

# Changes to Mental Health Legislation

## A Brief Guide for Mental Health Service Users and their Families

### THE REASON FOR THIS GUIDE

This Guide, for service users and their families, outlines how mental health legislation is changed by the **Mental Health Act 2007**, which largely comes into force in **October 2008**.

The **1983 Mental Health Act** is, and remains, the important piece of legislation setting out the legal framework for compulsory powers in England and Wales. The 2007 Act just **amends** the 1983 Act, it does **not** replace it. Unfortunately this means that mental health law has become more complicated and so this Guide briefly explains both where the law has changed, and also where it remains the same.

The 1983 Act was previously amended in 1995 by the Mental Health (Patients in the Community) Act which created “supervised discharge” or “after-care under supervision”, and this has been important for people receiving “**Section 25 aftercare**”. This 1995 Act **is replaced** by the 2007 Act, and “Section 25 aftercare” is to end. It is replaced by Supervised Community Treatment which is explained in more detail later.

Accompanying the 1983 Act is a **Code of Practice**, last revised in 1999, which gives guidance on how the Act should be applied. The Code, which covers England and Wales, is not a law which must be followed, but it is an important document as it offers “statutory guidance”, and professionals who do not follow this guidance can be challenged in court.

The Code is being rewritten to reflect the changes in the 2007 Act, and there is now to be a separate version **specifically for Wales**. The **Welsh Mental Health Act Code of Practice** is to be published in the summer of 2008 and it will be particularly important in directing how mental health legislation is applied in Wales.

So, to summarise, from October 2008, the important mental health statutory documents will be:

- the Mental Health Act 1983, as amended by the Mental Health Act 2007
- the Welsh Mental Health Act Code of Practice.

This Guide will now explain what, in practice, will remain the same and what will change.

## **WHAT HAS NOT CHANGED - Sections in the 1983 Act for Hospital Admission, Guardianship and Aftercare**

Starting with what has **not** changed, this includes the Sections which service users and families will be most familiar with. These are:

- **Section 2** used to admit and detain a person in hospital for **assessment** for up to 28 days,
- **Section 3** used to admit and detain a person in hospital for **treatment** for up to 6 months,
- **Section 4** used in an **emergency** to admit and detain a person in hospital for up to 3 days,
- **Section 5** again used in an **emergency** to detain a person already in hospital for up to 3 days by a doctor (**S5.2**) or 6 hours by a nurse (**S5.4**),
- **Section 7** used to receive a person into **Guardianship**,
- **Sections in Part 3** of the Act, including **Sections 37** and **41** used for people who come before a Court,
- **Section 117** placing a duty on authorities to provide **aftercare** to a person who has been detained for treatment,
- **Sections 136/137** about taking a person to a **place of safety** for assessment.

These Sections of the 1983 Act are unchanged by the 2007 Act, and remain in force. What should change is how they are applied in practice and this is what we will now look at.

## **WHAT DOES CHANGE**

In general terms, the 2007 Act introduces changes in seven areas:

- how **mental disorder** is defined
- the **professionals** who have specific roles within the Act
- additional rights for patients to displace their **Nearest Relative**
- how **treatment** is defined, and when it can be given
- the introduction of **Supervised Community Treatment (SCT)** and Community Treatment Orders (CTOs)
- a new right for patients to have an **advocate**
- some changes about how **Mental Health Review Tribunals** operate.

We will look at each of these areas in turn and consider them in more detail.

### **1 Definition of Mental Disorder**

In the 1983 Act there are references to four types of mental disorder – mental illness, mental impairment, psychopathic disorder and severe mental impairment. References to these types or categories of mental disorder are deleted by the 2007 Act and replaced by a simple definition of mental disorder as “**any disorder or disability of mind**”.

This change will have limited significance for service users with a mental illness. What it may mean is that people with the label of “personality disorder” will come within the scope of the Act. It remains clear that people who are dependent on drugs and alcohol are not seen as having a “mental disorder”, unless they also suffer from a recognised mental illness.

## 2 Professional Roles

A wider range of professionals can now undertake important roles under the Act. The changes are that:

- ASWs (Approved Social Workers) are replaced by **AMHPs (Approved Mental Health Professionals)**, and
- RMOs (Responsible Medical Officers) are replaced by **RCs (Responsible Clinicians)**.

As well as social workers, nurses, occupational therapists (OTs) and psychologists (but not doctors) can now be AMHPs, as long as they have the necessary skills and experience. AMHPs are approved and appointed by Local Authorities.

Similarly, as well as doctors, nurses, OTs, psychologists and social workers can now be RCs, again as long as they have the necessary skills and experience. Professionals have first to be approved and appointed by the NHS as **Approved Clinicians (ACs)** before they can act as RCs. However, some important functions, particularly related to supervision of medical treatments, are still restricted to doctors, and where a person's RC is not a doctor, another AC who is a doctor will have to undertake these restricted functions.

There is the potential that the different professionals assessing people, for example when considering a Section 2 or Section 3 hospital admission, may be well known to each other and, therefore, the independence of their assessments may be compromised. This is a growing issue as increasingly professionals work together in joint Community Mental Health Teams (CMHTs). New regulations are therefore being drafted to address such potential **conflicts of interest**. These regulations (to be known as the Mental Health (Conflicts of Interest) (Wales) Regulations 2008) are bound to be complex and detailed as they cover a wide range of situations. However, it is important that service users know they exist and that they can challenge professionals who do not make genuinely independent assessments.

## 3 The Patient's Nearest Relative

Under the 1983 Act, the Patient's Nearest Relative continues to have some important rights and roles, including those to:

- apply for admission to hospital
- block an admission for treatment (mainly under Section 3)
- discharge the patient from a compulsory admission
- information about the patient.

These are not changed by the 2007 Act, but what does change is who can act as the Nearest Relative. In future Civil Partners will have equal status to husbands and wives. This is a limited change, and a long term partner or close friend of a person still does not automatically become their Nearest Relative.

However, a more significant change is that the 2007 Act includes the new safeguard that a patient can apply to the Court to nominate the person they want to act as their Nearest Relative. This will in future give people a greater opportunity to have the person closest to them acting as their Nearest Relative.

## 4 Treatment

The 2007 Act introduces some changes about compulsory treatment which will clearly be important for service users affected. We summarise them under appropriate headings:

**Detention** Under the 1983 Act a major test for someone to be admitted for treatment was that the treatment would be “likely to alleviate or prevent deterioration” in their mental health. This test has now changed and in future a person with a mental disorder can only be admitted to hospital under Section 3 if an appropriate medical treatment is available for that person in that hospital. This is known as the “**appropriate medical treatment test**”.

A person is admitted to hospital under Section 3 for an initial period of 6 months, but this order can then be renewed for a second period of 6 months and after that for any number of further periods of one year. This is not changed by the 2007 Act, as long as appropriate medical treatment continues to be available for the person. However, the 2007 Act introduces a new safeguard that, if their Responsible Clinician decides to renew a Section 3 order, the RC must first consult with at least one other professional who is also involved in that person’s treatment. The order to renew a person’s detention can then only be made if this other professional states in writing that all the conditions are met.

**Definition** The 2007 Act also clarifies what medical treatment is. It states it can mean, in addition to medication and other recognised medical treatments, “nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care”. This is a wide definition and means, for example, that a person can be detained in hospital even if traditional mental health treatments like medication are not appropriate. However, as already stated, an appropriate medical treatment must be readily available for that person if he or she is being detained.

**Consent to Treatment** The 2007 Act has amended some aspects of the 1983 Act in relation to consent to treatment, especially around ECT which we consider next. For more usual forms of treatment, especially medication, there are no major changes. Wherever possible, Clinicians should seek the consent of the patient before giving treatment, as required by the Human Rights Act, but in some circumstances “appropriate” treatment can be given to patients on a treatment order without their consent. One safeguard is that if, after three months, a Clinician wants to continue treatment that a patient has not consented to, an independent doctor (known as a **Second Opinion Appointed Doctor** or SOAD) must be involved to consider the appropriateness of the treatment. The SOAD must consult with a number of people, including the patient, and agree that the treatment is appropriate before it can be continued.

**ECT** The 2007 Act has an important new Section setting out when a person may be given electro-convulsive therapy (ECT). For adults (people over 18) there are two usual situations when ECT can be given:

- First, where the detained patient consents. However, even then a doctor (usually an Approved Clinician) must state in writing that the patient understands the treatment and consents to it. In addition the patient can still withdraw their consent at any point.
- Second, if the patient is incapable of giving consent, an independent doctor (a SOAD) must give their approval before ECT can then be given, and this doctor

can only give their approval after going through a number of steps. First, the doctor must consult with two other people, one of whom must be a nurse and the other a professional involved in the person's care. Then the doctor must state in writing that the patient is incapable of giving consent and also that ECT is an appropriate treatment. Finally the doctor can only do this if the person has not made an "advance decision" stating that he or she refuses ECT.

There is an additional safeguard for teenagers (whether detained or informal) who are under 18. When a teenager consents to ECT, it still cannot be given until an independent doctor (a SOAD) has stated in writing that the teenager consents and the treatment is appropriate.

ECT should not be given, therefore, if a person understands the treatment and refuses consent. The one exception is that it can be given without a person's consent in an emergency, but then only if ECT is **immediately necessary** to save a person's life or to prevent a serious deterioration of their condition. This should be a highly unusual circumstance.

## **5 Supervised Community Treatment (SCT) and Community Treatment Orders (CTOs)**

One of the most important changes in the new Act is the introduction of Supervised Community Treatment (SCT), which allows people to be subject to compulsory powers, known as Community Treatment Orders or CTOs, when living at home. People can be considered for SCT if they:

- have been detained in hospital for treatment, usually under Section 3 and also Section 37,
- continue to need treatment but no longer need to be in hospital, and are believed to be at risk of not complying with their treatment.

When considering a CTO a Responsible Clinician (RC) must first discuss the conditions to be imposed on the person with an AMHP, and then get the agreement of the AMHP, before an order can be made. Once made, a CTO lasts initially for 6 months and allows the RC to recall the person to hospital if there are significant concerns about that person's health, even if they are complying with the conditions set in the CTO.

This is an important new compulsory power which will affect the discharge from hospital of many people with a severe mental illness who have been detained under, in particular, Section 3. As referred to at the beginning of this Guide, SCT replaces Section 25 "after-care under supervision", and in future Section 17 leave should only be used by a RC to agree to short term leave from hospital.

## **6 Advocacy**

A further important change in the new Act gives a person who is detained in hospital for more than 3 days (mainly Section 2 and Section 3), or who is subject to SCT or Guardianship, the right to be supported by an advocate, to be known as an Independent Mental Health Advocate (or IMHA).

People who are eligible for, and want, this service have a right to be put in touch with an IMHA. The IMHA should then meet with them, help them understand what is happening to them, have access to their records and help them challenge any decisions they are unhappy with. The NHS has a duty to ensure that IMHAs are available across Wales.

## 7 Mental Health Review Tribunals (MHRTs)

In future there will be separate Tribunals for England and Wales, although it is unclear what practical difference this will make. More importantly people on SCT, as well as people detained in hospital, will have a right to apply to a MHRT for their order to be lifted, and people on longer term orders will be referred to a tribunal at an earlier stage.

### THE CODE OF PRACTICE

We have already said that, whilst key sections of the Act have not changed, how they are applied in practice may change. This is where the new Welsh Code of Practice will be important. Hafal has lobbied hard to ensure the Code will properly reflect **best practice** for service users, families and carers. The Code is being finalised now and will be published imminently. We will update this Guide when it is.

### A MENTAL HEALTH “MEASURE” FOR WALES?

The National Assembly is moving towards developing a Mental Health Measure to give people with severe mental illness new legal rights. A “Measure” is the formal name for legislation passed by the Assembly specifically for Wales. The proposed Mental Health Measure could offer a balance to compulsory powers by giving people the right to appropriate assessment, treatment and advocacy before they become very ill. We believe that for some people this will mean compulsion becomes unnecessary. Again we will update this Guide with information on the progress of such a Measure.

### FURTHER INFORMATION

This Guide aims to offer only a brief overview of the 1983 Act as amended by the 2007 Act. It cannot, and is not intended to be, a comprehensive commentary on the legislation. If, therefore, you need more detailed information, it is important you seek further advice.

For further information about Hafal visit: [www.hafal.org](http://www.hafal.org)

For further information about mental health in Wales visit:  
[www.mentalhealthwales.net](http://www.mentalhealthwales.net)