

# Mental Health Act 2007

## Frequently Asked Question's

### Service Users

1. Will there be a brand new Mental Health Act?

*No. The MHA 2007 is an amending act. It changes some parts of the Mental Health Act 1983 but leaves a lot of it unchanged. The changes become part of the 1983 Act so we will continue to refer to the basic legislation as the MHA 1983*

2. Will section 2 & 3 and other current detention sections of the MHA 1983 remain in force?

*Yes, these two sections remain within the new Mental Health Act 2007 and will continue to apply (The only section being abolished is supervised after-care under section 25A).*

3. What are the main changes in the new Act?

- a. A change to the Definition of mental disorder. *(It's a new, simpler definition – and there's the removal of the rule that said a mental disorder didn't count if it consisted of sexual deviancy)*
- b. Changed Criteria for detention.
- c. The introduction of new Professional roles
- d. A change to who can be the Nearest Relative and how they can be displaced. *(Making civil partners each other's nearest relative in the same way as husbands and wives and also a change to how the Nearest Relative can be displaced)*
- e. The introduction of Supervised Community Treatment
- f. An increase in the access to Mental Health Review Tribunals
- g. The requirement that there be Age-appropriate Facilities for under-18s who have to go into hospital.
- h. The introduction of Independent Mental Health Act Advocacy (IMHA)
- i. Additional safeguards regarding the use of Electro-Convulsive Therapy

4. Will the new Act mean people can force their way into my home?

*All patients subject to Supervised Community Treatment (SCT) will have to make themselves available for medical examination. If there is a concern for the wellbeing of the individual under SCT or for their family and if the individual is not complying with the requirements then admission can be gained to a persons home.*

*The right to access an individual in their home is already present under Section 135 of the present Mental Health Act. Health & social services will still need to get a warrant from a magistrate before they can come into your home without permission.*

5. Will people be able to force me to have treatment in my own home?

*People on SCT will normally be expected to accept treatment either “at home” or somewhere else. If they don’t they might be recalled to hospital which means they might be taken to hospital for the treatment against their will. But no-one can be given treatment by force in their own homes or anywhere else except a hospital if they don’t want it. The only exception is if it is an emergency and a person is so ill they don’t have the capacity to decide whether to consent or not.*

6. Why would a doctor use SCT rather than section 17 leave?

*SCT is different from section 17 leave, which will remain appropriate in respect of short-term absences from hospital. Clinicians will at least have to consider the use of SCT if leave is to be granted for longer than 7 days or indefinitely. In such circumstances, it is important, not only that they do so, but also that they can show that they did so. (SCT can be used where the RC believes that the person’s disorder can be safely managed without the need for compulsory detention in hospital, subject to the safeguard of recall. S17 is used for people who still need access to compulsory treatment)*

*The criteria required for an individual to be placed on SCT includes all of the following:*

- *the patient is already detained for treatment under the Act.*
- *it is necessary for his or her health or safety, or for the protection of other persons, that he or she receives treatment;*
- *treatment can be provided outside of hospital, subject to the power of recall;*  
*and*
- *it is necessary that the Responsible Clinician should have the power of recall*
- *appropriate treatment is available for the patient.*

*The requirements that can be imposed on an individual under SCT must be “necessary or appropriate” to:*

- *ensure that the patient receives medical treatment;*
- *prevent risk of harm to his/ her health or safety; or*
- *protect other persons.*

7. What is the difference between a Community Treatment Order & Supervised Community Treatment?

*Basically nothing They are the same thing.*

*The Supervised Community Treatment is a description of the method of care and the Community Treatment Order is the description of the legal powers.*

8. Will my GP be able to force me to take the medication?

*It is important to note that although SCT may specify that a patient receive certain treatment in the community that treatment cannot be given against the patient's wishes in the community. Your GP is likely to be part of a care team who will ultimately be responsible for agreeing your care plan with you. The care plan may stipulate that medication be part of that plan. As your GP is based in your community it is unlikely that they would be present when medication is administered against an individual's wishes as the individual would have to have become unwell and be 'recalled' to a hospital before treatment could be administered against their wishes.*

9. What does "Treatment" mean under the new Mental Health Act 2007?

*Basically what it means now. Under the MHA 2007 the definition of what constitutes 'medical treatment' will include "nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care'. Medical treatment, "shall be construed as a reference to 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".*

*The MHA 2007 removes what is often referred to as the 'treatability test' – and replaces it with a new test that will have similar effect. The new test applies to any patient suffering from mental disorder who is to be detained for treatment or put onto SCT – and requires that "appropriate medical treatment is available for him [or her]".*

*The Government has confirmed that in order to be available to a patient, it will not be enough for a treatment to exist in theory; it will have to be capable of being accessed by him or her.*

10. What does “ Available” Mean under the new Mental Health Act 2007?

*In order that treatment be ‘available’ to a patient, it will not be enough for a treatment to exist in theory; it will have to be capable of being accessed by him or her.*

11. What will happen if I don’t like the community treatment/care and I don’t want it?

*When under SCT you should be in close contact with your health care team. If at any point you wish to express dissatisfaction with any part of your treatment then this should be shared with the team. It would be hoped that changes could be made to alleviate this unhappiness with your care regime.*

*If you are refusing the care agreed under SCT, then you may be recalled to hospital. In determining whether the power of recall is “necessary”, the RC must consider the risk of deterioration if you are not detained in hospital and if you are refusing or have neglected to receive the medical treatment required for your mental disorder. This specifically involves considering the history of the mental disorder and any other relevant factors, which will include any previous history of compliance with medication and medical advice, and the likely consequences of not receiving treatment.*

*The ‘Draft revised MHA 1983 Code of Practice’ states that during the planning of discharge from hospital on to SCT the patient ‘will need to be involved in planning’ their care and ‘be prepared and willing to accept and comply with the proposed treatment’.*

12. What will my rights be, how will these be protected and will there still be an appeals process?

*Like now there will still be an appeals process. This will be by application to the Hospital Managers (of the detaining hospital) or to the Mental Health Review Tribunal (MHRT). The new MHA introduces an order-making power to reduce the time before a case has to be referred to the MHRT by the hospital managers. It also introduces a single Tribunal for England, the one in Wales remaining in being. Previously there was a requirement that Hospital Managers refer patients under the age of 16 years of age to the MHRT after one year, this has now been extended to those under 18 years of age.*

*In addition, individuals under SCT will be able to apply to the MHRT when the SCT is imposed upon him or her, and subsequently, when it is renewed or revoked.*

13. What is Advocacy under the MHA 2007?

*The role of the independent mental health advocate will be to support patients in obtaining information, understanding their rights and engaging with decisions being made about their care and treatment.*

*The Mental Health Act 2007 introduces the provision of Independent Mental Health Advocacy (IMHA) services for detained patients. These advocacy services aim to give certain people who are subject to the powers of the Act access to a specially trained advocate.*

*Advocacy places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.*

14. There are not enough staff in mental health services at present, how will the amendments ensure that treatment rather than control is ensured?

*The number of staff available locally is a decision for local commissioners and providers of services.*

*The MHA 2007 provides for roles which are central to the operation of the 1983 MHA potentially to be performed by a wider range of professionals than at present. In particular the role of RMO is replaced with that of the 'Responsible Clinician' (RC) and the role of the ASW with that of the 'Approved Mental Health Professional' (AMHP).*

*These key changes will provide the opportunity for other professions such as nursing, psychology, occupational therapy and social workers to become RCs and the scope of professionals who can become AMHPs is widened to allow nurses, occupational therapists and psychologists to be potentially available to become AMHPs.*

15. Who's responsibility will it be to make sure the new Act works properly?

*Ultimately, the duty to ensure that the MHA 2007 is used legally is the responsibility of the detaining authorities, mainly the Mental Health Trusts and the Local Authorities, but also Independent Hospitals and care homes. A Code of Practice will be produced by the Government which will give guidance to these organisations as to how the Act should be used and will identify their key roles and responsibilities.*

*Current planning is that the new Act will come into effect in October 2008, but some provisions – such as age-appropriate environments and advocacy – will be introduced at a later date so that services can be built up. Some minor provisions have commenced already.*

16. Can I choose who my nearest relative is?

*The MHA defines who your nearest relative is, this person is not necessarily your next of kin or your carer. The detained patient cannot choose who their nearest relative is.*

*There are grounds on which applications can be made to the County Court to displace the nearest relative. There are clear grounds on which the application can be made to the court and by whom. The application to displace a nearest relative can be made by the, patient, any relative of the patient, anyone with whom the patient is residing or the AMHP.*

## Carers

1. Has the new Act affected my responsibilities as a Carer – especially will I be expected to ensure the patient adheres to the requirements of SCT?

*There is no statutory responsibility placed upon the Carer, unless they have also been identified as the 'Nearest Relative' under the meaning of the Act.*

2. Has the new Act affected my rights as a Carer?

*The rights of Carers have not been affected by the introduction of the MHA 2007, unless the Carer has also been identified as the 'Nearest Relative'.*

3. I understand the Act refers to a 'Nearest Relative, what is the difference between a carer and the nearest relative?

*The carer is not automatically the nearest relative and never has been.*

*The changes to the 1983 MHA simply gives civil partners the same nearest relative rights as married partners and modifies the system by which a nearest relative may be displaced by the court.*

*Under the MHA 1983, each partner in a same-sex relationship would qualify as the other's nearest relative on the same basis as a different-sex partner would - by virtue of six months' continuous cohabitation. Under MHA 2007, however, one civil partner will automatically become the nearest relative of the other, regardless of the length of their cohabitation. In this respect, at least, civil partners have been given the same rights as married people.*

*Nearest Relatives get certain legal rights. They must be told about these and unless the patient says "no", they have a right to be told about other things, eg when a patient being discharged or moved to another hospital.*

4. As a carer of a patient that is being treated under the 1983 and 2007 Mental Health Acts am I entitled to an advocate to put my case in discussions with the medical staff?

*The answer to 'entitlement' is no. But this will be dependent upon local provision.*

5. If I am a carer for a patient who is living in the community and is subject to a Community Treatment Order and I know the conditions of that order have been breached am I required to tell the patient's medical team?

*There is no compulsory power that 'makes' you responsible for informing the clinical team. However it is hoped that the plan of care has been developed with you and that you have a good understanding of how it is intended to provide your relative with appropriate care. The plan should include clear guidance as to how you can contact the team and it is hoped that your relationship with the team will mean that you have ready access to them and are willing to share developments.*

6. Aren't Community Treatment Orders just a way of shifting responsibility for the care of seriously ill people from hospitals onto unqualified and unpaid carers?

*No. It's about not keeping people detained in hospital when they don't need to be there. The Code of Practice suggests that particular attention should be paid to carers and their relatives when they raise concerns about the patient not complying with conditions or that their mental health appears to be deteriorating. The community team needs to give due weight to those concerns and any requests made by the carers or relatives in deciding what action to take.*

*As the carer of a patient under the Care Programme Approach (CPA) you are entitled to an assessment of your own needs and it would be good practice to review this before a patient was discharged under SCT. This direct contact may help to allay anxieties.*

*The MHA 2007 promotes the principle of least restriction. This means that treatment can be tailored to the needs of each patient, and that a patient will not be detained where it is not necessary.*

*At present some patients with mental health disorders do not continue with their treatment (in particular, their medication) when they are discharged from hospital. As a result, their health sometimes deteriorates to a stage at which they might become a danger either to themselves or to other people, possibly their carers. This may result in upsetting and distressing compulsory readmissions in which the Carer may be critically involved. The dichotomy of feelings may result in the carer being seen as the wrong doer by the patient. The aim of supervised community treatment is not to 'pass the buck' to carers but to ensure that such 'revolving door' patients continue to accept their treatment after discharge.*

7. The person for whom I care committed an offence during his/her last period of serious illness but the hospital is now considering discharge back into the community. Is it true that the victim of his crime has more rights than I do about knowing when he will be discharged and the basis of that discharge?

*When the assailant has been given a hospital order under MHA 2007, the rights of victims of violent or sexual attacks will be extended, so that they will be able to attend the tribunal hearing of an appeal by their assailant. The carer has no such statutory rights.*

8. Does the new Act change in any way the approach to treating those who are dependent on drugs and/or alcohol as well as being mentally ill?

*No. (Except that, like for everyone else, SCT may now be a possibility).*

9. I care for others in my home and my relative is being discharged on a Community Treatment Order. Do I have to have my relative live with me while he/she is on the order?

*No. (Unless the home belongs to your relative as well, or you rent it jointly). There is no compulsory power that 'makes' you responsible for looking after your relative and it is hoped that the plan of care has been developed with your input and that you have a good understanding of how it is intended to provide your relative with appropriate care. If there have been problems regarding your relative pestering you then the plan should include clear guidance as to what action you might want to take and how you can contact the clinical team.*

10. Will looking after a patient under Section change the confidentiality rules?

*The rules governing confidentiality remain unaffected by the MHA 2007, the code of practice states, 'before considering disclosure of confidential information the individual's consent should always be sought' but there will be circumstances where 'it is both justifiable and important to share otherwise confidential information' regarding patients who are subject to detention under the Act.*

*If a patient has committed certain kinds of offences, their victims may have a right to some limited information about what is happening to them. But people don't lose their general right to confidentiality just because they're detained under the Act.*

**In consultation with service users and carers, this list of frequently asked questions and answers has been drafted by the Service User and Carer Sub-group of the NIMHE's National Implementation team.**

**NIMHE as part of the Care Services Improvement Partnership has led the implementation of the MHA 2007 on behalf of the Government. It has been the aim of NIMHE to attempt to provide clarity regarding the design, development of the new MHA and help to put in place new ways of working and new systems to support the legislation.**

**To assist in this process NIMHE have a regional lead in each of the eight CSIP regions. Each lead has set up regional implementation networks**

**involving local NHS and social services, as well as service user groups, black and minority ethnic communities and others with a key interest in the Mental Health Act.**

**For more information about the Implementation Programme or this list of FAQs, please contact Bernie O'Hare. ([Bernie.o'hare@csip.org.uk](mailto:Bernie.o'hare@csip.org.uk))**

## JARGON BUSTER

Like most organisations, abbreviations and jargon is commonly used in mental health, which should be avoided wherever possible. However, when it is used, the list below explains what the abbreviations stand for.

<b>AMHP</b>	<b>Approved Mental Health Practitioner</b>
<b>MHAct</b>	<b>Mental Health Act</b>
<b>MHRT</b>	<b>Mental Health Review Tribunal</b>
<b>ASW</b>	<b>Approved Social Worker</b>
<b>CPA</b>	<b>Care Programme Approach</b>
<b>CSIP</b>	<b>Care Services Improvement Partnership</b>
<b>NIMHE</b>	<b>National Institute for Mental Health in England</b>
<b>RC</b>	<b>Responsible Clinician</b>
<b>CTO</b>	<b>Community Treatment Order</b>
<b>SCT</b>	<b>Supervised Community Treatment</b>
<b>Section</b>	<b>Refers to the Section of the Mental Health Act</b>
<b>DH</b>	<b>Department of Health</b>
<b>User</b>	<b>A person who receives mental health services</b>