Mental Health legislation

BLACKBELT
ADVOCACY

Introduction

Mental Health legislation exists to allow the assessment, care and treatment of people who have a mental disorder. It tells us how people should be treated and importantly sets out clear rights people have in this area.

A lot of people who are treated in hospital or another mental health facility have agreed or volunteered to be there. This is commonly referred to as being a 'voluntary' or 'informal' patient.

But there are cases when a person can be detained, also known as sectioned, under the Mental Health Act (1983) and treated without their agreement.

The Mental Health Act 1983 is the main piece of legislation which applies in England and Wales. It was amended in 2007 and (at the time of writing in 2021) is about to go through another review.

Introduction

In this booklet you will learn about:

- The MHA Code of Practice
- Underpinning principles of the Mental Health Act
- Human Rights and the MHA
- Advance decisions to refuse treatment
- The powers of the MHA to detain
- The power of the MHA to treat
- Leave under the MHA

Code of Practice

The Code of Practice shows professionals how to carry out their roles and responsibilities under the Mental Health Act 1983. The Act tells us what can happen - the Code tells us how this should happen.

All professionals with responsibility for duties under the Act and MUST follow the Code. This includes registered medical providers, approved clinicians, managers and staff of providers, local authorities and their staff.

As an advocate you need to use and refer to the Code throughout your work. It is an essential tool in your kit whenever you need to push for something or protect a person's rights.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Code of Practice

Most of the information taken in this information pack is taken from the Code. When you read the Code take note of where something is a must, a should or a could.

Must

When something is a 'must' this means that this is essential and has to happen. There are no exceptions to this. If you see a 'must' that is not happening, use the Code to challenge this - and if the issue persists you can seek legal advice.

Should

When the Code says something 'should' happen this means that they should do it unless there are reasons not to. As an advocate you can ask to see these reasons in writing.

Could

Wherever something is a 'could', this means that there isn't a legal duty to do it, but the Act allows for this to take place. As an advocate you could use this and refer to it being 'best practice'.

The 5 Principles

There are 5 overarching principles within the Mental Health Act 2007.

Principle 1:	**Least restrictive option and maximising independence**
Principle 2:	**Empowerment and involvement**
Principle 3:	**Respect and dignity**
Principle 4:	**Purpose and effectiveness**
Principle 5:	**Efficiency and Equity**

Principle 1 - Least restrictive option and maximising independence

Where it is possible to treat a person safely and lawfully without detaining them under the Act, the person should not be detained. If the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available, and be delivered as close as reasonably possible to a location that the patient identifies they would like to be close to (eg their home or close to a family member or carer)

Wherever possible a person's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person’s rights and freedom of action.

Restrictions that apply to everybody in a particular setting (blanket or global restrictions) should be avoided. Blanket restrictions should never be for the convenience of the provider

Principle 2 Empowerment and involvement

Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible.

A person's views, past and present wishes and feelings (whether expressed at the time or in advance), should be considered so far as they are reasonably ascertainable.

The persons choices and views should be fully recorded. Where a decision in the care plan is contrary to the wishes of the patient or others the reasons for this should be transparent, explained to them and fully documented. IMHAs can ensure that people's views are recorded in care plans.

Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision-making and any such assistance or support should be provided, to ensure maximum involvement possible.

Principle 3 Respect and dignity

Patients and carers should be treated with respect and dignity. Practitioners performing functions under the Act should respect the rights and dignity of patients and their carers, while also ensuring their safety and that of others.

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and culture.

There must be no unlawful discrimination.

Principle 4 - Purpose and effectiveness

Care, support and treatment given under the Act should be given in accordance with up-to-date national guidance and/or current best practice from professional bodies, where this is available. Treatment should address the individual needs of the person, taking account of their circumstances and preferences where appropriate.

People should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic. Practitioners should deliver a range of treatments which focus on positive clinical and personal outcomes, where appropriate. Care plans for detained patients should focus on maximising recovery and ending detention as soon as possible.

Commissioners, providers and professionals should consider the broad range of interventions and services needed to promote recovery not only in hospital but after a patient leaves hospital, including maintaining relationships, housing, opportunities for meaningful daytime activity and employment opportunities

Principle 5 Efficiency and equity

Commissioners and providers, including their staff, should give equal priority to mental health as they do to physical health conditions.

Where patients are subject to compulsory detention, health and social care agencies should work together to deliver a programme of care that, as far as practicable, minimises the duration of detention, facilitates safe discharge from hospital and takes into account the patient's wishes.

Commissioners, providers and other relevant organisations should establish effective relationships to ensure efficient working with accountability defined through joint governance arrangements. Joint working should be used to minimise delay in care planning needed to facilitate discharge.

Commissioners, providers and other relevant organisations should ensure that their staff have sufficient skills, information and knowledge about the Act and provision of services to support all their patients. There should be clear mechanisms for accessing specialist support for those with additional needs.

Human Rights & the MHA

Human rights legislation provides a framework for commissioners and providers to deliver the best possible outcomes for everyone who uses mental health services. This means:

- putting human rights principles and standards into practice
- aiming to secure the full enjoyment of human rights for all, and
- ensuring rights are protected and secured.

Within the MHA code of practice, the following guidance is given to help providers:

Participation

This includes enabling meaningful participation of key stakeholders in policy development. FOR ADVOCATES this could mean pushing services to co-produce policy with the people who use its services.

Human Rights & the MHA

Accountability

Accountability– ensuring clear accountability for human rights, through the system.

For ADVOCATES this could mean discussing with commissioners human rights issues that have been raised by the advocacy service throughout the period and finding out what has changed as a result of issues being raised)

Non discimination

Non-discrimination and equality– working to eliminate discrimination by embedding equality through systems, processes and outputs. It also requires the prioritisation of those in the most marginalised situations who face the biggest barriers to realising their rights.

For ADVOACTES this could involve monitoring data on equalities and holding services to account where issues of discrimination and inequality are highlighted.

Human Rights & the MHA

Empowerment

Empowerment– of all with knowledge, skills and commitment to realising human rights.

Individuals and communities should know their rights. For ADVOCATES this could include pro-active work in awareness raising of rights with patients, families and staff.

Legality

Legality– expressly applying the Human Rights Act 1998 (HRA) and linking to international and European standards and bodies. A human rights-based approach requires the recognition of rights as legally enforceable entitlements and is linked in to national and international human rights law.

For ADVOCATES this could include monitoring its own practice against the HRA for instance recording when and how the HRA is used by advocates.

Equality Act & the MHA

The Equality Act makes it unlawful to discriminate (directly or indirectly) against a person on the basis of a protected characteristic of the following protected characteristics:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex and sexual orientation

The protected characteristic of disability includes a mental impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities.

Equality Act & the MHA

Reasonable adjustments

The Equality Act places a duty on providers of services to the public and those exercising public functions, including NHS services, to make reasonable adjustments for people with an impairment (including mental impairment) that constitutes a disability under the Equality Act.

Examples of reasonable adjustments given in the MHA code of practice include:

- Assessment for detention is undertaken by professionals with the appropriate specialist skills to assess the person based on their individual needs, eg adjustments if the person has a learning disability, an autism spectrum disorder or is deaf.

- Ensuring the care environment is as accessible as possible, eg through appropriate signage and lighting.

- Ensuring information is in a format accessible to the person, eg using pictures and big print, or providing translations into the person's first language.

Equality Act & the MHA

- Ensuring there are adequate numbers of staff with the right skills and experience to communicate effectively with the person, eg staff who can use sign language or communicate in the person's first language.

- Providing specific or additional training for staff who work with people with learning disabilities or autism spectrum disorders.

- Ensuring meetings are accessible to people, eg providing materials in an appropriate format and holding the meeting in an accessible venue. The provision of an independent mental health advocate (IMHA) can support a patient to participate in decisions about their care and treatment.

Equality Act & the MHA

Keeping people informed of their rights

Those with responsibility for patient care should ensure that patients are reminded from time to time of their rights and the effects of the Act.

It may be necessary to give the same information on a number of different occasions or in different formats and to check regularly that the person has fully understood it. Information given to someone who is unwell may need to be repeated when their condition has improved. This includes information on how an IMHA can help understand information, use rights and be involved in decision making processes.

The Equality and Human Rights Commission has produced an excellent resource to help people understand and use their human rights. Please download from:

https://www.equalityhumanrights.com/en/publication-download/your-rights-when-detained-under-mental-health-act-england?utm_source=e-shot&utm_medium=email&utm_campaign=NORguidance2

Advance wishes & refusal of treatment

What is an advance decision?

An advance decision is a decision to refuse specified medical treatment made in advance by a person who has the mental capacity to do so.

Advance decisions are concerned only with refusal of medical treatment. Other advance expressions of views, wishes and feelings, often referred to as advance statements, may be about preferred medical treatment or other wishes and preferences not directly related to care, and may be about what the patient wants to happen as much as what they would prefer not to happen.

The Mental Capacity Act 2005 (MCA) says that people who have the capacity to do so, and who are at least 18 years old, may make an advance decision to refuse specified treatment which will have effect at a time when they no longer have capacity to refuse or consent to treatment. If a valid and applicable advance decision exists, it has the same effect as if the patient has capacity and makes a contemporaneous decision to refuse treatment.

Advance wishes & refusal of treatment

Sometimes, the fact that a person has made an advance decision refusing treatment for mental disorder will be one of the reasons why a decision is taken to detain them under the Act. That may be the only way to ensure they get the treatment they need.

Can advance wishes be overridden?

Yes. In certain circumstances, the Act allows people to be given medical treatment for their mental disorder without their consent - even though they have made a valid and applicable advance decision to refuse the treatment. This only applies to people who are detained under the Act and to anyone on community treatment orders (CTOs).

Even where clinicians may lawfully treat a person compulsorily under the Act, they should, where practicable, try to comply with their wishes as expressed in an advance decision. They should, for example, consider whether it is possible to use a different form of treatment not refused by the advance decision. If it is not, they should explain why to the person.

Advance wishes & refusal of treatment

Advance statements of wishes and feelings

There may be times when, because of their mental disorder, people who are subject to compulsory measures under the Act are unable or unwilling to express their views, or participate as fully as they otherwise would, in decisions about their care or treatment under the Act. In such cases, the person's past wishes and feelings – so far as they are known – take on a greater significance.

Individuals with mental health conditions should be able to express their views and preferences about their care and treatment. Some people will deliberately state their wishes in advance about a variety of issues, including their medical treatment, how families and carers should be involved, the steps that should be taken in emergencies and what should be done if particular situations occur. Such wishes should be given the same consideration as wishes expressed at any other time. Clinicians must consider advance statements when determining what is in the patient’s best interests if the patient subsequently loses capacity.

Advance wishes & refusal of treatment

Encouraging people to set out their wishes in advance is often a helpful therapeutic tool, encouraging collaboration and trust between people and professionals. It is a way in which effective use can be made of patients' expertise in the management of crises in their own conditions. IMHAs can provide important support to people who want to plan for a time should they lose capacity.

If you do offer support to a person to record advance wishes you should encourage them to identify as precisely as possible the circumstances they have in mind. If they are saying that there are certain things that they do not want to happen – eg being given a particular type of treatment, or being restrained in a particular way – try to encourage them to give their views on what should be done instead.

People should be made aware that expressing their preference for a particular form of treatment or care in advance like this does not legally compel professionals to meet that preference. However, professionals should make all practicable efforts to comply with these preferences and explain to patients why their preferences have not been followed.

Powers to detain under the MHA

The MHA 1983 lays down the criteria which have to be met before an application for detention can be made. Before any application is made the professionals involved in the assessment need to consider whether there are alternative ways of providing the care and treatment the patient needs.

The two most common sections of the Act that are used to detain a person are section 2 and section 3.

Section 2

The criteria for section 2 are that:

- the patient is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

- they ought to be so detained in the interest of their health or safety or the protection of others.

Powers to detain under the MHA

Section 3

The criteria for section 3 are that:

- the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital;
- it is necessary for their health or safety or for the protection of others, that they should receive that treatment;
- treatment cannot be provided unless they are detained under section 3;
- appropriate medical treatment is available for them

In deciding whether a person should be detained in hospital under the Act, careful consideration must be given to which section, if any, would be the most appropriate, particularly bearing in mind the principle of least restriction.

Being detained under the MHA

Detained patients may not leave the hospital without permission.

Within the hospital, there will normally be restrictions on their movement, for instance, when they can leave their own ward, when they can use communal facilities. There will be other rules that patients are expected to follow – e.g. about where they keep their possessions, not having anything that might be dangerous, when and where they can see visitors. These rules are up to the hospital, but they must be reasonable.

Except in the high security hospitals (Broadmoor, Rampton and Ashworth) hospitals cannot withhold post from patients, and they can only stop patients sending post if the person to whom it is addressed has asked them to do so. (Section 134 of the Act).

Being detained under the MHA

Renewal of detention

Detention under section 3 lasts initially for up to six months, but can be renewed by the responsible clinician for a further six months and then for a year at a time.

Before renewing the detention, the responsible clinician must examine the person and decide whether the criteria for continued detention set out in section 20 of the Act are met. These criteria are essentially the same as the criteria for the initial application for detention. Another professional (from a different profession) who has been involved in the patient's treatment must sign a form to say they agree with the responsible clinician's decision.

Detention under section 2 cannot be renewed. If detention needs to continue, an application under section 3 has to be made. That is done in the normal way, even though the person is already in hospital.

Being detained under the MHA

Discharge from detention

A persons responsible clinician can discharge them from detention under section 2, 3 or 4 at any time. As a result, responsible clinicians should always be thinking about whether the person needs to remain detained.

The patient's nearest relative can also discharge them, unless their responsible clinician completes a form (sometimes called a "barring order") under section 25 saying they think the patient is likely to act dangerously if discharged. To give the responsible clinician time to think about this, the nearest relative has to give the hospital managers at least 72 hours' notice of their intention to discharge the patient.

The hospital managers can also discharge the patient. In practice, these decisions are taken on their behalf by "managers' panels" of three or more people, who aren't actually part of the management team of the hospital.

Powers to treat under the MHA

Compulsion under the MHA 1983 exists primarily to ensure that people with mental disorders get the treatment and care they need to prevent harm to themselves or to other people.

Under the common law, people who have the capacity to decide for themselves whether to consent to treatment cannot be given it unless they do, in fact, consent. In some cases, the MHA 1983 over-rides this general rule in common law, and allows professionals to treat patients without their consent for their mental disorder.

The rules about when detained patients can be treated without their consent are set out in Part 4 of the Act.

There are also some rules about certain special kinds of treatment for mental disorder which apply to all patients, whether or not they are detained or otherwise subject to the Act. Those rules are also in Part 4.

Powers to treat under the MHA

“Although the Mental Health Act permits some medical treatment for mental disorder to be given without consent, the patient’s consent should still be sought before treatment is given, wherever practicable. The patient’s consent or refusal should be recorded in their notes, as should the treating clinician’s assessment of the patient’s ability to consent”

The rules in the MHA about treatment are only about treatment for mental disorder. It does not deal with treatment for other health issues. If the person requires treatment for physical conditions (for instance if they require treatment for cancer) this could not be authorised by the Mental Health Act - they would need to consent to this. If the person lacks the capacity to make these decisions the Mental Capacity Act would need to be used to decide what treatment (if any) should be sought.

Powers to treat under the MHA

Treatments requiring consent and a second opinion under section 57

Section 57 is about neurosurgery for mental disorder (sometimes called "psychosurgery") and surgical implantation of hormones to reduce male sex drive. In practice, these treatments are very rarely used.

Where section 57 applies, the treatment can be given only if all three of following requirements are met:

- the patient consents to the treatment
- a SOAD (and two other people appointed by the Care Quality Commission) certify that the patient has capacity to consent and has done so; and
- the SOAD also certifies that is appropriate for the treatment to be given to the patient.

Leave

A person can be given leave of absence under section 17 of the Act (sometimes known as "section 17 leave"). Leave can either be short or long term. It covers everything from a walk around the grounds, a brief trip to the local shops to a sustained period where the person returns home, or lives in other accommodation away from the hospital.

Before granting leave for more than 7 days (or extending it so that it lasts more than 7 days in total), responsible clinicians must think about whether it would be more appropriate to discharge the patient onto supervised community treatment (SCT) where that is a possibility.

But, if the responsible clinician decides against SCT, there is nothing to stop leave of absence being for more 7 days.

Leave

Leave of absence is often subject to conditions, e.g. about where the person must or must not go, or (for long term leave) where they should live. These conditions are for the responsible clinician to decide.

Sometimes leave is “escorted leave” – which means that the person must stay in the company of a member of staff (or another specified person).

“Ground leave” usually means permission to leave the ward and move around the hospital and its grounds. It is not technically section 17 leave because the person does not leave the hospital.

If a person leaves the hospital without permission they are considered to be “absent without leave” (AWOL) and can be taken into custody and brought back to the hospital. The same applies if they don’t return from leave when they are told to, or if they abscond from their escort while on escorted leave.

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