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Review Article

Understanding The Mental Health Act Changes – Challenges And Opportunities For Doctors

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Abbreviations

MHA	Mental Health Act
COP	Code of Practice
SCT	Supervised Community Treatment
AMHP	Approved Mental Health Professional
ASW	Approved Social Worker
AOT	Assertive Outreach Team
PICU	Psychiatric Intensive Care Unit
AC	Approved Clinician
RC	Responsible Clinician
NR	Nearest Relative
LPA	Lasting Power of Attorney
SOAD	Second Opinion Appointed Doctors
ECT	Electric Convulsive Therapy

We are in the middle of the greatest changes in mental health law in a century. This started with the introduction of the Mental Capacity Act in October 2007, continued with amendments to the Mental Health Act (MHA) in November 2008, and will finish with a final flourish when the Deprivation of Liberty Safeguards come into effect to April 2009.

But what do these changes mean for Psychiatrists and other doctors? This article explores the changes.

All these changes need to be seen within the context of the Guiding Principles and the clarified legal status of the Code of Practice (COP).

- The MHA tells us WHAT to do
- The COP explains HOW to do it
- The Guiding Principles help us to apply the MHA and COP in INDIVIDUAL SITUATIONS

The Mental Health Act 1983 (as amended by the Mental Health Act 2007)

Although the structure of the Mental Health Act remains the same, the Act has been amended in the following ways:

Key Change 1	Introducing a Simplified Single Definition of Mental Disorder.
Key Change 2	Abolishing the 'Treatability' Test and introducing a new Appropriate Medical Treatment Test.
Key Change 3	Ensuring that Age Appropriate Services are available to any patients admitted to hospital who are aged under 18 (anticipated by 2010).
Key Change 4	Broadening the Professional Groups that can take particular roles.
Key Change 5	Introducing the right for patients to apply to court to displace their Nearest Relative, and including civil partners in the list of potential nearest relatives.
Key Change 6	Ensuring that patients have a right to an Advocacy Service when under compulsion (implemented in 2009).
Key Change 7	Introducing new safeguards regarding Patients and Electro-Convulsive Therapy.
Key Change 8	Introducing a new provision to allow Supervised Community Treatment. This allows a patient detained on a treatment order to receive their treatment in the community rather than as an in-patient.
Key Change 9	Earlier automatic referral to a Mental Health Review Tribunal (Tribunal) where patients don't apply themselves. & new Tribunal system structure.
Key Change10	New '2nd Professional' role for renewal of section 3.

The status of the Code of Practice

The Act makes it clear that professionals, including doctors, are expected to follow the guidance of the Code of Practice, or explain why they haven't done so. It also makes it clear that professionals are expected to take account of a number of issues, the guiding principles, when making decisions.

The Principles:

Purpose	Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm.
Least restriction	People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.
Respect	People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.
Participation	Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.
Effectiveness, efficiency and equity	People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

In the future, it is likely that doctors will be expected to justify decision making with reference to above principles.

Key Change 1: Definition of Mental Disorder:

The definition of disorders covered by the MHA is now "any disorder or disability of the mind". This simplified definition now applies to all sections of the Act. The four forms of mental disorder (mental illness, mental impairment, severe mental impairment and psychopathic disorder) have disappeared. This potentially means some people previously excluded are now included. For example, there may be some people with an acquired brain injury who were not covered by the term "mental impairment or severe mental impairment" who could now benefit from the protections of the Act.

The Learning Disability Qualification has been introduced to preserve the status quo (e.g. under section 3, a person with a learning disability alone can only be detained for treatment or be made subject to Guardianship if that learning disability is associated with abnormally aggressive or seriously irresponsible conduct.) and now applies to all those sections that relate to longer-term compulsory treatment or care for a mental disorder (in particular section 3, section 7 (Guardianship), section 17A (Supervised Community Treatment) and forensic sections under Part 3 of the Act). It means that if the use of longer-terms forms of compulsion are being considered solely on the basis that a person has a learning disability, that disability must also be associated with abnormally aggressive or seriously irresponsible conduct. This does not, of course, preclude the use of compulsion for people who have another form of mental disorder (such as a mental illness) in addition to their learning disability.

Key Change 2: The Appropriate Medical Treatment Test

The MHA introduces a new "appropriate medical treatment" test that will apply to longer-term powers of compulsion concerned with treatment(for example, section 3 and Supervised Community Treatment). As a result, it will not be possible for patients to be compulsorily detained for treatment or compulsion continued unless medical treatment which is appropriate taking into account the nature and degree of the patient's mental disorder and all other circumstances of the case is available to that patient.

"Medical treatment" includes psychological treatment, nursing, and specialist mental health habilitation, rehabilitation and care as well as medicine. It does not have to be the "perfect" treatment, but doctors will be expected to satisfy themselves that appropriate treatment, taking into account all the circumstances of the case, is available and state in their recommendations in which hospital(s) it will be available to the patient. When making recommendations for section 3, the recommending doctors will need to confirm that there will be appropriate medical treatment available, and state on the

recommendation form the hospital, hospitals or part of a hospital that the treatment will be given in.

Example:
Ellie was seen by 2 doctors in A&E after having been found by the police naked and dancing in the street. She was sexually disinhibited, and aggressive both physically and verbally. Ellie was well- known to the AOT team and was assessed by her own consultant and GP. Because they both knew her well, and knew what treatment would be of benefit to her, they felt confident in signing the form saying that appropriate medical treatment would be available, However, given her current presentation, they did not feel it would be safe to admit her to an open, mixed sex ward. Instead, her consultant rang and negotiated with the bed manager that she be admitted to a women only PICU bed. The ward name and hospital name were inserted onto the section 3 recommendation form, and the AMHP was only able to admit Ellie to that ward.

Key Change 3: Admitting young people to suitable environments

The effect of this change is that hospital managers are placed under a duty to ensure patients under 18 who are admitted to hospital for assessment or for treatment under the legislation, or who are voluntary patients are in an environment that is suitable for their age (subject to their needs). There is flexibility in the amendment to allow for patients under 18 years to be placed on adult psychiatric wards where the patient's needs are better met this way. This is expected to come into force in 2010, by which time it is hoped new services will be available.

Section 140 of the existing Mental Health Act has also been amended to put a duty on Primary Care Trusts to let Local Social Service Authorities know where services especially suitable for admitting young people are to be found. The amendment to section140 has already come into force.

It is also now no longer possible to admit a competent and objecting 16 or 17yr old to hospital for treatment for mental disorder on the say of their parents.

Key Change 4: The Broadening of access to professional roles

This change widens the group of practitioners able to train to fulfil functions previously undertaken by Approved Social Workers (ASWs) and Responsible Medical Officers (RMOs). It does this by introducing two new roles:

Approved Mental Health Professionals (AMHPs): AMHPs are mental health professionals with specialist training in mental health assessment and legislation. The training will be opened up to include mental health and learning disability nurses, clinical psychologists and occupational therapists as well as social workers. AMHPs will assess "on behalf of" Local Authorities, who will continue to be responsible for approving AMHPs and for ensuring a 24hr AMHP service is available.

The final part of this change concerns the Approved Clinician (AC), the professional status/qualification a practitioner must obtain before they can take on the responsibilities of a Responsible Clinician (RC) for a particular person.

The RC is the old Responsible Medical Officer role which has now been opened up to include social workers, mental health and learning disability nurses, clinical psychologists and occupational therapists. The RC has overall responsibility for a patient's case. This change allows more flexibility – for example, making it possible to transfer responsibility to professionals from different groups of staff as the patient's needs change.

Directions make it clear that all professionals who want to be a RC need to meet particular levels of competence, undertake a short course to demonstrate their state of readiness and be approved by Strategic Health Authority as an AC.

Transitional arrangements for doctors:

Doctors with Section 12 status: for doctors with section 12 status, that status will continue unaltered for as long as had been expected to. For example, a doctor whose section 12 approval was due to expire in April 10, this will still be the case.

Doctors with section 12 status who have acted as an RMO for a patient in the 12 months prior to 3rd Nov 2008: such doctors will automatically be given Approved Clinician Status so that they can be Responsible Clinicians for people detained under the Act. If their section 12 status was due to expire during the next 12 months, it will be extended until 2nd Nov 2009.

Doctors (such as community consultants) who are section 12 approved, have been responsible for a patient's medical treatment but have not acted as an Responsible Medical Officer (RMO) in the 12 months prior to 3rd Nov 08: such doctors will need to complete a course for Approved Clinicians before 2nd Nov 09, and as long as they do so their approval will last for a full 3 year period until 2nd Nov 2011.

In the future, a doctor (but not a professional from one of the other 4 eligible groups) who completes an Approved Clinician Course will also automatically receive section12 approval.

Accessing Approved Clinician Training:

AC training will be the responsibility of Strategic Health Authorities. Generally, people wishing to be Approved Clinicians will need to be recommended by employers – and will need to be able to demonstrate how they meet the competences for the role *prior* to undertaking the AC training

course. The course is likely to be a few days at most, so preparatory training will be important. Each area will need to develop its own systems and policies, these are likely to be influenced by the pilot studies that have been taking place around the country in preparation for this change in the law.

Responsibilities of the Responsible Clinician (RC):

- Renew detention with the agreement of another professional from a different professional background
- Discharge patients from detention
- Grant leave for patients.
- Discharge patient on to supervised community treatment, with the agreement of an amhp
- Set conditions on the community treatment order for sct with the agreement of an amhp
- Extend sct with the agreement of an amhp
- Recall sct patients to hospital, if necessary
- Re- detain an sct patient by revoking the community treatment order, with the agreement of an amhp
- Discharge patients from sct

Key Change 5: Nearest Relative Changes

Changes give patients the right to make an application to court to displace their nearest relative and introduces a new ground for displacement: that the current Nearest Relative(NR) is "otherwise unsuitable for the role". The provisions for determining who is the NR have also been amended to include civil partners on equal terms with a husband or wife.

Key Change 6: Independent Mental Health Act Advocate (IMHA) service

Gives the right for patients who are subject to compulsion to have access to advocacy services. (that is, those on section 2, 3, section 7 Guardianship, SCT and similar forensic sections. Those on short term sections such as section 136 will not be eligible) Advocates will have the right to meet with patients in private. They will also have access to patient records, where a patient with capacity gives consent, and to meet and discuss the patient with professionals, such as doctors, involved in their care. In the case of patients lacking capacity to make such decisions, access must not conflict with decisions made by a deputy, Lasting Power of Attorney (LPA) donee or Court of Protection, and the person holding the records must agree that such access is "appropriate". The principles of the COP should be used to decide whether it is appropriate to disclose information in a particular case.

It is planned that the new "Independent Mental Health Advocacy" services will be available from April 2009.

Key change 7: ECT and Patient Rights

Except in emergencies, detained patients may in future only be given ECT if they have capacity and agree or, (as now) if they do not have capacity, the ECT is authorised by a Second Opinion Appointed Doctor (SOAD).

In other words, this means that a detained patient can refuse to have ECT, and, except in emergencies, this can be overturned only if a SOAD agrees that the patient does not have capacity to make the decision and that giving the ECT treatment would be appropriate. In this case, the SOAD also needs to be sure that there is no valid advance decision refusing the use of ECT. If such an advance decision has been made, then ECT cannot be given, except in an emergency.

In the case of young people (aged under 18), even if the patient agrees, unless it is an emergency, they may only be given ECT with the additional agreement of a SOAD. These rules apply to young people whether or not they are detained.

In all these cases, it is only an emergency if the ECT is immediately necessary to save the patient's life or prevent serious deterioration in their condition.

Key Change 8: Supervised Community Treatment

Introduces Supervised Community Treatment (SCT) for patients following a period of detention in hospital for treatment (mainly those on section 3 or unrestricted forensic sections such as section 37). It will allow a small number of patients who currently disengage from support once discharged from hospital to be cared for in the community, subject to the possibility of being recalled to hospital if necessary. This is to ensure they continue to get the treatment they need. There is no lower age limit.

As a statutory framework, SCT is intended to support such vulnerable patients (including some who may pose a risk to others) to:

- live in the community;
- help improve engagement with the care team by shifting the balance of power more in the patient's favour;
- act upon any clinical signs of relapse at an early stage;
- be a mechanism to manage actual or potential relapse; and
- ensure that services are aware of and responsive to any changes of circumstances which arise for the patient or their carers.

The criteria for consideration of the use of SCT include:

- the person is suffering from a mental disorder and detained under s3 (or similar forensic section) for treatment;
- the need for medical treatment;
- the existence of a risk to the patient's health or safety or that of others;
- that appropriate treatment is available; and that the patient does not need to be in hospital to receive it but does need to be liable to recall to hospital to ensure that the risk can be managed; and
- that it is necessary for the patient's health or safety or the protection of others that the patient remains liable to recall.

Key Change 9: Changes to the Tribunal system

Changes to the MHA have introduced earlier referrals by Hospital Managers of detained patients who have not used their rights of appeal to the Tribunal.

To protect patients, everyone who is compulsorily admitted to hospital must have their detention review by the Tribunal service within the 1st 6 months, and every 3 years after that. If the patient themselves doesn't request a tribunal referral within the above timescales, the hospital managers must do so.

For under 18s, they must be seen annually by the tribunal.

The Secretary of State has the power to reduce further these periods for referral by Hospital Managers in the future.

The MHA 2007 has also introduced the immediate referral of patients who have had their SCT revoked.

The structure of the Tribunal Service has been changed to provide a '1st' and '2nd' tier. The purpose of the 2nd tier is to allow appeals and clarification of legal points, without having to use the judicial review process.

In addition, new rules have been issued as guidance for professionals about what is expected to be covered in reports to tribunals.

Key Change 10: the role of the 2nd Professional in the renewal of section 3

In addition to the Responsible Clinician, the written agreement of a second professional is needed to renew section 3.

The second professional must

- come from a different professional discipline compared with the RC
- be involved with the care of the patient
- be able to reach independent decisions
- have sufficient expertise and experience to make a judgement about whether the criteria for detention continue to be met.

Even if the RC disagrees with the view of the 2nd Professional, they should not normally seek to find another professional. In such circumstances the section 3 would not be renewed. In very exceptional circumstances where a different opinion is sort, this must be brought to the attention of the hospital managers who are also required to consider and approve the renewal of the section.

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