



current practice

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Changes to the Mental Health and Mental Capacity Acts: implications for patients and professionals

SUMMARY

The new Mental Health Act 2007 for England and Wales has introduced substantial amendments to the 1983 Mental Health Act and has also amended the Mental Capacity Act 2005. Most provisions came into

effect in November 2008. The introduction of supervised community treatment, changes to professional roles such as the role of 'responsible clinician', and the introduction of deprivation of liberty safeguards in the Mental Capacity Act are

discussed. Many of the new safeguards in the Act are welcomed by clinicians and service user groups. However, other changes are more controversial and could potentially lead to an increase in the work load of clinicians.

The Mental Health Act 2007, which applies to England and Wales, has substantially amended the Mental Health Act 1983. It has also introduced into the Mental Capacity Act 2005 the deprivation of liberty safeguards that address the 'Bournewood gap' concerning the detention of compliant incapacitous individuals. In this article we summarise the most important changes and discuss some of the implications for patients and clinicians.

Mental health law is about balancing the need to detain people in order to protect them or other people from harm and the need to respect peoples' human rights and autonomy, and there was much concern during the development and passage of the new legislation that the government had got this balance wrong. Many of these concerns have been addressed in the updated Code of Practice to the 1983 Mental Health Act¹ which is an essential guide to practicing under the Act. There is no legal duty to comply with the Code, but professionals must have regard to it and record the reason for any departure from the guidance (which can be subject to legal challenge). One fundamental change is the introduction of five key principles into the Code of Practice which, for example, promote a greater awareness of culture and diversity, and encourage patient participation in treatment decisions (Box 1). The Code does not prioritise the principles, stating that 'the weight given to each principle in reaching a particular decision will depend on the context', although most of the principles only apply if the 'purpose' principle is met.

Box 1. The five principles in the Code of Practice

Purpose: clinicians must minimise the undesirable effects of the mental disorder by maximising patient safety, well-being and promoting recovery and protecting others from harm.

Least restriction: attempts should be made to impose as fewer restrictions as possible on patient liberty by selecting the least restrictive options where possible.

Respect: the need to respect the diverse values and needs of patients including their ethnicity, religion, culture, age, gender, sexual orientation and disability. The views and wishes of individuals should be taken into consideration where possible, whether expressed at the time or in advance. No one should be discriminated against.

Participation and effectiveness: as far as it is possible, patients should be involved in the planning, developing and reviewing of their care plan to ensure that it is delivered in an effective and appropriate way. The involvement of carers and those interested in the individual's welfare is encouraged.

Efficiency and equity: resources should be used in an effective, efficient and equitable way in order to meet the needs of patients.

Assessment for compulsory detention

Notwithstanding the changes to professional roles detailed later, the role reserved to doctors (registered medical practitioners) approved under section 12 in making recommendations for admission under the Act or reception into guardianship is unchanged. However, the criteria for compulsion have changed in relation to the

current
practice

simplified definition of mental disorder, and the new 'appropriate medical treatment' test.

Simplification of the definition of mental disorder

One fundamental change to the Act is to the definition of mental disorder, which is now defined as 'any disorder or disability of the mind'. Although this reduces confusion regarding who is eligible for detention under the Act, it widens the scope for the inclusion of disorders that were previously excluded from the Act. It is explicit that people with personality disorders, autism and those with mental and behavioural disorders secondary to the use of psycho-substance use (with the exception of dependence) are included. The old legal definition of 'psychopathic disorder' with its behavioural criteria and associated 'treatability' test has been removed, as has the exclusion of sexual deviancy. However, although the 'mental impairment' definitions have been removed, the Act does continue to exclude people with learning disability from treatment orders or guardianship unless the learning disability is associated with seriously irresponsible or abnormally aggressive behaviour. It is notable that this exception has not been made for people with autism, despite much lobbying. It remains to be seen whether the widening of the definition of mental disorder leads to an increase in the number of people compulsorily detained, since there is still clinical discretion about whether to apply the Act in an individual case.

'Appropriate medical treatment' test replaces 'treatability' test

The Act states that a person should not be detained under a treatment order unless appropriate medical treatment is available for their mental disorder in the hospital in which they are to be detained. 'Medical treatment' is very widely defined and covers a range of treatment modalities including nursing and psychological therapy, specialist mental health habilitation (development of new skills) and rehabilitation. The treatment must be appropriate taking into consideration the nature and degree of the mental disorder, and all the circumstances relating to the individual including their age, gender, ethnicity, culture and religion.

The treatment must have the purpose of alleviating or preventing worsening of the mental disorder or one of its symptoms or manifestations. Therapeutic 'purpose' is not the same as the 'likelihood' of the old treatability test: somewhat controversially, it is the intention of the treatment that is crucial (rather than whether it is actually effective). The Code of Practice makes clear that it should never be assumed that any particular disorder or an individual is inherently untreatable.¹ Making the availability of treatment an essential criterion may improve the range and quality of treatments offered to people, but the Code points out it does not have to be the ideal treatment or address every aspect of the person's disorder.

Sections 5(2), 135 and 136

The 72-hour holding power for informal hospital in-patients under section 5(2) is extended to approved clinicians (see below) in charge of an individual's treatment, as well as the doctor in charge. Nominated deputies under section 5(2) can now be other approved clinicians as well as doctors.

One change that has the potential to significantly improve patient care in emergency and high-risk situations is the new power to transfer people between places of safety (such as from a police station to an accident and emergency department) who are subject to section 135 or 136, although the duration of the powers remains at up to 72 hours.

Changes to professional roles

The government have introduced a 'competency-based' approach to professionals fulfilling statutory roles governed by the Mental Health Act. This means that the roles are open to a range of provisions listed in regulations and directions.

'Approved mental health practitioner' replaces 'approved social worker'

The new approved mental health practitioner role will be open to four professions: social workers, mental health or learning disability nurses, occupational therapists and chartered psychologists.² It is similar to the approved social worker role, except there are new responsibilities relating to the new provisions for supervised community treatment (see below). The training is substantial and designed to help professionals develop the competencies required. The *Reference Guide to the Mental Health Act 1983* lists these competencies.⁴

One concern about the loss of the approved social worker role was its importance in taking a non-medical, social perspective when considering the use of the Mental Health Act powers. However, this is explicitly reflected in the approved mental health practitioner competencies. Another concern was the perceived independence of the approved social worker role, and whether this would be watered down for approved mental health practitioners. This is said to be safeguarded by all approved mental health practitioners acting on behalf of the local social services authority, whoever their employer is, and that the three assessors conducting a Mental Health Act assessment should not all work for the same team, except in an emergency.

'Responsible clinician' replaces 'responsible medical officer'

In order to be appointed by a hospital or trust as the responsible clinician for an individual patient, a person must first be an 'approved clinician'. The professions that can be responsible clinicians are registered medical practitioners, plus all those who can be approved mental

current
practice**Table 1. Competencies for approved clinicians**

Competency	Examples of detail
Role	Legal and policy framework Mental health legislation Human Rights, Mental Capacity and Children Acts National Institute for Health and Clinical Excellence guidelines
Assessment	Identify presence and severity of mental disorder Determine if of kind or degree warranting compulsory confinement Assess risk in an evidence-based framework Incorporate biological, psychological, cultural and social perspectives
Treatment	Physical, psychological and social interventions Different treatment approaches and their applicability High level of skills in determining capacity to consent
Care planning	Combining health, social services and other resources
Leadership and multidisciplinary team working	Assimilate diverse views and maintain an independent view Make decisions in complex cases without supervision
Equality and cultural diversity	Understand how cultural factors and personal values can affect practitioners' judgement and decisions
Communication	Writing reports Presenting evidence to courts and tribunals

health practitioners (i.e. social workers, mental health or learning disability nurses, occupational therapists and chartered psychologists).³ In order to become an approved clinician, professionals will have to demonstrate the successful attainment of competencies (Table 1).

These, of course, require a substantial amount of training to achieve (e.g. that required for doctors to be listed on the specialist register). In addition, professionals will have to also attend an approved specific 2-day training course. Consideration of the competencies, which are given in full in the *Reference Guide to the Mental Health Act 1983* make it apparent that it will only be appropriate for professionals at a senior level to take this on.⁴ The most controversial competencies are around assessment and treatment, and the use of the medical terms like 'diagnose' has been deliberately avoided. Issues such as the appropriate remuneration for responsible clinicians, what is an appropriate case load and who will mentor those new to the role are said to be for local determination.

Many psychiatrists are concerned about the transitional arrangements that apply for existing and soon to be appointed consultants. These are summarised in Table 2 and given in detail in the Approved Clinician Directions.³

Compulsion in the community

The introduction of supervised community treatment

The most important changes being introduced in the community provisions are the repeal of supervised discharge and the introduction of 'supervised community treatment'. The guardianship powers are retained, albeit with the addition of a power to convey the person to the place they are required to live for the first time. The revised Code gives some guidance on choosing between guardianship (social care led; focus on welfare needs), section 17 leave (short-term leave where further stay in hospital necessary) and supervised community treatment (more structured system, no need for further treatment as a detained patient for the time being).¹

Criteria for making a community treatment order

The government said that supervised community treatment was designed for 'revolving door' patients, but in

Table 2. Transitional arrangements for doctors becoming approved clinicians

Position of doctor	Transitional arrangement for approval as approved clinician
Section 12 approved and carried out the functions of an responsible medical officer within past 12 months	Approved for 1 year, or to end of section 12 approval, which ever is later
Section 12 approved and not a responsible medical officer, but in overall charge of the medical treatment for mental disorder of a person within past 12 months, and a registered medical practitioner (e.g. consultant in charge of community patients and/or informal patients)	Approved for 1 year, and for a further 2 years if complete a course for initial training of approved clinicians
Section 12 approved and not an responsible medical officer, and not in overall charge of medical treatment, but appointed to a post of consultant psychiatrist in 18 months to 2 November 2009	Approved until 2 November 2009



current
practice

fact there is no requirement for a history of multiple admissions. Individuals can only be discharged on to a community treatment order if they are currently on an unrestricted treatment order (i.e. section 3, or an unrestricted Part 3 order such as section 37). The responsible clinician makes the order, and an approved mental health professional must agree it is appropriate. The criteria for making a community treatment order are:

- (a) the individual is suffering from mental disorder of a nature or degree that makes it appropriate for them to receive medical treatment;
- (b) it is necessary for their health or safety or for the protection of other people that they should receive such treatment;
- (c) subject to their being liable to be recalled, such treatment can be provided without their continuing to be detained in a hospital;
- (d) it is necessary that the responsible clinician should be able to exercise the power to recall the individual to hospital;
- (e) appropriate medical treatment is available.

The community treatment order means that 'conditions' are imposed on the individual – two of these are obligatory: to attend for 'medical' examination to consider extending the community treatment order, and to be examined by a second opinion doctor. Other conditions can be set, but they must be necessary and appropriate to ensure the person receives treatment for their mental disorder, to prevent risk of harm to the individual's health or safety or to protect other people. Conditions may not be set for any other purpose.

All section 58-type treatment on a community treatment order needs to be authorised by a second-opinion doctor even if the individual consents, and there is a '1-month rule' for medication to allow for time for the doctor to see the patient. If the responsible clinician changes, then a new certificate needs to be issued by the second-opinion doctor. Treatment cannot be forced upon the person, but of course the individual is not completely free to choose whether they take medication or not, because of the power of recall.

Recall to hospital

Grounds for recall are that the individual needs treatment for a mental disorder in hospital (as an in-patient or an out-patient) and there is a risk to the health or safety of the individual or risk to other people. A separate ground is to examine for renewal or by a second-opinion doctor. The individual must be given notice in writing, and there is an authority to take and convey them to hospital. Once an individual is recalled, there are 72 hours to decide whether to return them to the community on a community treatment order (e.g. if an individual has been given their depot medication), or the responsible clinician can revoke the order if the person requires in-patient medical treatment for a mental disorder under the Act, and an approved mental health professional agrees. The individual is then back on their original in-patient treatment order. (Individuals transferred from supervised discharge

to a community treatment order whose order is revoked will be detained under section 3.⁵)

The duration of community treatment orders are the same as section 3, and extension of the order is by the responsible clinician, with the agreement of a person who has been professionally concerned with the individual's medical treatment but who belongs to a profession other than that to which the responsible clinician belongs. The responsible clinician must also obtain the written agreement of an approved mental health practitioner.

So, supervised community treatment certainly has more teeth than a guardianship order, especially with the power of recall to hospital, and may prove useful for 'revolving door' patients. However, there is clinical discretion about its use, and some may think that for individuals with capacity who are currently well, it is for the person themselves to decide what treatment to accept for their mental disorder.

Safeguards for patients

There are several new rights and safeguards for patients that should lead to improvements in their experience of compulsion. These include:

- a right for patients to displace their nearest relative;
- registered civil partners can be nearest relatives;
- a statutory right to advocacy for all detained patients;
- electroconvulsive therapy (ECT) cannot be given to capacitous individuals if they refuse (except in an emergency) or incapacitous individuals with a valid advance decision refusing ECT. Electroconvulsive therapy cannot be given to children under the age of 18 without the approval of a second-opinion doctor (unless in an emergency) even if they consent;
- hospital managers must ensure that individuals under the age of 18 are accommodated in an environment that is suitable for their age;
- hospital managers must refer patients for an automatic tribunal at 6 months of detention (including any period under section 2), and there is power for the Secretary of State to shorten this time period. Furthermore, children under the age of 18 who have not had a tribunal in the previous 1 year must be referred (this time period remains 3 years for adults).

Deprivation of liberty safeguards

The Mental Capacity Act 2005 has been amended to allow 'supervisory bodies' (local authorities for social care settings, primary care trusts for health settings) to make orders of up to 12 months to authorise the deprivation of liberty of incapacitous adults where it is judged to be in their best interest. The orders just authorise deprivation of liberty; other acts in connection with the care or treatment of incapacitous people are governed by the other provisions of the Mental Capacity Act. The process is described in detail in its own code of practice.⁶ The use of these provisions need to be considered as a possible alternative when people without capacity are being



current practice

assessed for admission, community treatment or guardianship under the Mental Health Act.

Six assessments are required:

- (a) the age assessment, to determine that the person is aged 18 or over;
- (b) the 'no refusals' assessment, to ensure that there is no conflict with an existing authority to make decisions such as an advance decision to refuse treatment or a valid decision of a donee or deputy;
- (c) the mental capacity assessment, to determine whether the person lacks capacity;
- (d) the mental health assessment, to determine whether the person has a disorder or disability of mind;
- (e) the eligibility assessment, to determine whether they should be or are detained under the Mental Health Act, or whether there is conflict with the community provisions of the Mental Health Act; and
- (f) the best interests assessment, to determine whether the deprivation of liberty is in the best interests of the person.

Trained 'best interests assessors' will make the best interests, no refusals and age assessments, and can make the mental capacity assessment, and if they are also an approved mental health practitioner, the eligibility assessment. They can be social workers, occupational therapists, nurses or psychologists. 'Mental health assessors' make the mental health assessment and can make the mental capacity and eligibility assessments. In order to become a mental health assessor, section 12 doctors will need to undergo a day's course or online training provided by the Royal College of Psychiatrists.⁷

Conclusion

Most of the changes to the Mental Health Act were implemented in November 2008, with the deprivation of liberty safeguard in April 2009. Other changes such as the provision of independent mental health advocates and the requirement of age-appropriate services will come into effect in 2009–2010. Many of the new safeguards in the Act are welcomed by clinicians and service user groups. However, other changes are more controversial and could potentially lead to an increase in the workload of clinicians. There are concerns that supervised

community treatment will not be practicable and will have limited utility for those individuals who have a history of poor adherence. On the other hand, it offers a less restrictive option and may enable individuals to leave hospital sooner.

Perhaps the most controversial change is the introduction of the responsible clinician role. Although the new arrangements have the potential to enhance multi-disciplinary working, there are concerns they may lead to conflict between professionals and possibly undermine the role of the psychiatrist. Other professions will need to put together portfolios to demonstrate they have the requisite competencies, train to take on the role, and obtain their employer's support, so the transition is likely to be gradual. We hope it will prove to benefit those subject to the Act's powers.

Declaration of interest

None.

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