Most of the changes to mental health law that are described in this article were implemented in November 2008. Where implementation dates differ they will be stated. Users of the Mental Health Act 2007 will be pleased to know that where at all possible section numbers in the Act remain unchanged and in the main, new material is added as a subsection of the numbers identified in the 1983 Act. Strictly speaking the legislation referred to is the Mental Health Act 1983 as amended by the Mental Health (Amendment) (North Ireland) Order 2004. The mental capacity of individuals must be assessed to determine if the deprivation of liberty of the mentally incapacitated person could apply when considering compulsion under the Mental Health Act 1983 (Department for Constitutional Affairs 2007).

Guiding principles

It is important to understand what influences the legal framework of mental health and how this affects the care and treatment of individuals. The Mental Health Act is the law. Case law develops as a result of challenges to the interpretation of that law. The Mental Health Act Code of Practice provides guidance on how practitioners should undertake duties under the Mental Health Act. The guiding principles are based on evidence-based practice and value-based approaches linked to ethical considerations and individual rights. The guiding principles include purpose, least restrictive alternative, respect, participation, and effectiveness, efficiency and equity.

Purpose

When considering compulsion, decision makers should try to minimise any harm to the individual and other people as a result of bringing that person into compulsion. Due regard must be given to physical as well as mental wellbeing.

Least restrictive alternative

Decision makers should ensure that restrictions to liberty are proportionate to the risk posed, and only restrict where there is evidence of need to do so.

Respect

An individual’s needs should be considered, including race, religion, culture, gender, age and sexual orientation. No person should be unlawfully discriminated against.

Participation

Practically, this means patients should be involved in care planning and decisions about their care and, where appropriate, carers and family members should be involved.

Effectiveness, efficiency and equity

The emphasis for practitioners is meeting individual needs, but this is tempered with the need to deploy resources efficiently using evidence-based treatments.
Nine key changes to the act

This section outlines the nine key changes brought about by the new Mental Health Act.

1. A single definition of mental disorder

Since November 3 2008 a single definition of mental disorder has replaced the various categories used previously. The definition has changed from ‘mental illness, arrested development of mind, psychopathic disorder and any other disability or disorder of mind’ to ‘any disorder or disability of the mind’. Addiction solely to drugs and alcohol remain excluded from the Mental Health Act.

People with a learning disability are viewed slightly differently to other people in terms of the definitions leading to eligibility for compulsion. In respect of short-term sections such as Section 2, there is no difference with other diagnostic categories, but for Section 3 and other longer-term sections there are two routes to compulsion:

- When the person’s learning disability leads to ‘abnormally aggressive behaviour’ and ‘seriously irresponsible conduct’. Abnormally aggressive behaviour means observed actions that are outside the normal range of aggressive behaviour. Seriously irresponsible conduct means behaviour that demonstrates little or no regard for consequences (Department of Health (DH) 2008). In practical terms, the judgement required to be sure that the individual’s behaviour meets this criterion must be made by those with high levels of expertise and experience in the assessment and treatment of people with a learning disability.

- When, like any other individual, the person has a mental disorder as defined in the new Mental Health Act.

2. Criteria for detention

The new legislation abolishes the ‘treatability test’. This involved assessing whether a patient would respond to psychiatric interventions, in order to exclude people with diagnoses of personality disorder. The new act replaces this with an appropriate medical treatment test. This test will be applied to all longer-term sections such as Section 3 and the new Community Treatment Order (CTO). Individuals being assessed for Section 2 or other shorter-term sections of the Mental Health Act are excluded from this test.

Practitioners involved in the assessment must be sure that treatment is available at a particular place and that it is suitable for that individual’s needs. The new Mental Health Act defines appropriate medical treatment as ‘treatment to be given to a patient if the treatment is appropriate in this case, taking into account the nature and degree of the mental disorder from which he is suffering and all other circumstances of his case’.

Medical treatment, as well as the provision of medication, also includes nursing care, psychological interventions, habilitation and rehabilitation. The purpose of the medical treatment must also be to alleviate or prevent worsening of the mental disorder or symptoms arising from that disorder. Treatment in this instance is defined as an intervention for the purpose of alleviating or preventing a worsening of mental disorder or one or more of its symptoms or manifestations.

The Code of Practice suggests that healthcare professionals making the assessment should try to develop a wider focus that includes a number of social factors including age-appropriate services, whether the treatment is available locally, its implications for the person’s family and social relationships, his or her gender, culture and ethnicity, and any other health problems he or she may experience.

When professionals make decisions about appropriate treatment they must also assess the nature or degree of the person’s mental disorder and whether they warrant the person being subject to compulsion. The case of R v Mental Health Review Tribunal for the South Thames Region, ex parte Smith [1999] is case law that defines degree and nature (Jones 2009). This case law has established that nature refers to the particular mental disorder which the patient has, its chronicity, its prognosis and the person’s previous response to receiving treatment for the disorder.

3. Age-appropriate services

This change recognises that children have often been detained inappropriately on adult wards. Hospital managers now have a duty to ensure that patients under 18 years who require admission to hospital under a section of the Mental Health Act or are voluntary patients are admitted to environments that are suitable for young people. It could mean they will be sent to units for younger people or it might be appropriate to treat them in an adult psychiatric ward – this will depend on where their needs can best be met.

There are many complex factors to consider when managing children and young people who may require inpatient admission. Mental health trusts are expected to develop age-appropriate services by 2010. The new legislation also places a duty on primary care trusts to let social service authorities know where they can access services that will admit young people in an emergency.

4. Broadening professional groups

Under the new legislation there are two new professional roles: the approved mental health professional and the responsible medical officer. The approved mental health professional takes over from the approved social worker and will be sourced from occupational therapy, psychology, social work,
learning disability or mental health nursing. The responsible medical officer role is replaced by the approved clinician and the responsible clinician; these roles will be performed by doctors, occupational therapists, psychologists, social workers, learning disability nurses and mental health nurses.

Before any of these people can act as responsible clinicians they will first have to be approved clinicians. All responsible clinicians will be drawn from the strategic health authority’s approved clinicians list. In practice, the responsible clinician should be someone who has regular contact with the patient and is familiar with his or her care and treatment, and has the most appropriate expertise to meet the patient’s main treatment needs (DH 2006a).

Training for approved clinicians is likely to be between two and five days and will be for those professionals already working at a high level. For approved mental health professionals the training is similar to the previous approved social worker training and the first non-social work approved mental health professionals qualified in early 2010.

In terms of the Mental Health Act assessment process, only an approved clinician who is also a section 12 approved doctor can recommend bringing someone into detention in hospital. 5. Nearest relative The nearest relative is important in terms of the Mental Health Act and is clearly defined in Section 26. The term ‘next of kin’ has no meaning in mental health law (James and Cornock 2008). The nearest relative can apply for detention or guardianship, they can object to the approved mental health professional making application for admission to hospital or a guardianship, ask for his or her relative to be assessed under the act and be told why he or she was not admitted if this is the outcome. The nearest relative can also discharge patients from most sections. Therefore, it is imperative that the correct nearest relative is located and appropriately consulted.

The new legislation also gives patients the right to displace their nearest relative and replace him or her with one of their choosing. The Code of Practice is clear that just because a nearest relative agrees to the admission under the Mental Health Act this is not on its own sufficient grounds for displacement. Legitimate grounds for displacement are: the patient does not have a nearest relative; the nearest relative is too ill; the nearest relative unrealistically objects to the patient’s admission; the nearest relative has discharged the patient without due regard for the individual’s or the public’s safety; or the nearest relative is otherwise unsuitable – for example, where there is evidence of abuse (DH 2006b).

6. Advocacy Independent mental health advocates have been provided to all patients under compulsion, including those on a guardianship order and those on CTOs from April 2009, with the exception of those on short-term sections such as Sections 4, 5, 135 and 136. Informal patients will not have a statutory right to advocacy.

These advocates will help patients under compulsion to understand the legislation they are subject to and any restrictions this places on them. They would also support explanations of medical treatments and explain the authority under which the treatment would be given. To help advocates in this task they will be able to interview the patient in private, visit and interview any person who is concerned with the patient’s medical treatment, and will have the right of access to records (both NHS and social service authority) about the patient if the patient consents to this.

It is the duty of the hospital managers, responsible clinicians and social services (in the case of guardianship) to inform patients and the nearest relative, should the patient wish them to, about advocacy services.

7. Electroconvulsive therapy Before November 3 2008 an informal patient with capacity who might be thought to benefit from electroconvulsive therapy (ECT) could be sectioned under Section 3 and given ECT with the sanction of a doctor approved to give a second opinion. Under the new Section 58A this is no longer possible. The only time patients with capacity can be forced to have ECT will be in an emergency. If patients lack capacity they can be given ECT with the agreement of an approved doctor giving a second opinion, and a responsible clinician.

The exceptions to this are those people with a valid advanced decision (one made when the patient had capacity that states he or she does not want ECT). In the case of children, if they consent they still need a second opinion from an approved doctor to assess whether the treatment is appropriate. Finally, a competent child’s refusal to have ECT is valid.

8. Supervised community treatment The CTO (Section 17) was brought in to replace supervised discharge (Section 25) to offer a modern approach to managing people with serious mental health issues in their own communities. This section of the new legislation has been the most controversial, with Paul Farmer, chief executive of Mind, suggesting that CTOs are like mental health anti-social behaviour orders (Mind 2007).

It is likely that the initial uptake and use of CTOs will be slow. Evidence from around the world would suggest the level of use varies from 2 per 100,000 of the population in Canada to more than 60 per 100,000 in Australia.
(Lawton-Smith 2005). However, where teams are committed to community oriented care, the CTO allows them to further develop crisis and assertive outreach teams. Other factors that will influence the use of the CTO will be the availability of beds and the prevalence of mental disorder in the population (DH and National Institute for Mental Health in England 2008). Lawton-Smith (2005) argued that the number of community treatments is increasing annually, and the more mature the supervised community treatment system is, the greater the use of CTOs.

CTOs can be applied to patients already in hospital under Sections 3, 37, 45A, 47 or 48 of the Mental Health Act. While they are subjected to a CTO, their hospital section is suspended. The procedure involves a responsible clinician and an approved mental health professional agreeing that the use of the CTO is appropriate. The CTO can last for a maximum of six months, but is renewable.

Criteria include:
(a) The person is suffering from a mental disorder of a nature and degree that makes it appropriate for them to receive medical treatment.
AND
(b) It is necessary for the health or safety of that person or the protection of other people that they receive the treatment.
AND
(c) Subject to him or her being recalled, such treatment can be provided without his or her continued detention in hospital.
AND
(d) It is necessary that the responsible clinician should be able to recall the person to hospital.
AND
(e) Appropriate medical treatment is available.

Individuals on the CTO have to abide by two mandatory conditions, which are (DH 2006c):
- They must make themselves available for examination by either the responsible clinician or the doctor approved to give a second opinion.
- Other discretionary conditions can be applied, but are not enforceable in the community. Failure to comply can lead to recall to hospital.

The recall process is set in motion when the person does not comply with the conditions set by the responsible clinician. When recalled to hospital the person can be treated as if under the original detention. The responsible clinician has 72 hours to decide either to return the patient to the community or keep him or her in hospital and revoke the CTO. If the person stays in hospital, he or she will start at day one again, which in the case of a Section 3 could mean a further six months in hospital.

9. Mental Health Review Tribunals
Patients brought into compulsion who have not used their right of appeal may now be referred earlier to the Mental Health Review Tribunal by hospital managers. The six-month referral rule must take account of the time spent under Section 2. The annual review of those aged under 16 has been raised to those under 18. Within the supervised community treatment framework all patients whose CTO is revoked must be immediately referred to the Mental Health Review Tribunal.

Conclusion
Mental health and learning disability nurses, along with other professionals, now have the opportunity to enhance their roles with the development of the responsible clinician and approved mental health professional roles under the new Mental Health Act. It is important that nurses engage with these changes and are at the forefront of taking on these responsibilities, while ensuring that the desired benefits of the act are achieved NS.

References


R v Mental Health Review Tribunal for the South Thames Region ex parte Smith [1999] CO0148.

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