# **Section 61 Review of Treatment form**

## Who must complete this form

A report under section 61 of the Mental Health Act must be completed by the approved clinician (AC) in charge of the treatment.

## When to complete this form

On the occasions referred to in Section 61 when a patient is being given treatment under:

* Section 57(2) – This is where neurosurgery for mental disorder certified by a CQC appointed panel has been carried out. Please note the following report form does not relate to Section 57(2) treatments (neurosurgery for mental disorder). You must complete a separate form for this specific treatment, which is available on request from our Mental Health Act Operations – SOAD team by emailing: SOADSection61Audit@cqc.org.uk
* Section 58(3)(b) - medicine for mental disorder certified by a SOAD
* Section 58A (4) or (5) - ECT certified by a SOAD; or
* Section 62A in accordance with a Part 4A certificate that falls within section 64C(4) – treatment for mental disorder has been administered during a period of recall to a patient where the treatment is specifically certified to be given on recall by a SOAD and the patient subsequently remains on a Community Treatment Order (CTO). In all other circumstances a report under section 61 is not required to be submitted for a patient subject to a CTO.

## How to complete this form

* You must provide an answer to every field marked with an asterisk (\*). Other fields are optional, but if you have the information please provide it.
* Attach a copy of the current statutory certificate(s) (Forms T2, T3, T6 etc…) that certify all treatment for mental disorder with this submission.
* Include any current section 62 paperwork.

## How to submit this form

**Submit this form, including attachments, via secure email to:** [**SOADSection61Audit@cqc.org.uk**](mailto:SOADSection61Audit@cqc.org.uk) **or** [**S61.Audit@CQC.cjsm.net**](mailto:S61.Audit@CQC.cjsm.net)

## Details about the clinician and provider

### Approved Clinician details

This tells us:

* which Approved Clinician has submitted the section 61 report submission
* who to address any questions/practice points relating to the submission or the patient’s treatment

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| --- | --- |
| \*First Name: | Click or tap here to enter text. |
| \*Last Name: | Click or tap here to enter text. |
| \*Mobile Telephone number: | Click or tap here to enter text. |

Please provide a secure email address for any communications about this section 61 submission.

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| \*Secure Email Address: | Click or tap here to enter text. |

### Provider details

This tells us:

* which provider is responsible for the patient’s care and treatment

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| \*Which provider is responsible for the patient’s detention/CTO? | Click or tap here to enter text. |

For detained patients:

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| \* Name of the location where the patient is detained: | Click or tap here to enter text. |
| \*Name of the Ward/Unit where the patient is detained: | Click or tap here to enter text. |

### Mental Health Act Office contact details

This tells us:

* which MHA office is relevant to the section 61 report submission
* who to address any questions/practice points relating to the submission

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| \* Email address:  This should be a secure email address for communication relating to this report e.g. nhs.net, cjsm.net or an email accredited to secure email standard. | Click or tap here to enter text. |
| \* Telephone number: | Click or tap here to enter text. |

## Patient details and diagnosis

### Patient details

We need this to:

* identify who the section 61 submission report is related to
* identify the report in future communications with the AC
* identify the patient and review their history

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| \* Patient’s first name | Click or tap here to enter text. |
| \* Patient’s last name | Click or tap here to enter text. |
| \* Patient’s date of birth | Click or tap to enter a date. |
| NHS Number: | Click or tap here to enter text. |

We need this to:

* be aware of the patient’s physiology when considering the potential interactions/impacts of medicine
* to be aware of how the patient identifies when considering their circumstances to effectively regulate to advance equality and protect people’s Human Rights to tackle inequalities

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| \*What is the patient’s sex? | Choose an item. |
| \*Is the gender the person identifies with the same as the sex registered at birth? | Choose an item. |
| [IF NO AT QUESTION ABOVE] \*How does the person describe their gender identity? | Choose an item. |
| \*What is the patient’s ethnic group? | Choose an item.  If other, please describe:  Click or tap here to enter text. |

### Patient diagnosis details

Please record all diagnoses

We need this to:

* be aware of the patient's condition(s)
* to understand what the treatments are being given for

What is the patient’s diagnosis (diagnoses)?

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| Click or tap here to enter text. |

### Patient consent details

We need this to:

* be aware of the patient’s wishes/preferences and circumstances in relation to treatment

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| \* What is the patient’s current consent status?  Please select more than one option if the patient’s consent status is different for different treatments. | Capable of consent  Capable of consent and refusing  Incapable of consent |

## Detention status

We require this to:

* confirm that the patient is detained under an applicable section of the MHA
* that a section 61 report is statutorily required and has been submitted at the correct time
* provide an understanding of the circumstances of the patient’s detention

For 17A – please note a section 61 report submission is **only** required **if** treatment for mental disorder has been administered during a period of recall to a patient where the treatment is specifically certified to be given on recall by a SOAD and the patient subsequently remains on a Community Treatment Order (CTO). **In all other circumstances** a report under section 61 is **not** required for a patient subject to a CTO.

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| \*What MHA Section is the patient currently detained under?  This is the list of sections of the MHA that a patient can be detained under where Part IV/4A of the MHA applies and a section 61 report may be required. | Choose an item.  If Other, please provide further details:  Click or tap here to enter text. |
| \*When did the patient’s current section commence?  Please record the first date the patient was detained in the current continuous period and not the last renewal date. | Click or tap to enter a date. |
| \*Please record the date of examination for the purposes of renewing detention/CTO or in relation to a restricted patient reporting to Secretary of State. | Click or tap to enter a date. |

## Statutory Certificates

We require this to confirm:

* which certificate(s) is/are certifying treatment(s)

Add the date and type of statutory certificate(s) currently authorising treatments:

### 1st Certificate

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| \*Date: | Click or tap to enter a date. |
| \*Certificate type: | Choose an item. |

### 2nd Certificate

|  |  |
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| Date: | Click or tap to enter a date. |
| Certificate type: | Choose an item. |

## Urgent/Emergency MHA powers

We require this information to:

* understand if medicine treatment is being given under urgent treatment powers
* understand the entire scope of treatment and under what authority this is being given

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| \* Are urgent MHA powers under section 62 currently being used to authorise medicine? | Choose an item.  \*If yes, what date did you first start using these powers?  Click or tap to enter a date. |

### Second opinion requests

We need this information to confirm if a further second opinion request has been submitted for any new proposed treatments.

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| \*Has a second opinion request been submitted for treatment? | Choose an item. |

### Copies of the statutory certificates/s62 paperwork

We require this to:

* confirm the authority for each described medicine
* know whether this is a SOAD certificate or a certificate signed by the AC

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| \* Please also submit a copy/copies of the statutory certificate(s) which currently certify all medicines for mental disorder and any current section 62 paperwork | Copy/copies of the statutory certificate(s) attached  Any current s62 paperwork attached |

## Treatment plan

### Medicines

We require this information to understand:

* the medicine treatment plan to consider the continued appropriateness of treatment and the SOAD’s certificate
* what treatments are covered by which certificate

Please list all medicines for mental disorder and medicines for physical disorder that are currently being given or proposed to be started.

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| \*Medicine name  (Please provide the specific name of each medicine rather than its category). | \*Current dosage | \*Frequency | \*Regular or prn | \*Route | \*Currently being given or proposed to be started?(Enter C or P) |
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### ECT

We require this to understand:

* If ECT is being administered as part of the treatment plan
* what treatments are covered by which certificate

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| If applicable, indicate the number of applications of ECT given: | Click or tap here to enter text. |
| Date last given | Click or tap to enter a date. |

## Patient’s condition

This tells us:

* why this specific treatment plan is being given to this patient at this time
* any proposed changes to the treatment
* how the patient has responded to the treatment plan
* the patient’s experience of the treatment
* the continued benefits of treatment against the risks/side effects
* how the treating team are monitoring the patient’s physical health and whether there have been any effects as a result of the treatment

\*What is the current rationale for this specific treatment plan for this patient?

This should be a concise statement to capture the thinking in respect of treatment with medicine. If high dose medication is part of the treatment plan, there should be an explanation of the justification (considering professional guidance) and how any risks are being mitigated. If the treatment is unusual, especially complex, or off-licence and not mainstream, then it will be necessary to provide more detail.

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| Click or tap here to enter text. |

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| Are you intending to stop or change any of the listed medicines? | Choose an item.  If yes, please provide further details:  Click or tap here to enter text. |

\*What has been the patient’s response to the treatment?

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| Click or tap here to enter text. |

\*Which adverse effects does the patient exhibit?

Please record ‘none’ if the patient has not exhibited adverse effects from the treatment plan. Please include information on the severity of any adverse effects and actions that have been taken to minimise them

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| Click or tap here to enter text. |

\*Please provide details of any physical health monitoring

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| Click or tap here to enter text. |

Please provide any additional details not covered previously that you believe we should be aware of when considering this section 61 report submission:

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| Click or tap here to enter text. |

## Additional demographic data

Responding to the following questions is optional and is for equality monitoring purposes only to gain a better understanding of health inequalities.

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| Does the patient have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more? | Choose an item. |
| Does their condition or illness\do any of their conditions or illnesses reduce their ability to carry-out day-to-day activities? | Choose an item. |
| Physical health  What do you know about the patient’s physical health, does the patient have any of these impairments?  You must answer for each one. | Sight impairment (partial or full blindness)? Choose an item.  Hearing impairment (deafness or partial hearing)? Choose an item.  Mobility or gross motor skills impairment (using the large muscles of the body in legs, torso or arms for activities such as walking or sitting)? Choose an item.  Manual dexterity impairment (fine motor skills - such as holding cutlery or using a keyboard)? Choose an item.  Stamina problems, breathing impairment or fatigue? Choose an item. |
| Neurological health  What you know about the patient’s neurological and mental health: does the patient have any of these impairments?  You must answer for each one. | Mental ill health? Choose an item.  Learning disability (such as ability to concentrate, learn or understand)?  Choose an item.  Autistic spectrum conditions?  Choose an item.  Other neurodiverse impairment (such as ADHD, dyspraxia or dyslexia)?  Choose an item.  Memory loss (for example people with dementia)? If memory loss issues are associated with a learning disability, select 'yes' for learning disability instead. Choose an item. |
| Other health conditions  What do you know about the patient’s other health conditions: does the patient have any of these impairments?  You must answer for each one. | Progressive and long-term health conditions (such as HIV, cancer, multiple sclerosis, epilepsy)?  Choose an item.  Other impairment, disability or long-term health condition? Choose an item. |
| What is the patient’s sexual orientation? | Choose an item. |

## Signature

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| \*Signature of approved clinician in charge of treatment | Click or tap here to enter text. |
| \*Name of approved clinician in charge of treatment (Please use capital letters) | Click or tap here to enter text. |
| \*Date | Click or tap to enter a date. |