

>> Briefing

December 2008

Mental Health Act 2007

Introduction

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The government's original intention had been to pass a wholly new Mental Health Act to replace the 1983 Act. However, opposition to many of its proposals meant that the 2007 Act, which received Royal Assent on 19 July 2007, is shorter than originally planned. It amends, rather than replaces, the 1983 Act.

The Mental Health Act 2007 applies to England and Wales (as does the Mental Health Act 1983). The Scottish Parliament has powers over mental health legislation in Scotland and in 2003 passed its own Mental Health Act (the Mental Health (Care and Treatment) (Scotland) Act 2003), which came into effect in 2005. Although this legislation has the same broad purpose as the 2007 Act in England and Wales, the two Acts differ significantly in substance, so comparisons need to be treated with caution.

Most provisions of the 2007 Act came into effect in November 2008. Especially notable are extended powers of compulsion in the community – Supervised Community Treatment (SCT) – and a widening of the professional groups that can apply to fulfil new roles that exercise power under the Act – approved mental health professional (AMHP) and responsible clinician (RC).

This briefing focuses on these policies in relation to England. It does not provide a comprehensive account of all of the Act's provisions.

The Department of Health has issued a revised Code of Practice for England to guide mental health professionals in implementing the Act correctly and appropriately (Department of Health 2008).

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Background to the 2007 Act

The 2007 Act was the culmination of many years' attempts by the government to reform mental health legislation for England and Wales, and in particular to tackle concerns about risks to the public posed by people with a serious mental disorder living in the community.

First indications of a reform of legislation came on 1 January 1998 with the publication of the government's *Mental Health Policy: Safe, sound and supportive* (Department of Health 1998). In this, Secretary of State for Health, Frank Dobson, wrote, 'care in community has failed' because 'it left far too many walking the streets, often at risk to themselves and a nuisance to others'. The law was to be updated to ensure that patients who were considered a danger to themselves or others could not refuse to comply with treatment and to permit the detention of people with dangerous, untreatable psychiatric disorders.

The process of reforming the Mental Health Act 1983

The process of implementing the reform has been slow. The Richardson Committee, appointed by the government to advise it on a root-and-branch review of the Act, published its report in July 1999 (Richardson 1999). Thereafter the process involved:

- a Green Paper published in November 1999 (*Reform of the Mental Health Act 1983: proposals for consultation*)
- a White Paper published in December 2000 (*Reforming the Mental Health Act*)
- based on the White Paper, a draft Mental Health Bill and consultation document published in June 2002
- in view of continuing concerns about the proposals, a revised draft Mental Health Bill published in September 2004
- a joint House of Commons and House of Lords Committee report on the draft Bill on 23 March 2005, criticising many of the draft Bill's proposals
- the government's response to the Joint Committee's report published on 13 July 2005
- a further, shorter, Mental Health Bill introduced into the House of Lords on Thursday 16 November 2006. This received Royal Assent on 19 July 2007, to become the Mental Health Act 2007.

The fundamental purpose of mental health legislation has not been changed by the 2007 Act. Although there were calls during the reform process for a new Act that focused on rights rather than risk, the amended Act remains designed to set out the circumstances in which certain people with a mental disorder can be compulsorily detained and treated (whether in hospital or in the community) and the safeguards for patients against inappropriate use of the legislation, including a formal appeals process and review of compulsory detention and treatment.

The main changes introduced in the 2007 Act

Definition of mental disorder

The original definition of mental disorder in the 1983 Act was quite complex: 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'; the categories of 'severe mental impairment', 'mental impairment' and 'psychopathic disorder' had their own definitions. The 2007 Act removes all these distinctions and simply defines mental disorder as being 'any disorder or disability of the mind'.

Exclusions from the Act

The 1983 Act excluded people from being dealt with under the Act 'by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs'.

The amended Act contains an exclusion only by virtue of 'dependence on alcohol or drugs'. Society's views of what constitutes promiscuity and immoral conduct – and how it should be regarded – have changed significantly over the past 25 years and the government assumes that no professionals would ever use the Act to detain and treat someone purely on these grounds. However, the removal of 'sexual deviancy' does allow paedophiles to come within the scope of the Act so long as they fulfil all the conditions for its use.

The Act also excludes people with a learning disability, 'unless that disability is associated with abnormally aggressive or seriously irresponsible conduct'.

Conditions for admission and treatment under the Act

Under the civil procedures, to be admitted for *assessment* under the amended Act (section 2) a person must be:

- (a) *suffering from a mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and*
- (b) *he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.*

To be admitted for *treatment* under the amended Act (section 3):

- (a) *a person must be suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and*
- (b) *it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and*
- (c) *appropriate medical treatment is available for him.*

The main change from the 1983 Act concerns a patient's 'treatability' under section 3. Under the original 1983 Act, detention and treatment on grounds of mental impairment or psychopathic disorder could be authorised only if it was considered that treatment was 'likely to alleviate or prevent a deterioration' of the patient's condition. The government was concerned that some people with a personality disorder who were perceived to be a danger to the public might not be detained because clinicians could argue that there was no treatment they could offer that would meet this requirement. Accordingly, this has been replaced by the requirement for availability of 'appropriate medical treatment'. This is defined as including 'nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care', and it must be medical treatment 'the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations'. In other words its *purpose* must be to alleviate or prevent a deterioration, but it no longer needs to be *likely to*.

The inclusion of a requirement that appropriate treatment is actually available is also new to the Act. One effect of this is that services must be made available to any patient placed under SCT (if services are not available, SCT could not be ordered).

Professional roles

The main changes to professional roles come with the creation of 'approved mental health professionals' (AMHPs) and 'responsible clinicians' (RCs).

Under the original 1983 Act, the professional with the power to apply for the detention of a person in hospital, and obtain the necessary medical agreement, was a social worker specially trained for this task – referred to in the Act as an approved social worker (ASW). The 2007 Act has opened up this role to a wider group of professionals and has renamed the role ‘approved mental health professional’ (AMHP). This leaves it open, for example, for nurses, psychologists and occupational therapists to train to become an AMHP and exercise powers under the Act, as well as social workers. Doctors are, however, excluded from becoming an AMHP.

Under the original 1983 Act the professional with the power to treat people and to discharge them from hospital or extend their detention, was the responsible medical officer (RMO), usually a consultant psychiatrist. The 2007 Act allows these powers to be exercised not just by a registered medical practitioner but also by other professionals who undertake the necessary training, and redefines the role as a responsible clinician (RC). The RC will additionally be responsible under the amended Act for discharging a patient under SCT.

There has been controversy over whether this change meets the requirement of a European Court of Human Rights ruling (Winterwerp 1979) that any decision to detain someone on the grounds of mental disorder must be backed by objective medical evidence. Although under the 2007 Act detention has to be authorised by two medically trained people, any renewal of detention could be authorised by an RC who is not a doctor, raising the question of whether this meets the requirement of ‘objective medical evidence’.

Transitional arrangements have ensured that all ASWs and almost all RMOs automatically became AMHPs and RCs respectively in November 2008. All new AMHPs and RCs, from whatever profession, will have to undergo specialist training for these roles.

Supervised Community Treatment (SCT)

Possibly the highest-profile change in the 2007 Act is the introduction of SCT, which extends powers of compulsion in the community through Community Treatment Orders (CTOs). The chief purpose of SCT is to allow non-compliant patients living in the community to be treated without their consent at an early stage of relapse, rather than to wait until they become severely ill again and have to be readmitted to hospital under the Act (the ‘revolving door’ syndrome).

SCT replaces the power of aftercare under supervision. Supervised aftercare allowed conditions to be imposed on patients in the community and gave the power to recall a non-compliant patient to hospital (as does SCT), but it did *not* give professionals the power to treat a patient who had been returned to hospital without that patient’s consent unless they went through a formal compulsory re-admission. This led to many professionals viewing it as ineffective when faced with a patient’s non-compliance (Franklin *et al* 2000).

What SCT adds to the Act is a power to convey a non-compliant patient to hospital and hold them there for up to 72 hours for the purpose of treating them, in effect as an outpatient. If they do not comply with treatment in that time, the CTO may be revoked and the patient would revert to detained status.

It is important to note that the new SCT powers do not allow patients to be forcibly compelled to take treatment in a community setting – the ‘injection over a kitchen table’ scenario.

SCT may only be authorised for a patient already detained in hospital for treatment under the Act – it cannot be used for patients admitted to hospital only for assessment, or for patients under a restriction order. The authorisation may be made by a patient’s RC, with agreement from an AMHP. CTOs are authorised for a six-month period, renewable

for a further six months and then annually if considered necessary. The RC is required to review the CTO within two months of its expiry to assess whether it needs to be renewed or whether the patient can be discharged from it. A patient under a CTO may appeal against the imposition of SCT to a tribunal in the same way as a patient detained in hospital, but cannot appeal to a tribunal against the conditions set out in their CTO.

The Mental Health Act 1983 contains other powers to impose conditions on some patients living in the community, which will remain. *Guardianship* enables patients with general welfare needs (not just medication requirements) to receive care outside hospital when it cannot be provided without the use of compulsory powers. *Leave of absence (LOA)* is intended to allow inpatients leave from hospital for short periods only. Under the amended Act, if a responsible clinician wishes to grant LOA for longer than seven consecutive days, he must first consider whether the patient should instead be placed under SCT.

A right to advocacy

The 2007 Act places a duty on 'the appropriate national authority' – in effect, the Secretary of State of Health in England – to make advocacy services available to most detained patients (it excludes those detained in an emergency and those taken into custody by the police) and to all patients subject to SCT and guardianship arrangements. The services will be provided by new independent mental health advocates (IMHAs), whose role will include helping patients to obtain information about, and understand, what powers they are subject to under the Act, their treatment and their rights. There is, however, no obligation on the patient to seek support from an IMHA.

This provision follows the pattern of the Mental Capacity Act, which established independent mental capacity advocates (IMCA) for people subject to that Act. To ensure adequate advocacy services are available, the IMHA provisions will come into effect on April 2009.

Children's safeguards

The 2007 Act introduces a new requirement that children and young people under the age of 18 must be treated in 'age-appropriate' settings. The responsibility to arrange this lies with hospital managers. This follows concerns about children having been detained on adult wards where adult patients' disorders and behaviour have had a negative impact on their recovery. In practical terms, hospitals may find it difficult to adapt their existing buildings/wards to meet this requirement, so the implementation of this requirement has been delayed until April 2010.

Changes to the Mental Capacity Act – the 'Bournewood gap'

In 1997 a 49-year-old man with autism who lacked mental capacity to consent to hospital treatment was detained at Bournewood Hospital in Surrey despite the fact that he was admitted as a voluntary patient. The hospital claimed that this was in his own best interests, and that he was detained under common law. The patient's carers took his case to the European Court of Human Rights, who ruled that the patient had been deprived of his liberty unlawfully without legal procedures for safeguards or speedy independent appeal. The effect of this ruling was that many thousands of people could be considered illegally detained in hospitals or nursing homes, mainly people suffering from severe learning disabilities or dementia.

To close what became known as the 'Bournewood gap', the government has used the 2007 Mental Health Act to amend the Mental Capacity Act 2005, adding new provisions on the restriction of the deprivation of liberty for someone who lacks capacity (sections 4A and

4B of the Mental Capacity Act). These provisions, known as the Deprivation of Liberty Safeguards (DOLS), require that before anyone can be deprived of liberty then either:

- a) the Court of Protection must have ordered it or
- b) a formal authorisation must be obtained from a local authority, in the case of someone in a care home, or a primary care trust in England or the Welsh Assembly in Wales, for someone in a hospital. Authorisation must be obtained in advance except in cases of urgent need, though in such cases standard authorisation must be obtained within seven days of the start of the deprivation of liberty.

The provisions are aimed at people over 18 who suffer from a mental disability or disorder, lack capacity to give informed consent and for whom, following an independent assessment, care is considered necessary in their best interests to protect them from harm.

The DOLS are expected to be implemented from 1 April 2009.

Principles underpinning the legislation

The 2007 Act and new Code of Practice for England amend the principles that are set out in the original Code of Practice. The government resisted calls for the principles to be moved from the Code of Practice into the Act itself. Accordingly, the principles appear to provide guidance that should inform professionals' decisions taken under the Act, rather than being principles that must be followed as a statutory duty, as is the case of principles set out in the Mental Capacity Act 2005 and the equivalent Mental Health (Care and Treatment) (Scotland) Act 2003.

The amended Act does, however, introduce for the first time a statutory requirement to have guiding principles. It lists various 'matters' that must be addressed in preparing the statement of principles in the Codes, such as respect for patients' past and present wishes and feelings, respect for diversity, minimising restrictions on liberty and effectiveness of treatment. The matters also include public safety, reflecting one of the underlying drivers behind the 2007 Act.

Other changes

In addition to the main changes listed above, other detailed changes result from the 2007 Act.

- 'Nearest relatives' – the 1983 Act sets out a prioritised list of people who have the power to apply for compulsory admission of someone to hospital and for discharge. 'Civil partner' has been added to the top of the list alongside 'husband or wife'. Also, patients now have the power to apply through a county court to change their nearest relative on grounds of unsuitability.
- Electro-convulsive therapy (ECT) – under the original 1983 Act, ECT could be given without consent to a person with decision-making capacity if it was agreed by a second opinion doctor (SOAD). The 2007 Act changes this so that ECT cannot be given without consent if a person has decision-making capacity.
- Victim's rights – victims of sexual or violent offences committed by individuals subsequently held in hospitals as opposed to prison can make representations as to whether a patient should be conditionally discharged and what conditions should be placed on them if they are discharged under a Community Treatment Order.

Support for implementation of the Act

Responsibility for implementing the Act in England falls to mental health trusts, supported by the National Institute for Mental Health/Care Services Improvement Partnership (NIMHE/CSIP). Details of the implementation programme, delivered through NIMHE/CSIP's eight Regional Development Centres, can be found on the NIMHE/CSIP website (www.mhact.csip.org.uk). The programme focuses primarily on informing staff involved in implementing the Act of the changes introduced by the 2007 Act and implications for their working practice, ensuring that they receive the necessary training to implement the new provisions.

What impact will the Act have?

The government has achieved much of what it set out to do in 1998, although it failed to achieve the root-and-branch review of mental health legislation that it originally planned. The amended Act does, as it intended, break the link between compulsory treatment and hospital by extending compulsion to certain patients in the community. In redefining mental disorder and removing the 'treatability' test it allows clinicians to detain certain people who could avoid detention under the original 1983 Act. It also expands the professional groups who are able to undertake key roles under the Act. Organisations concerned about the government's proposals, working primarily through the Mental Health Alliance (www.mentalhealthalliance.org.uk) had some success in modifying the proposals, but failed to achieve their aim of a capacity-based Act that established a legal right to assessment, care and treatment as a first step to ensuring a reduction in the use of compulsory powers.

It remains to be seen what impact the 2007 Act will have on the numbers of people subject to compulsory powers and the outcome of their treatment. It is possible that as the number of people living in the community under SCT rise, then the number of people compulsorily detained in hospital will fall. This has been the experience of Scotland two years after introducing similar legislation (Mental Welfare Commission for Scotland 2008). Some reduction in readmissions to hospital is to be expected, although SCT does not guarantee success. In terms of protecting the public, SCT is unlikely to bring an end to the occasional high-profile homicide committed by people with a serious mental disorder, as many are committed by people who have not previously been in contact with services or had been assessed as low risk. However, SCT should lead to fewer and less violent incidents in specific cases as patients maintain treatment regimes they might otherwise ignore.

The statutory requirement for services to be available to people on SCT will put pressure on local community mental health services to focus on this group, possibly at the expense of maintaining good levels of support for other community mental health patients. There is a danger that those with lesser needs may lose out given the limited resources available. The government expects savings to be made from reduced bed usage as a result of SCT, but there is no guarantee these savings – if actually made – will be channelled into community mental health services. SCT also imposes extra costs on local authorities that will need to be found from within tight budgets.

The amended legislation may become subject to challenges in the courts in a number of areas. The Deprivation of Liberty Safeguards (DOLS) requirements will involve the assessment of possibly tens of thousands of people currently living in care homes and in hospital, and the assessment process is complicated, particularly if the person has fluctuating capacity. It may require test cases in the courts before a consistent approach to assessments is achieved. The exact status of the Code of Practice, and in particular the principles set out in the Code, may be challenged in the courts to determine the

circumstances in which guidance in the Code may be set aside. The power of a non-medical responsible clinician to authorise the renewal of detention and compulsory treatment could also face legal challenge. The requirement to ensure an 'age-appropriate' setting in hospital for all children and young people under the age of 18, although it is delayed to April 2010, may tax some trusts, and if they fail to provide such a service they could end up being taken to court. A failure to provide sufficient independent mental health advocacy support, as required under the amended Act by April 2009, may also lead to court cases.

The changes in professional roles, allowing a wider range of professions to fulfil duties under the Act, are unlikely to have any immediate impact on the mental health workforce. In practice most future AMHP and RC responsibilities will still be undertaken by social workers and registered medical practitioners respectively. However, to be successful, this change will require medical and social work professions to accept that staff from other professions are capable of fulfilling responsibilities that have traditionally been their preserve.

How smoothly the amended Act is implemented will depend on the ability of a range of professionals to operate in a complex new environment. This involves an understanding of not only the amended Mental Health Act but also the Mental Capacity Act 2005, the new Deprivation of Liberty Safeguards, the submergence of Mental Health Review Tribunals into a new generic tribunal established by the Tribunals, Courts and Enforcement Act 2007, and the possibility of people who lack capacity being allowed to have individual personalised budgets under the Health and Social Care Act 2008. In the wider context, mental health staff involved with patients subject to the amended Act will also need to be ready to adapt to the ongoing changes in the NHS as a result of Lord Darzi's NHS Next Stage Review, and the impact on mental health services of choice, world class commissioning and Payment by Results.

It is inevitable that, in the first few months following implementation, some professionals will be uncertain about the new powers introduced by the 2007 Act and the new guidance set out in the Code of Practice. This was the experience of Scotland following the implementation of its equivalent legislation in 2005. Many mental health service users and carers are also likely to be uncertain, and possibly anxious, about how the changes to legislation will affect them. This will need to be addressed by professionals at local and individual level.

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