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- Mental Health Act -

Introduction

The aim of this module is to provide guidance and information on the Mental Health 'Act 2007' for those working in Health and Social Care settings. The Act 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. It is implemented in England and Wales only. Northern Ireland and Scotland have their own laws.

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

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.**

Mental Health

The provision of treatment for mental health issues can be complex, particularly when it comes to children and young people. It is crucial that professionals providing care and treatment to children and young people are aware of who is consenting to them providing that care. This could be the young person themselves, their parents, or the law.

The 'Mental Health Act 2007 (MHA)' is the legislation governing the formal detention and care of people with mental disorders in hospitals. It is essential that mental health professionals have a good understanding 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 significant 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. While 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.

Definition of Mental Disorder

The definition of mental disorder has been changed 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 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.

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 patients.

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 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 encompasses more than a patient's agreement to undergo treatment; it encompasses the entire decision-making process a patient goes through. This process might involve multiple meetings with various clinicians, all of which should be considered part of the 'consent' process. It is essential to recognise that consent can take different forms depending on the significance of the medical treatment and the individual circumstances of each patient.

A critical aspect of deciding how children and young people receive treatment is understanding whether they can provide consent on their own or if someone else can act on their behalf. Consent to treatment is considered 'voluntary' or 'informal' for eligible patients. All patients have the right to choose or refuse medical intervention, even if their decision may not seem to be in their best interest. Neglecting to obtain valid consent could harm the doctor-patient relationship. Consent is not limited to merely confirming or refusing treatment; it encompasses the entire decision-making process involving various meetings with different clinicians.

Healthcare professionals must adhere to their patients' requests and rights, as failure to do so may result in disciplinary proceedings, civil actions, or criminal charges, and may be considered a breach of the 'Code of Conduct/Practice' issued by their clinical governing body. 'The Mental Capacity Code of Practice' emphasises that healthcare professionals should not express an opinion on a person's lack of capacity without conducting a proper examination and assessment.

The Mental Capacity Act of 2005 and Competence

The 'Mental Capacity Act of 2005' (MCA) defines lacking capacity as follows: '...a person is unable to make a decision for themselves in relation to a matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

According to the principles of the MCA:

- Capacity is presumed unless proven otherwise.
- Every effort should be made to support individuals in making decisions.
- Making an unwise decision does not necessarily indicate a lack of capacity.

To have the capacity for consent, a patient must be able to:

- Understand the nature and purpose of the treatment in simple language.
- Grasp the main benefits, risks, and alternatives of the treatment.
- Have a general understanding of the consequences of not receiving the treatment.
- Retain the information long enough to make a decision.
- Exercise free choice.

If an adult is deemed to lack competence based on these criteria, they cannot provide valid consent, and certain decisions may be made without their direct consent. Treatments that are in the patient's best interest and not prohibited by an advance decision (living will) may still be provided. In cases where a patient lacks capacity, this should be documented on a specific form, available from the relevant organisation.

Key Aspects of the Mental Capacity Act 2005 in Relation to Consent

The Mental Capacity Act's Consent to Treatment Provisions are addressed in Part 4, which applies to treatments for mental disorders. It covers all formal patients except those detained under sections (4), (5), (35), (135), and (136). The Act does not extend to individuals under Guardianship or Supervised Discharge, who have the right to refuse treatment except in emergencies.

If a person has previously given consent to treatment under Section (57) or Section (58) and is deemed competent, they can withdraw their consent at any time. Treatment must then cease, and proper procedures should be followed, unless discontinuing treatment would cause 'serious suffering' to the patient, in which case the treatment can continue.

Determining capacity

Having an 'impairment of, or disturbance in, the functioning of the mind or brain' does not automatically imply a lack of capacity. Capacity assessments are specific to the time and issue at hand, focusing on the ability to make decisions about a particular matter at a given moment. Some decisions may be more challenging to make than others.

Acting on behalf of someone lacking capacity

If it is determined that an individual lacks capacity and decisions need to be made on their behalf, it is crucial to act in their best interests and in a manner that respects their rights in the least restrictive way possible.

Assessing Capacity for Individuals Aged 16 and Above under the Mental Capacity Act 2005

The 'Mental Capacity Act 2005' addresses the question of whether young people aged 16 and above can provide consent for treatment. It establishes the presumption of capacity, requiring that a person should be assumed to have capacity unless proven otherwise. The Act also emphasises that a person should not be considered unable to make decisions unless all reasonable efforts have been made to assist them without success and that unwise decisions should not automatically indicate a lack of capacity.

For individuals aged 16 and above, capacity assessment involves a two-stage test. The first stage examines whether there is any impairment or disturbance in the functioning of the person's mind or brain. The second stage assesses whether this impairment or disturbance leads to a lack of capacity at the specific time and for the particular decision being considered.

This determination is based on four key questions:

- Can the individual understand the relevant information?
- Can the individual retain the information?
- Can the individual weigh up or utilise the information to make a decision?
- Can the individual communicate their decision?

If all four questions are answered affirmatively, someone over 16 years old is deemed to have the capacity to make decisions, regardless of any impairment or unorthodox decisions they may exhibit.

Assessing competence for individuals under 16 years

The 'Mental Capacity Act (MCA)' does not apply to individuals under 16 years old. For children in this age group, competence is evaluated based on their understanding and intelligence to comprehend the proposed treatment fully. If a child under 16 is deemed to possess enough intelligence, competence, and understanding to appreciate the implications of their treatment, they can provide their own consent. This state of being is referred to as being 'Gillick Competent'.

The criteria for 'Gillick competence' determines whether children under 16 have the legal capacity (in England and Wales) to consent to medical examination and treatment. To demonstrate Gillick competence, they must show sufficient maturity and intelligence to understand and evaluate the nature and consequences of the proposed treatment, including potential risks and alternative courses of action.

Competent children under 16 years of age are entitled to make decisions regarding their healthcare, and they should be allowed to do so. The concept of competence relates to a child's ability to understand a specific issue. Therefore, younger children are less likely to possess the required intelligence and understanding to consent to complex medical or health decisions. While they may competently agree to simple procedures like a blood test or tooth extraction, they might not have the capacity to consent to intricate surgeries.

Consenting for a non-competent child under 16 years

A child may be incapable of making a choice because they are extremely ill and have lost the capacity to make decisions that they would normally possess, or because they have not yet reached the age where they have developed that ability. In the majority of cases, parents can and will make decisions for their children, unless the treatment required exceeds what a parent can reasonably consent to or the parent is not acting in the child's best interests.

In most cases, someone with parental responsibility (usually the child's parent) can consent to their hospital treatment unless it is highly invasive or restrictive. As previously stated, from a legal standpoint, a child is considered to lack capacity or competence in making decisions about their healthcare; this responsibility then falls on the parent or someone with parental responsibility (not necessarily 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 three means:

- jointly registering the birth of the child with the mother
- 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 Mental Capacity Act (MCA) allows individuals to plan for situations where they may be unable to make decisions in the future. This planning can include creating a 'Lasting Power of Attorney (LPA)' or an advance decision. If a person hasn't made such plans and loses the capacity to decide, the MCA permits someone else, like a friend, relative, carer, doctor, social worker, or nurse, to make decisions on their behalf.

The MCA also offers legal protection to individuals who make decisions or take actions regarding the care or treatment of someone lacking mental capacity.

The responsibility for determining whether an individual can give consent lies with the healthcare professional in charge of their treatment. This professional should consult with others involved in the patient's care, as well as their family and close friends. If it is concluded that the patient lacks the capacity to give consent, treatment may be provided in their best interests.

Although the MCA doesn't define 'best interests,' it provides a checklist of factors to be considered when making decisions on behalf of someone else.

Note: Some major treatments require approval from the 'Court of Protection' before they can be administered.

Applying these principles in real-life situations

Applying these principles in practice involves considering the legal context for admitting children and young people to the hospital for the assessment or treatment of mental disorder. The key factors to consider are their age and whether they have the capacity or competence to consent.

For 16 and 17-year-olds with capacity:

- If they consent, offer informal admission.
- If they refuse and meet detention criteria, use the 'Mental Health Act 2007'.

It is crucial to bear in mind that the 'Mental Capacity Act (MCA)' is intended to assist individuals who cannot make decisions about their treatment. This will likely apply to a relatively small group of 16 and 17-year-olds. For those who do not agree with the proposed treatment (rather than being incapable of making decisions), using the 'Mental Health Act (MHA)' is a more suitable approach.

For 16 and 17-year-olds who lack capacity:

- If the admission may involve invasive or restrictive treatment, use the MHA.
- If the admission does not entail invasive or restrictive treatment and is in the best interests of the young person, it can proceed with parental consent using the MCA.

For individuals under 16 who are competent:

- If they consent, offer informal admission.
- If they refuse and meet detention criteria, use the MHA.

Children under the age of 16 who lack competence

In most instances, a parent or guardian can provide consent for a child's treatment admission, unless the required treatment exceeds what a parent can reasonably consent to or if the parent's decision is not in the child's best interests. However, there are situations where a parent might not be the appropriate person to give consent. Another individual with parental responsibility or, if the child is under the care of a local authority, may need to provide consent on the child's behalf.

If the treatment exceeds the scope of parental consent, the 'Mental Health Act (MHA)' might need to be utilised.

NOTE:

These four categories are not exhaustive, and the legal and clinical scenarios can be more complex. Seeking expert advice in such cases is essential.

Applying the Mental Health Act (MHA)

Introduction to MHA Sections

For adults in need of in-patient treatment, there are two ways of admission: voluntary or compulsory under sections 2, 3, and 4 of the MHA, following the amendment after 3rd November 2008.

The MHA authorises various 'sections,' with the most common being:

- Section 2, allowing assessment and/or treatment for up to 28 days
- Section 3, authorising treatment for up to 6 months

Being detained under a specific section is a potential outcome of a 'Mental Health Act' assessment, which follows a process with 'checks and balances.' It is essential to note that not being detained can also be the result of the assessment.

Who is involved in an Assessment?

An MHA assessment involves three individuals:

- Two doctors - who provide medical recommendations, typically in consultation with each other, but based on their independent clinical judgment. These doctors should possess special expertise in the assessment or treatment of mental disorders (a Section 12 Doctor) or have prior knowledge of the patient.
- Approved Mental Health Professional (AMHP)

The 'Mental Health Act 2007' introduced the role of 'Approved Mental Health Professional (AMHP)' to replace the previous title of approved social worker. An AMHP is authorised to apply for the detention of a patient in a hospital if they believe the necessary criteria for detention are met. While approved social workers used to fulfil this role exclusively, it has now been expanded to include other qualified professionals. The AMHP plays a crucial non-medical role in the assessment process and holds the ultimate responsibility for deciding whether an individual should be detained in a hospital.

Additionally, the AMHP is required to consult with the nearest relative of a child or young person, typically someone with parental responsibility (PR). Specific rules determine the identity of the nearest relative, but for most young individuals with PR, it will be the older of their mother or father. In cases where the child or young person is under a care order from the local authority, the local authority itself will be considered the nearest relative.

Regarding Section 2 of the MHA, the AMHP is only obligated to inform the nearest relative about the situation and their rights. However, for Section 3, detention cannot proceed if the nearest relative objects to the decision.

Applying the Mental Health Act 2007

As previously mentioned, the majority of individuals undergoing treatment for a mental disorder do so voluntarily, making detention unnecessary for receiving treatment. However, while having a mental disorder is a prerequisite for detention, it does not imply that everyone with a mental disorder should or must be detained.

Nature and degree:

To justify detention, the mental disorder must be of a nature or severity that warrants the person's confinement in a hospital. The aspects of nature and degree are closely interconnected, although only one of them is sufficient for a 'section' to be applied.

Nature: The term 'nature' pertains to the specific mental disorder experienced by the patient, including its duration, the potential for improvement, and the patient's past response to treatment for the disorder.

Degree: The term 'degree' refers to the current extent or severity of the patient's mental disorder.

Continued: Compulsory admissions

For adults in need of in-patient treatment, there are two possible routes: voluntary admission or detention under sections 2, 3, and 4 of the MHA, following the amendments made after 3rd November 2008.

Section 2: Admission for Assessment

An 'approved mental health professional (AMHP)' now replaces the role of the approved social worker (as per the 2007 amendments) and can request admission for assessment, which can last up to 28 days. To initiate this, either the AMHP or the patient's nearest relative must have seen the person within the previous 14 days. The admission requires authorisation from two doctors who must agree that:

a) The patient is experiencing a mental disorder of a nature or degree that warrants hospital detention for assessment.

b) Detention is necessary for the patient's health and safety or for the protection of others.

The patient can be discharged by a responsible medical officer (now replaced by the responsible clinician), 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 them, an approved mental health professional can initiate the process. Detention can last for up to six months once two doctors confirm that:

a) The patient is suffering from a mental disorder of a nature or degree that necessitates medical treatment in a hospital.

b) The treatment is in the patient's best interest for their health and safety and the safety of others.

c) Appropriate treatment is available for the patient.

Section 3 admissions can be extended for an additional six months and subsequently for 12-month periods. The responsible clinician, hospital managers, the nearest relative (if the responsible clinician

denies discharge, the nearest relative can appeal to the MHRT within 28 days), or the MHRT can discharge the patient.

Section 4: Admission for assessment in cases of emergency

An approved mental health professional or nearest relative can apply for emergency admission, having seen the patient within the previous 24 hours. The patient can be detained for up to 72 hours, provided that one doctor confirms:

a) The detention is urgently necessary.

b) Waiting for a second doctor's approval under section 2 would cause undesirable delays.

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

Police officers have the authority to remove individuals deemed to be mentally disordered, and in need of immediate care and control from public places to places of safety. Preferred places of safety include hospitals and care homes, with police stations being used as a last resort. Under section 136, individuals can be held and assessed by a doctor and an AMHP for up to 24 hours, potentially extended to 36 hours in specific circumstances.

Sections 2 (for assessment and/or treatment) and 3 (for treatment) have already been mentioned. Many individuals who are 'sectioned' in the community and taken to hospitals are placed under Section 2 for a maximum of 28 days.

The MHA also includes several less frequently utilised sections, such as those pertaining to the treatment of individuals who have committed criminal offenses:

- **Section 4:** In emergencies, an AMHP and only one doctor can use this provision if any delay would pose unacceptable risks. It permits admission for up to 72 hours, during which another doctor can assess the patient and potentially convert it to a Section 2 or 3 if deemed appropriate.

- **Section 5(2):** If an informal or voluntary patient withdraws their consent to remain in the hospital, a doctor can detain them for up to 72 hours to conduct an MHA assessment, determining whether they should be kept under Section 2 or Section 3. This ‘holding power’ applies to all inpatients, not just those in mental health units, but only to individuals already admitted to the hospital who later change their minds. It does not apply to people in outpatient clinics or the A&E department.

- Section 5(4): Similar to Section 5(2), this is a ‘holding power’ available for nurses' use. It lasts for up to 6 hours and ends when a doctor arrives to assess the patient.