Safeguards under the MHA

Introduction

An essential part of provisions within the Mental Health Act is that it introduces a number of safeguards for people who are affected by the Act. It recognises that having your liberty take away, being held in hospital against your will and being administered medication that you do not want is a massive infringement on a person's rights and should only ever be done when it is absolutely necessary.

The Mental Health Act introduces the following safeguards which will cover through this

- Nearest Relative
- Second Opinion Approved Doctor
- IMHAs
- Care Quality Commission

Nearest relative

The MHA 1983 confers a number of rights and powers upon a person's nearest relative (if they have one). These include:

- nearest relatives can make applications for the person to be detained
- the nearest relative, must be informed either beforehand or as soon as practicable afterwards, if an AMHP makes an application for detention under section 2 or 4
- the nearest relative msut be consulted before making an application for detention under section 3 or an application for guardianship. The application cannot be made if the nearest relative objects
- in many cases, the nearest relative has the right to discharge a patient from detention or SCT (although this may be blocked by the RC)
- nearest relatives always have the right to discharge people from guardianship (unless the patient is on a guardianship order imposed by a court under section 37). Discharge from guardianship cannot be blocked
- in some circumstances, nearest relatives can apply to the Tribunal for a patient's discharge

Nearest relative

- generally, nearest relatives will be told when the patient has applied to the Tribunal, unless the patient requests otherwise
- unless the patient requests otherwise, nearest relatives generally have to be given a copy of written information that hospital managers or local social services authorities are required to give patients about their rights (etc) under the Act
- unless they ask not to be told, or the patient requests otherwise, nearest relatives generally have to be told if the patient is discharged from detention or SCT, preferably seven days in advance.

Nearest relative

Who is the nearest relative? (section 26)

A person cannot choose their nearest relative. The Act itself sets out a so-called “hierarchical list” in section 26 to determine who the nearest relative is.

- husband, wife or civil partner
- son or daughter
- father or mother
- brother or sister
- grandparent
- grandchild
- uncle or aunt
- nephew or niece

The basic rule is that the person who comes highest in the list is the nearest relative. If two or more people come in the same position, the nearest relative is the older or oldest (regardless of gender).

Nearest relative

However, there are many significant exceptions to these rules. In particular:

- people who have lived together for at least six months as if they were husband and wife or civil partners are normally treated as if they were, in fact, the patient's husband, wife or civil partner
- people who have lived together for at least five years are treated as relatives, whether or not they are actually related. They start at the bottom of the hierarchical list
- relatives (including people treated as relatives) who live with, or care for, the patient generally take precedence over those who do not.

There are other exceptions to these basic rules. Before talking to a person about who their nearest relative is, it is worth studying section 26 of the Act carefully.

Nearest relative

Changing the nearest relative

Nearest relatives can delegate most of their powers by authorising someone else in writing to act on their behalf. They can also withdraw this authorisation to act any time they wish. If the nearest relative wants to appoint someone to act in this way it is important that it is done in writing. This is set out in regulations under the Act, rather than in the Act itself. The nearest relative must tell the patient if they have delegated their powers to someone else in this way (or have taken their powers back).

Patients cannot choose their own nearest relative. But it is possible for a patient – and certain other people – to apply to the county court for the appointment of an acting nearest relative in place of whoever would normally be the nearest relative. This is sometimes called “displacing” the nearest relative.

Nearest relative

Section 29 sets out five grounds for this:

- the patient has no nearest relative as far as can be determined
- the nearest relative is incapable of acting as such
- the nearest relative unreasonably objects to the making of an application for detention or for guardianship
- the nearest relative has exercised the power of discharge without due regard to the interests of patient or other persons, or is likely to do so
- the nearest relative is otherwise not a suitable person to act as such.

The third ground is sometimes used when a nearest relative objects to an AMHP making an application for detention under section 3, or an application for guardianship. If the AMHP thinks that the nearest relative is being unreasonable, they may decide to apply for the nearest relative to be replaced by someone else. If the patient is detained under section 2 at the time, their detention under that section can be extended until the court case is finally resolved.

Nearest relative and advocates

The IMHA role (as set out in the MHA) includes providing information to the person about the rights of others as they affect them - which includes the Nearest Relative. If you are working in mental health settings with people who have a Nearest Relative, you should make sure you offer information to your partner about what their Nearest Relative can and cannot do.

You must respond to a referral from a Nearest Relative however you must make sure that you are working to the person being detained. For people who have capacity to instruct you would not normally work with the Nearest Relative unless your partner tells/asks you to. However if your partner lacks capacity to instruct you, it may well be very sensible to talk to the Nearest Relative when planning your advocacy involvement.

Nearest relative or Nominated Person

The MHA White Paper published in 2021, suggests a new system to replace the Nearest Relative. This is because the system is felt by many to be no longer fit for purpose: many people who are actively involved in a person's life do not appear on the Nearest Relative list which is itself a very outdated patriarchal hierarchy.

The proposed system suggests replaced the Nearest Relative role with that of a nominated person. Whenever a person comes into hospital they will be asked to identify or choose someone they wish to take on this role.

Second Opinion or SOAD?

There is a difference in law between getting a 'second opinion' and requesting a 'SOAD' (second opinion approved doctor).

Anyone has the right to request a second opinion about anything connected with their mental health - whether this is a diagnosis, treatment, medication etc. However there is no legal right to have a second opinion (just to request one). As an advocate you can support people to make this request where they feel it would be helpful.

A SOAD, however is a legal right and a critical safeguard within the MHA.

SOAD

The SOAD service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are assessed as lacking the capacity to make decisions (include consenting) about their care and treatment.

The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.

Section 58 – treatment requiring consent or second opinion

Section 58 is about medication for mental disorder, but it only applies once three months have passed from the day on which any form of medication for mental disorder was first administered to the patient during the patient's current period of detention under the Act.

This three month period applies even if the section under which the patient is detained changes, or they go onto SCT.

SOAD

Detained patients cannot be given medication to which section 58 applies unless:

- the approved clinician in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and has done so; or
- a SOAD certifies that the treatment is appropriate and either that the patient does not have the capacity to consent, or the patient has the capacity to consent but has refused to do so.

A SOAD is an independent psychiatrist appointed by the Care Quality Commission or Healthcare Inspectorate Wales to decide whether to authorise treatment under the MHA. They are independent of the professionals responsible for the patient's care. Before deciding whether to issue a certificate, SOADs visit and examine patients. They also talk to professionals involved in their treatment.

SOAD

Section 58A – electro-convulsive therapy

Section 58A is about electro- convulsive therapy (ECT) (and the medication which is administered as part of ECT). Detained patients who have capacity to consent may not be given treatment to which section 58A applies unless they consent. In other words, they have the right to refuse ECT, even though they are detained (unless it is an emergency).

A patient who lacks the capacity to consent may not be given treatment under section 58A, unless a SOAD certifies that the patient lacks capacity to consent and that:

- the treatment is appropriate
- no valid and applicable advance decision has been made by the patient under the Mental Capacity Act 2005 refusing the treatment
- no suitably authorised attorney or deputy objects to the treatment on the patient's behalf; and
- the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

No-one under 18 can be given section 58A treatment unless a SOAD has certified that the treatment is appropriate (even if they consent).

SOAD

Exceptions in emergencies – section 62

Section 62 says that sections 58 and 58A do not apply in emergencies. An emergency is where treatment is immediately necessary to:

- save the patient's life
- prevent a serious deterioration in the patient's condition, so long as the treatment is not irreversible: or
- (except for ECT) to alleviate serious suffering, so long as the treatment is neither irreversible nor hazardous
- prevent the patient from behaving violently or being a danger to themselves or others, so long as the treatment is neither irreversible not hazardous and represents the minimum interference necessary

Because sections 58 and 58A do not apply where treatment is immediately necessary in these terms, the treatment can be given without a SOAD certificate.

It also means that ECT which is immediately necessary to save the patient's life or prevent a serious deterioration in their condition can be given without a detained patient's consent, even though that would not normally be allowed.

IMHAs

IMHAs are an important safeguard within the MHA as they provide an independent source of protection for a person's rights as well as ensuring the person has access to information, support and representation.

The role is firmly embedded within human rights and IMHAs are expected to promote and defend a person's rights.

There are different arrangements in England and Wales for IMHA provision - in Wales more people are entitled to support from an IMHA...

IMHAs

In England people are eligible for support from an IMHA if they are:

- detained under the Act
- conditionally discharged restricted patients
- subject to guardianship; or
- supervised community treatment (SCT) patients

For these purposes, detention does not include being detained on the basis of an emergency application (section 4) until the second medical recommendation is received,under the holding powers in section 5, or in a place of safety under section 135 or 136

Other patients (“informal patients”) are eligible if they are:

- are being considered for a treatment to which section 57 applies: or
- under 18 and being considered for electro-convulsive therapy or any other treatment to which section 58A applies

IMHAs

In Wales the IMHA role includes the people above however was extended under the Mental Health (Wales) Measure 2010 to include the right to an IMHA to all people admitted to psychiatric hospitals specifically:

- patients on shorter term emergency sections of the Act (principally s4, s5) and
- patients in hospital voluntarily or informally (who are not subject to the MHA)

People who are eligible to receive support from an IMHA are referred to as Qualifying Patients through the Act and Code of Practice.

IMHA - the role

The role of the IMHA, like all other advocacy roles, is one of supporting the person to make decisions, express choices, be heard and achieve their own goals.

As the IMHA is a specialist advocate working within mental health settings, this is always related to supporting the person on issues connected with their mental health, treatment under the MHA and how the Act affects them.

The Code of Practice sets out how the IMHA can support qualifying patients in a range of ways to help them to understand their rights under the MHA 1983 and to ensure they can participate, as fully as possible, in the decisions that are made about their treatment and care.

IMHA - the role

The Act says that the support which IMHAs provide must include helping patients to obtain information about and understand the following:

- their rights under the Act
- the rights which other people (e.g. nearest relatives) have in relation to them under the Act
- the particular parts of the Act which apply to them (e.g. the basis on which they are detained and which therefore make them eligible for advocacy
- any conditions or restrictions to which they are subject (e.g. as a condition of leave of absence from hospital, as a condition of a community treatment order, or as a condition of conditional discharge)
- medical treatment that they are receiving or might be given
- the reasons for that treatment (or proposed treatment) and
- the legal authority for providing that treatment, and the safeguards and other requirements of the Act which would apply to that treatment

The IMHA role also includes helping patients to exercise their rights, which can include representing them and speaking on their behalf.

Care Quality Commission

The Care Quality Commission is responsible for inspecting or monitoring the quality of mental health hospitals. Their role is to check that patients' basic human rights are maintained while they are being cared for or treated under the Mental Health Act.

The CQC has specific duties in the Act to act as a general protection for patients by reviewing, and where appropriate, investigating the exercise of powers and the discharge of duties in relation to detention, community treatment orders (CTO) and guardianship under the Act.

The CQC also has a duty to appoint second opinion appointed doctors.

The CQC monitor, inspect and regulate services to make sure providers meet fundamental standards of quality and safety. CQC's findings are published, including performance ratings to help people choose care.

Care Quality Commission

Complaints

The CQC can investigate complaints from people where they are unhappy with the use of powers or how duties have been carried out under the Mental Health Act.

As an advocate you can support a person to contact the CQC to raise concerns and make a complaint.

For more information about making a complaint to the CQC please see

https://www.cqc.org.uk/contact-us/how-complain/complain-about-use-mental-health-act

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