The Mental Health Act


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INTRODUCTION

This purpose of this module is to provide information and guidance of the provisions of the Mental Health Act 2007 for those working in Health and Social Care settings. The Act (which superseded the Mental Health Act 2003) allows people with a 'mental disorder' to be admitted to hospital, detained and treated without their consent – either for their own health and safety, or for the protection of other people and is implemented in England and Wales only. Northern Ireland and Scotland have their own laws.

Learning Objectives

By the end of this session you should be able to:

- Define mental disorder
- Explain the background and purpose of the Mental Health Act 2007 including the role of the regulations
- Describe the key principles of The Mental Health Act (MHA)
- Identify the key aspects of the Mental Health Act 2007 and the related provisions of the Mental Health Act 1983
- Identify what is meant by medical treatment
- Apply the basic key principles in practice

MENTAL HEALTH

The law around providing treatment for mental health problems can be complicated, especially when it comes to children and young people. It is vital that professionals providing care and treatment to children and young people are aware of who is agreeing to them delivering that care. It could be the young person themselves, their parents or the law can be used.

The Mental Health Act 2007 (MHA) is the legislation governing the formal detention and care of mentally disordered people in hospital. It is essential that mental health professionals have a sound knowledge of the most commonly used 'Sections' and procedures; comply with the Act and adhere to the associated Code of Practice.

The 2007 Mental Health Act made several key changes to the 1983 Mental Health Act, which laid down provisions for the compulsory detention and treatment of people with mental health problems in England and Wales. Where the 1983 MHA focused on patients' rights to seek independent reviews of their treatment, the 2007 MHA is largely focused on public protection and risk management. The amended legislation extends the powers of compulsion and introduces compulsory community treatment orders, making patients' compliance with treatment a statutory requirement.

This module will follow the terminology used by the Mental Health Act [1] Code of Practice and will refer to:

- 'Child' or 'children' being individuals who are under the age of 16 years
- 'Young person' or 'young people' in relation to those aged 16 or 17 years.

DEFINITION OF MENTAL DISORDER

A single definition of mental disorder, replacing the categories of disorder found in the 1983 MHA. The definition changes from the four categories of "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disability or disorder of mind" to "any disorder or disability of the mind". People with learning disabilities will not be considered to be suffering from a mental disorder, however, unless the disability is "associated with abnormally aggressive or seriously irresponsible conduct". Dependence on drugs or alcohol is no longer categorised as a mental disorder. (MHA, 1983)

THE MENTAL HEALTH ACT 1983

The Mental Health Act 1983 is the legal framework that governs the care and treatment of people with a mental disorder in England and Wales. The main purpose of the Mental Health Act 1983 is

> *'to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patient'*
>
> (DoH, 2012)

Being detained under the MHA is more commonly referred to as being 'sectioned' and can be applied to any individual, of any age group. However, there are other ways that children may, more appropriately, be given treatment for a mental disorder that they are unable or unwilling to agree to. Equally, there are some circumstances in which the MHA might be exactly the right framework to use.

CONSENT

'Consent as a term does not only relate to a patient confirming acceptance of a treatment; it is the term for the entire decision making process that a patient will go through. This decision could have involved many different meetings, with many different clinicians; all of which should be considered part of "consent". It is important to note that consent can be provided in multiple forms, due to the importance of the medical treatment under discussion, as well as each individual patient's circumstances.'

(NHS UK, 2016)

Crucial to decisions about how children and young people receive treatment is an understanding of whether they can consent to treatment in their own right, and if they can't or won't, who else can. Valid consent to treatment is referred to a '*voluntary*' or '*informal*' patient. All patients have the right to choose or refuse a medical intervention, even if their decision does not appear to be in their best interest. Ignoring this right by failing to obtain valid consent may jeopardise the doctor-patient relationship. It does not only relate to a patient confirming/refusing treatment; it is the term for the entire decision making process that a patient will go through. This decision could have involved many different meetings, with many different clinicians; all of which should be considered part of the "consent" process.

Healthcare professionals may face disciplinary proceedings, civil actions, or criminal charges if they fail to adhere to the request and rights of their patient's choice and in breach of the Code of Conduct/Practice issued by their clinical governing body. The Mental Capacity Code of Practice states that healthcare professionals should not express an opinion on a person's lack of capacity without carrying out a proper examination and assessment.

MENTAL CAPACITY ACT (2005) AND COMPETENCE

The Mental Capacity Act 2005 (MCA) states the following: "…*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain*"

According to the principles of the MCA:

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision.

In all circumstances, for a patient to have the capacity for consent, they must be able to:

- Comprehend what the treatment is and its purpose when explained in simple non-technical language
- Understand the principal benefits, risks, and alternatives
- Understand in broad terms the consequences of not receiving the treatment
- Retain the information long enough to make an effective decision
- Exercise free choice

If an adult is considered to be lacking competence according to these criteria, they cannot provide valid consent, and some decisions may be made without their direct consent. As long as a treatment is considered in the patient's best interest and is not expressly forbidden by an advance decision (living will) then it can be provided. When a patient lacks capacity, it must be marked on a specific form (which can be ordered from your current organisation) which states that this is the case.

MENTAL HEALTH CAPACITY ACT 2005 RELEVANT TO CONSENT

The Consent to Treatment Provisions are dealt with in Part 4 of the Mental Health Capacity Act, which applies to:

Treatments for mental disorder.

All formal patients except those who are detained under sections (4), (5), (35), (135) and (136). The Act does not apply to those people subject to Guardianship or Supervised Discharge, who have the right to refuse treatment, except in emergencies.

Where a person has been deemed competent to have given their consent to treatment under Section (57) or Section (58), the person can withdraw that consent at any time. The treatment must then stop, and the appropriate procedures be followed, unless discontinuing treatment would cause 'serious suffering' to the patient, in which case the treatment can be continued.

Judging capacity

Just because a person has an 'impairment of, or disturbance in, the functioning of this person's mind or brain' doesn't mean they automatically lack capacity. Capacity judgements are time and issue specific, which means they are about making a decision at this time, about this issue, and some decisions are more difficult to make than others.

Acting on behalf of someone lacking capacity

If you determine that someone lacks capacity and decisions need to be made on their behalf, it is important to understand that you have a responsibility to act in:

- Their best interests
- A way that is the least restrictive of their rights

INDIVIDUALS 16 YEARS AND OVER AND THE MENTAL CAPACITY ACT

The issue of whether young people of 16 years and above can consent to treatment is covered by the Mental Capacity Act 2005 [2].

- A person must be assumed to have capacity unless it is established that he/she lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

FOR PEOPLE OF 16 YEARS AND OVER AND ASSESSING CAPACITY

There is a two-stage test for the assessment of capacity. The first stage is to ask:

"Is there an impairment of, or disturbance in, the functioning of this person's mind or brain?"

The second stage of the test is to ask:

"Does this impairment or disturbance mean that this person lacks capacity at this particular time to make a particular decision?"

How is this decided?

This is decided by asking:

- Can they understand the information?
- Can they retain the information?
- Can they weigh up or utilise the information?
- Can they communicate their decision?

If you can answer 'yes' to all four questions, then someone over 16 years has the right to make decisions, even if they have 'an impairment of, or disturbance in, the functioning of [their] mind or brain', or if they are making a decision that doesn't seem sensible.

FOR PEOPLE UNDER 16 YEARS: ASSESSING COMPETENCE

Individuals under 16 years, the MCA doesn't apply. Instead a child is considered to be competent if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed. Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being "Gillick Competent".

Gillick competence criteria refers to the test for Gillick competence. This identifies children aged under 16 who have the legal (England and Wales) capacity to consent to medical examination and treatment, providing they can demonstrate sufficient maturity and intelligence to understand and appraise the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

Children under 16 years might be competent to make decisions around their own healthcare, and if they are, they should be allowed to do so. The idea of competence relates to what children think about a specific issue, it is therefore, less likely that younger children will have sufficient 'intelligence and understanding' to agree to complicated medical or health decisions. A younger child might well be able to competently agree to a blood test or having a tooth removed, but not be competent to agree to a complicated operation.

FOR PEOPLE UNDER 16 YEARS: CONSENTING FOR A NON-COMPETENT CHILD

A child might not be competent to make a decision because they are very unwell, and have lost the ability to make choices that they would normally have, or because they are too young to have developed that ability.
In most situations like this, parents can and will make decisions for their child, unless the treatment needed is beyond what a parent can reasonably consent to or the parent is not acting in the child's best interests.
In most cases a person with parental responsibility (usually the child's parent) can consent to their treatment in hospital unless that treatment is very invasive or restrictive.

Generally, as discussed, from a legal perspective a child is seen to lack capacity or competence in providing decisions about their healthcare; this responsibility then falls on the parent, or someone with parental responsibility (not always a biological parent). A child's mother automatically has parental responsibility, unless she lacks capacity. According to current law, a father has parental responsibility through one of these three routes:

- jointly registering the birth of the child with the mother (from 1 December 2003)
- getting a parental responsibility agreement with the mother
- getting a parental responsibility order from a court

Only one parent is required to consent to treatment, but it is preferred that a consensus is reached on treatment from both parents.

The MCA allows people to plan for what should happen if they ever become unable to make certain decisions in the future. In particular, it allows people to make a Lasting Power of Attorney (LPA) or an advance decision. If a person has not made plans and becomes unable to make a particular decision, the MCA says that someone else may make that decision. This could be a friend, a relative, an informal carer, a professional carer, a doctor, a social worker or a nurse, for example.

The MCA also protects a person from legal liability if he or she takes actions and decisions in connection with the care or treatment of a person who lacks the mental capacity to deal with their own care or treatment.

The health professional in charge of the treatment makes the decisions about whether the individual can give consent. That professional should discuss any issues with others involved in the patient's care and with the patient's family and close friends. If it is decided that the patient lacks the capacity needed to give consent, the treatment can be given if it is deemed to be in the person's best interests.

The MCA does not contain a definition of the term "best interests" but does set out a checklist of issues that should be considered by anyone taking an action or decision on behalf of someone else.

Note: certain major treatments cannot be given without approval from the Court of Protection.

APPLYING THESE PRINCIPLES IN PRACTICE

So, in practice, what determines the legal context for admission to hospital for the assessment or treatment of mental disorder in children and young people?
How old are they?
Can they consent? In other words, do they have capacity or competence?

For 16 and 17 year olds with capacity;

- Offer informal admission if they consent
- Use the Mental Health Act 2007 if they refuse, and meet criteria for detention

It is important to remember that the MCA is used to help people who cannot make decisions around treatment. This is likely to be a relatively small group of 16 and 17 year olds, and using the MHA is a much more appropriate way of providing treatment to those who do not (rather than cannot) agree to what is proposed

16 and 17 year olds who don't have capacity;

- Use the MHA, if the admission is likely to lead to invasive or restrictive treatment
- If the admission doesn't lead to invasive or restrictive treatment, and is undertaken in the young person's best interests, it can be undertaken using the MCA and parental consent

Under 16s who are competent

- Offer informal admission if they consent
- Use the MHA if they refuse and meet criteria for detention

Under 16s who are not competent

In most cases, a parent will be able to consent to a child's admission for treatment, unless the treatment needed is beyond what a parent can reasonably consent to or the parent is not acting in the child's best interests. There are some cases when a parent is not the right person to consent. Someone else might have parental responsibility or, if a child is on a care order to the local authority, then they will have to consent to treatment on the child's behalf.

If the treatment is beyond what a parent can consent to on behalf of their child, the MHA might have to be used.

NOTE

These four categories do not cover all situations. Both the law and clinical reality are more complicated. In such cases, it is important to get specialist advice.

USING THE MENTAL HEALTH ACT

Introduction to Sections

COMPULSORY ADMISSIONS

Adults requiring in-patient treatment can be informally admitted of their own accord, or detained under sections 2, 3 and 4 of the MHA as it will stand after 3 November 2008
There are a range of possible 'sections' authorised by the MHA. The most common are:

- A Section 2, which authorises assessment and/or treatment for up to 28 days
- A Section 3 which authorises treatment for up to 6 months

Being detained under a Section is a possible outcome of a Mental Health Act assessment. An MHA assessment is a process that includes 'checks and balances' and not being detained can be the result of the assessment.

Who's Involved in an Assessment?

Three individuals are involved in an MHA assessment:

- Two doctors- make medical recommendations, in consultation with each other usually but based on their own independent clinical judgement. These doctors should either have special expertise in the assessment or treatment of mental disorder (a 'Section 12 Doctor'), or have previous knowledge of the patient.
- Approved Mental Health Professional (AMHP)

AMHP 2007 replaced the title of approved social worker to approved Mental Health Provider (AMPH). An AMHP can then make an application for the detention of the patient in hospital if they believe the criteria for detention are met. The role of the AMHP used to be undertaken by approved social workers, but has now been opened up to other suitably qualified professionals. The AMHP provides a vital non-medical perspective to the process of assessment and is ultimately responsible for the decision to detain an individual in hospital.

The AMHP also has to consult with the patient's next of kin (NOK). For a child or young person, this usually has to be someone with parental responsibility (PR). There are specific rules to identify who the nearest relative is, but for most young people, as long as they both have PR, it will be the older of their mother or father, or if the child or young person are on a care order to the local authority, it will be the local authority.

For a Section 2 the AMHP just has to inform the NOK of what is happening and what their rights are, but for a Section 3 the detention cannot proceed if the NOK objects

IMPLEMENTING THE MENTAL HEALTH ACT 2007

As mentioned earlier, most people who receive treatment for a mental disorder do so with their agreement, so being detained is not a necessity for receiving treatment.
However, although having a mental disorder is necessary for being detained, not everyone with a mental disorder can or should be detained.

Nature and degree
For detention to be appropriate the mental disorder must be 'of a nature or degree that warrants the detention of the person in hospital'. Nature and degree are 'inevitably bound up' although only one is necessary for a section to be used.

Nature

The word 'nature' refers to the particular mental disorder from which the patient suffers, how long for, the likelihood of improvement and the patient's previous response to receiving treatment for the disorder.

Degree

The word 'degree' refers to the current severity of the patient's disorder.

COMPULSORY ADMISSIONS (continued)

Adults requiring in-patient treatment can be informally admitted of their own accord, or detained under sections 2, 3 and 4 of the MHA as it will stand after 3 November 2008:

Section 2: Admission for assessment

An approved mental health professional (this replaces the role of the approved social worker – see below under the 2007 amendments) or nearest relative can apply for admission for assessment, which can last up to 28 days. Either party must have seen the person in the previous 14 days. The admission must be authorised by two doctors, who should both agree that:

a) The patient is suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment; and

b) The patient ought to be detained for his or her own health or safety, or the protection of others.

The patient can be discharged by a responsible medical officer (the role is being replaced by responsible clinician – see below under the 2007 amendments), hospital managers, the nearest relative, or the Mental Health Review Tribunal (MHRT).

Section 3: Admission for treatment

A nearest relative can apply for admission or, in cases where the nearest relative does not object, or has been displaced, or it is not reasonably practicable to consult him or her, an approved mental health professional. Detention can last for up to six months after two doctors have confirmed that:

a) The patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital; and

b) The treatment is in the interests of his or her health and safety and the protection of others; and

c) Appropriate treatment must be available for the patient.

Section 3 admissions can be renewed for a further six months and thereafter for periods of 12 months at a time. The patient can be discharged by the responsible clinician, hospital managers, the nearest relative (if the responsible clinician refuses, the nearest relative can apply to a MHRT within 28 days), or the MHRT

Section 4: Admission for assessment in cases of emergency

An approved mental health professional or nearest relative can apply for admission, having seen the patient in the previous 24 hours. A patient can be detained for up to 72 hours, after one doctor has confirmed that:

a) The detention is of "urgent necessity"; and
b) That waiting for a second doctor to approve the detention under section 2 would cause an "undesirable delay".

Section 136: Police powers to remove from a public place to a place of safety

Police officers have the power to remove from a public place anyone deemed to be mentally disordered and requiring immediate care and control, to a place of safety. The preferred places of safety include hospitals and care homes, although police stations can be used as a last resort. People can be held under section 136 for up to 72 hours, within which time they should be assessed by a doctor and an AMHP.

Section 2, for assessment and/or treatment, and Section 3 for treatment have already been mentioned. Many people who are 'sectioned' in the community and taken to hospital are placed on Section 2 for a maximum of 28 days.

There are several less commonly used parts of the MHA, such as sections for treating people who have committed criminal offences….

Section 4

This can be undertaken in an emergency by an AMHP and only one doctor, in a situation where any greater delay would be unacceptably risky. It allows for admission for up to 72 hours, to allow another doctor to assess the patient and convert it to a Section 2 or 3, if appropriate.

Section 5(2)

If an informal, or voluntary, patient withdrew their consent to remain in hospital they could be detained for up to 72 hours by a doctor in order to allow time for an MHA assessment to take place to determine if they should remain in hospital under Section 2 or Section 3. This 'holding power' applies to all inpatients, not just patients in mental health units, but only to people who have already been admitted to hospital, and subsequently changed their minds. It doesn't apply to people in outpatient clinics or the A&E department.

Section 5(4)

This is a 'holding power', like a Section 5(2), that nurses can use. It lasts for up to 6 hours and ends when a doctor arrives to assess the patient.