

The new Mental Health Act: a guide for clinicians

Wai-Ching Leung

The White Paper proposals for a new Mental Health Act have recently been published. This article examines the controversial changes in this proposal and their implications for doctors.

Psychiatrists, GPs and doctors working in accident and emergency departments frequently encounter mentally ill patients who refuse treatment necessary to protect both their own health and safety and that of the public. Doctors in other specialties may also encounter such problems in the course of their clinical duties. Many doctors are familiar with the Mental Health Act 1983, which has for the last 17 years governed when and how such patients may be treated against their wishes. However, this will soon be superseded by a new Mental Health Act outlined in a recently published White Paper *Reforming the Mental Health Act* (Department of Health, 2000a,b). Doctors and other professionals will undoubtedly need to thoroughly understand this White Paper. This article aims to outline the basic principles and practical implications of the White Paper proposals for this new act.

THE DILEMMA

The basic dilemma is to balance the patient's autonomy and civil liberty with the need to protect and maintain health and safety for him/herself and the public. Recent events have exaggerated this dilemma. On the one hand, the patient's right to liberty and freedom from degrading treatment is enshrined in section 5 and section 3 of the Human Rights Act 1998 respectively, which came into force on 2 October 2000. This argues for more restricted use of compulsory treatments. On the other hand, several high-profile homicides committed by mentally ill patients exert considerable public and political pressure for more power to impose compulsory treatments. This dilemma is evident by comparing the *Scoping Report* (Richardson, 1998), which places great emphasis on self-determination, and the subsequent White Paper (Department of Health, 2000a), which mainly seeks to protect the public.

Under the Mental Health Act 1983, compulsory care and treatment can only be given in hospitals. The rationale is that if patients are not sufficiently ill to require hospital care, they should not lose their civil liberty and autonomy. However, care and treatment of mentally ill patients have changed considerably in the past two decades, and most patients with mental disorders are now treated in the community.

Unfortunately, there is a gap in services for those who do not require hospital admission but who do require compulsory medication and/or follow-up. To close this gap, the proposed new Mental Health Act allows patients to be assessed or treated compulsorily in the community.

KEY CHANGES INTRODUCED BY THE PROPOSED NEW MENTAL HEALTH ACT

The overall key changes are set out in *Table 1*.

DEFINITION OF MENTAL DISORDERS

Unlike section 3 of the Mental Health Act 1983, which requires patients to be categorized into

TABLE 1.
Key changes introduced in the proposed new Mental Health Act

Broadening of the definition of the term mental disorder
Uniform three-stage procedures for all patients
Compulsory treatment to take place either in hospital or in the community
Distinguishing between patients treated in their best interests and those on the grounds of risks to others in determining care and treatment orders
Care and treatment orders to be authorized by a tribunal chaired by a lawyer
New provisions to detain those with 'dangerous severe personality disorder' who have not committed an offence

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one of four clinical types, the proposed new Mental Health Act simply defines a mental disorder broadly as:

‘any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.’

The exact clinical diagnosis is no longer important. Personality disorders are clearly included within such a definition. Unlike the Mental Health Act 1983, patients with alcohol and drug misuse are not explicitly excluded.

UNIFORM PROCEDURES TOWARDS COMPULSORY CARE AND TREATMENT

Unlike the Mental Health Act 1983, there will be a uniform three-stage procedure towards compulsory care and treatment (*Table 2*). This three-stage process clarifies and simplifies the 1983 act where clinicians cannot be certain whether to apply for section 2 (compulsory assessment) or section 3 (compulsory treatment). Many patients become compliant with a care plan in the first 28 days.

Stage 1. Preliminary examination

Under the proposed Act, any interested party (e.g. patient, carer, GP, criminal justice agency) can request a preliminary examination from the NHS trust or primary care trust responsible for providing specialist mental health services. Two doctors and a social worker (or another suitably trained mental health professional) are required to examine the patient to decide whether the patient should be assessed and given initial treatment under compulsory powers. The criteria are set out in *Table 3*. This assessment may take place in the community, which might eliminate the necessity for an inpatient stay.

If it is decided that these criteria are satisfied, the social worker or trained mental health professional will be responsible for coordinating the administrative steps to proceed to the next stage.

TABLE 2. Uniform three-stage procedure towards compulsory care and treatment	
Stage 1	Preliminary examination
Stage 2	Formal assessment and initial treatment order (maximum 28 days)
Stage 3	Care and treatment order (maximum 6 months on two occasions, 12 months thereafter)

Stage 2. Formal assessment and initial treatment under compulsory powers

This may take place in hospital or in the community. The maximum period is 28 days from the time the decision is registered. A written care plan of the patient's health and social needs must be agreed and recorded in a standard pro-forma within 3 days and kept in the patient's notes. Compulsory treatment (apart from urgent treatment) cannot be given before the care plan is drawn up and recorded. If the patient is to be detained for more than a few days, a detailed care plan according to the care programme approach pro-forma is required, and the treatment plan must state what symptoms or behaviours arising from the mental disorder it is intended to address (Department of Health, 2000a).

If compulsory treatment is considered necessary after 28 days by the clinical supervisor (usually the responsible consultant psychiatrist), he or she must apply to the new Mental Health Tribunal for the authorization of a care and treatment order. In practice, a period of 28 days is probably rather limited to complete a full assessment and care plan and to prepare for a tribunal. Hopefully, when patients are stabilized on community orders, the need for compulsory detention would diminish with time as patients regain insight into their conditions.

Stage 3. Care and treatment orders

On application by the clinical supervisor for a care and treatment order, an appointed independent doctor, preferably with expertise in the relevant type of mental disorder, will see the patient, in order to provide expert evidence to the panel. The panel consists of at least three members. The chair of the tribunal will be a qualified lawyer. One of the members will be a person with a clinical background with experience in mental health services. The third member will usually have a background in community or voluntary sector service provision and experience in mental health services. This differs from the current arrangement under

TABLE 3. Criteria for formal assessment and initial treatment order (maximum 28 days)
The patient needs further assessment or urgent treatment by specialist mental health services
Without it, the patient might be at risk of serious harm or pose a risk of serious harm to other people

the Mental Health Act 1983 under which an independent psychiatrist is always on the panel. Under the new proposals, it is not clear whether an independent psychiatrist would always be asked to give an opinion or whether this would occur only in difficult cases.

In deciding whether to issue a care and treatment order, the tribunal will apply the criteria shown in *Table 4* to the evidence available.

If the tribunal makes a care order, it will specify the following:

- How long the order is to last (maximum 6 months in the first two occasions, 12 months on subsequent occasions)
- Whether and where the patient will be detained (either community or hospital, although medication will only be given against the patient's active resistance in hospitals)
- Whether he/she should be conveyed to a hospital or clinic to have medication administered compulsorily
- The consequences of non-compliance with the plan (if the patient is not detained)
- Whether the clinical supervisor may grant leave, transfer the patient to another location or discharge the patient (if the patient is detained).

EMERGENCY ADMISSION TO HOSPITAL

Similar to section 4 of the Mental Health Act 1983, a patient may be compulsorily admitted to hospital as an emergency for a maximum of 72 hours with the recommendation of one doctor and a social worker or a trained mental health professional.

HOLDING POWER OF PATIENTS ALREADY IN HOSPITAL

Similar to section 5(2) of the Mental Health Act 1983, a patient already in a specialist mental health unit requiring urgent treatment may be detained for a maximum of 72 hours by one doc-

tor. Unlike the Mental Health Act 1983, for patients in a hospital other than a specialist mental health unit, recommendations from either two doctors or a doctor and a social worker/trained mental health professional are required.

Similar to section 5(4) of the Mental Health Act 1983, a nurse of appropriate seniority and experience can authorize the detention of a patient for up to 6 hours.

PATIENTS WITH LONG-TERM MENTAL INCAPACITY

The Bournemouth case (*R v Bournemouth*), heard by the House of Lords in 1998, exposed a gap in the mental health law for patients incapable of consenting to informal admission (e.g. patients with dementia or learning disability). Such patients do not enjoy protection of the safeguards of Mental Health Act 1983. However, there are insufficient resources to invoke Mental Health Act 1983 procedures for all such patients.

The proposed new Mental Health Act provides a new procedure for patients incapable of consenting to informal consent, but who do not actively resist treatments and do not pose a risk to others. The clinical supervisor must:

- Arrange a full assessment and develop a detailed care plan covering all aspects of care and treatment, including any steps which might restrict the patient's freedom
- Arrange an independent doctor to examine the patient. The doctor may suggest changes to the care and treatment plan
- Consult the patient's carers or close relatives and social care representative
- Notify the Commission for Mental Health that a plan is being drawn up
- Finalize the plan within 28 days.

At any stage, the patient and his or her representative may apply to the tribunal to challenge or to request a review of the detention. However, it is expected that most cases can be resolved by informal discussion.

TABLE 4.
Criteria for care and treatment order

The patient must be diagnosed as suffering from a mental disorder
The mental disorder must be of such a nature or degree as to warrant specialist care and treatment
A plan of care and treatment must be available to address the mental disorder
If the order is primarily for the patient's own interests, the plan must be expected to be of direct therapeutic benefit to the patient
If the order is primarily to protect others from risks, the plan must be considered necessary to treat the underlying mental disorder and/or to manage behaviours arising from the disorder

DANGEROUS PEOPLE WITH SEVERE PERSONALITY DISORDER

This is perhaps the most controversial part of the new Mental Health Act, as it might entail curtailment of liberty to individuals who have not committed an offence and who do not benefit from treatment. Under the Mental Health Act 1983, dangerous people with severe personality disorders who have not committed an offence cannot be detained unless their conditions are treatable. After several high-profile homicides by such patients, public protection becomes high on the political and public agenda. The working definition of 'dangerous people with severe personality disorders' is individuals who:

- Show significant disorder of personality
- Present a significant risk of causing serious physical or psychological harm from which the victim would find it difficult or impossible to recover (e.g. homicide, arson), and the risk presented appears to be functionally linked to the personality disorder.

KEY POINTS

- The law on compulsory treatment for mentally ill patients involves a delicate balance between the need to protect the patient's autonomy on the one hand and public safety on the other.
- A recent White Paper proposed a new Mental Health Act to replace Mental Health Act 1983.
- Under this proposal, the definition of mental disorder is broadened.
- A uniform three-stage procedures apply to all patients:
 1. Preliminary examination
 2. Formal assessment and initial treatment order
 3. Care and treatment order.
- Compulsory assessment and treatment may take place in the hospital or in the community.
- Dangerous people with severe personality disorder may be detained even if no treatments of direct therapeutic benefit are available.

The proposed criterion for issuing care and treatment orders is: 'if the order is primarily to protect others from risks, the plan must be considered necessary to treat the underlying mental disorder and/or to manage behaviours arising from the disorder'. This essentially means that such patients can be detained as long as they pose risks to others, irrespective of the treatability of their conditions.

The government anticipates this will only apply to a relatively small number of extremely dangerous people, the current estimate being approximately 2500 individuals. An assessment period is suggested in order to clarify the benefits of using this order.

There is considerable resistance to this proposal by forensic psychiatrists. Some patients would be detained in prison and others in secure hospital facilities. It is not at all clear how this will be decided.

CONCLUSIONS

The new Mental Health Act White Paper proposes considerable controversial changes to how mentally ill patients who require compulsory treatment should be managed. There are objections raised by both professionals and patient representatives. For these reasons, the White Paper proposals might be open to further scrutiny and undergo further changes before enactment. Even after they are enacted, their compatibility with the Human Rights Act 1998 may be legally challenged. **HM**

Conflict of interest: none.

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