss with their manager, who is likely to telephone the clinical supervisor and social supervisor if any additional information is needed.

As soon as there is an agreement with the MOJ that a recall warrant will be issued, the social supervisor should alert the police via 101 initially and be prepared to give full details, including any risks. The social supervisor should ensure they are given an incident number and that they give the police their mobile contact number in addition to their office number.

The MOJ usually issues a recall warrant within 2 hours of the request. The clinical supervisor should ask for the warrant to be sent to the social supervisor as well as to themselves.

The police will also want to know the address of where the person is being recalled to and the phone number.

The custody sergeant or the duty inspector should then contact the social supervisor to discuss how recall will be achieved practically (there will be an expectation that the social supervisor accompanies the police to execute the warrant). There is also likely to be discussion regarding risks.

The recall warrant does not give the police power of entry. The social supervisor should consider whether to approach a magistrate for a section 135(2) warrant if they have reason to believe the patient will not allow them entry.

Whilst waiting for the recall warrant photocopy any useful information for the ward such as Functional Analysis of Care Environments (FACE) risk profile, history, family contacts, etc.

As soon as the recall warrant is received it should be faxed to the police and then a time should be agreed by phone as to when to execute the warrant.

Contact the ward with an estimated time of admission and leave your mobile number.

The patient should be informed as to why they are being recalled and if practicable the social supervisor should follow the police to hospital.

If possible, the ward should then be contacted again, just prior to transportation, and agreement made on what entrance will be used on the ward.

Appendix 1 – Case Law

R (on the application of MM) -v- Secretary of State for the Home Department (2007)

This case law supports two points of action

- the person doesn't necessarily need to be acutely mentally ill. Current behaviour (e.g., drug use) may indicate a likely deterioration to illness and risk to others
- where medical evidence of mental disorder should be sought, in emergency this is not required. MOJ may take verbal evidence over the phone. This conversation should be recorded in detail at both ends

Approval and Authorisation History

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Name	Job Title	Date
Approved by Paul Emerson	Senior Practitioner – Mental Health	January 2015
Approved by Carole Robinson	Group Manager – Mental Health	January 2015
Authorised by Quality Assurance Group		September 2017

Change History

Version	Date	Name	Reason
Version 1	January 2015	Paul Emerson	Issue of new guidance
Version 2	September 2017	Paul Emerson	Review to reflect current practices
Version 2a	May 2020	Paul Emerson	Full review – requested by Legal Services in light of Covid 19. Minor change to contact details on p4.
Version 3	February 2024	Paul Emerson	Review and update