Mental Health Act 2007, Mental Capacity Act & DOLS in practice.

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MHA 2007

- The MHA (2007) made Nine key changes to the MHA (1983)
- Introduced through the Code of Practice Five Guiding principles
- Strengthened the importance of the Principles, refines the legal status of the Code of Practice.
Nine Key changes

1. Introduced a single definition of Mental Disorder
2. Changed the criteria for detention by abolishing the Treatability test and introduces a new appropriate treatment test.
3. Ensures that age appropriate services are available
4. Broadened the professional groups that can take particular roles
Nine Key Changes

5  Introduced the ability for patients to change their nearest relative
6  A right to advocacy when under compulsion
7  Safeguards regarding ECT
8  Introduced provision to allow Supervised Community Treatment
9  Made provision for earlier referral to Mental Health Review Tribunal
Five Principles

• Purpose (minimising harm done by mental disorder to patient and the public)
• Least restrictive alternative
• Respect
• Participation (Patient, carer, family involvement)
• Resources (use in the most effective, efficient and equitable way)
Statement of Principles

• Professionals have an obligation to follow the Code of Practice unless they have good reason not to.
Step one

Coming into Compulsion
Single definition of mental disorder

“any disorder or disability of the mind”

Still requires section 12 approved Doctor
The criteria for detention

• The mental disorder is of such a nature or degree as to warrant the provision of medical treatment.
• It is necessary that medical treatment be provided for the protection of the patient from suicide or serious self-harm or serious self-neglect of his/her health or safety, or for the protection of others.
• Medical treatment cannot lawfully be provided to the patient without the patient being subject to Part 2.
• Medical treatment is available which is appropriate.
Age appropriate services

• Under 18s should be treated in an environment suitable for their age.
Step 2

The Decision Makers
The professional groups involved

The Approved Social Worker was replaced by the Approved Mental Health Professional

• Social Worker
• Nurse,
• Psychologist,
• Occupational Therapist
Professional groups involved

The RMO was replaced by the Responsible Clinician

- Nurse
- Psychologist
- Social Worker
- OT
The nearest relative

• The patient can have more say in who this should be
Advocacy

• There is a duty to provide advocacy for all detained patients.

• Exclusions are those on section 4, 5, 135, 136, guardianship and those subject to Community Treatment Orders
Step 3

Supervised Community Treatment

After detention in hospital it is possible for some patients to continue to receive care and treatment in the community. However, they can be recalled to hospital.
Step 4

Ending Compulsion

Referral to Mental Health Review Tribunal

- Time spent on Section 2 included
- Automatic annual referral for 16 to 18 year olds.
- Period from detention to automatic referral can be reduced in the future
Learning Disabilities

Conditions for detention for treatment is similar to the Mental Health Act (1983)
“and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.” Mental Health Act (1983)

Does not apply to admission for assessment.
MHA Restrictive practice

- Physical restraint should be
- Reasonable, justifiable and proportionate
- Used only as long as necessary
- Involve recognised technique
- Does not depend on deliberate application of pain
- Be carried out by trained personnel.
MHA Restrictive practice

• Last resort
• In an emergency as a last resort
• De-escalation to be used first and throughout
MHA Restrictive practice

• Doctor should be called
• Staff should be alert to risk of respiratory or cardiac distress
• Emergency resuscitation devices available
• Physical and psychological wellbeing of the patient should be monitored.
MHA Restrictive practice

- Decision and reasons need to be recorded
- Every episode needs to be documented and reviewed
- Post incident review
MHA Restrictive practice

• Use of mechanical restraint would be exceptional
• Restraint should not be used with informal patients who have the capacity to refuse treatment.
• If restraint is deemed necessary consideration should be given to whether formal detention under the MHA is appropriate.
Seclusion

- Supervised confinement in a room, which may be locked
- Aim is to contain severely disturbed behaviour.
- Last resort
- Shortest possible time
- Should not be used as a sole means of managing self harm.
Seclusion

• Patient safety needs to be ensured
• Care and support provided
• Environment needs to take account of dignity and wellbeing
• Record, monitor (every 15 minutes) and review.
• Procedures for use need to be in place
• Skilled professional readily available in sight and sound
Informal patients and community placements.
Can the service user consent to a care plan which includes physical or mechanical constraint?

- People with severe and profound levels of learning disability are unlikely to be able to provide consent to such treatment
- Is the use of Restraint in their best interest
The Mental Capacity Act 2005

• Came into force in April 2007
• Allows adults to make as many decisions as they can for themselves
• Answers the question- Who decides?- for people who cannot in the areas of personal welfare, healthcare and finance.
• Ensures that decisions are made in the person’s best interest.
MCA 2005

• Ensures the appointment of Independent Mental Capacity Advocates (IMCA) where the person is unable to make decisions.
• Provides protection against legal liability for carers and professionals.
Principles of the MCA

- With any service user who we may consider using restraint we start with the presumption that they have capacity
- Can the service user be supported in any way to make a decision
- The service user has the right to make unwise decisions
Principles of the MCA

• Anything we do for or on behalf of service users who do not have capacity must be done in their best interest.

• Anything done for or on behalf service users who do not have capacity should be the least restrictive of their rights and freedom of movement.
I don’t think this person has capacity to decide

A person is unable to make a decision for themselves if:

• “at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain”
The test of capacity

A person is unable to make a decision for himself if he is unable to:

1. Understand the information relevant to the decision
2. Retain the information
3. Use and weigh the information relevant to the decision
4. Communicate the decision
Understand the information relevant to the decision

• Explanation in broad terms what the intervention is.

• Must include information about the consequences of deciding one way or another, or of failing to make a decision.
Retain the information

- Information should be retained for the time it takes for the decision to be made
- The fact that a person can retain information for a short period only does not prevent him from being able to make the decision.
Use and weigh the information relevant to the decision

• The information must be believed
• Is the person’s thinking dominated by fear, a phobia or compulsive disorder.
• Is the person under undue influence?
Communicate the decision

This can be by

• Talking
• Using signs
• Or any means
Best interest

• If a person cannot make a decision then they may act in the person’s best interest

• This is a PROCESS, not a definition
Best interest

- The professional or parent/carer must consider whether the person is likely to regain or gain capacity
- **They must encourage the person to participate in the decision**
- They must consider the person’s past and present wishes and feelings
- **The beliefs and values that would be likely to influence his decision if he had capacity**
- The other factors that he would be likely to consider if he were able to do so.
Best interest

The decision maker must, if practicable and appropriate, consult with:-

• Anyone named by the person to be consulted
• Anyone engaged in caring for the person or interested parties
• In some circumstances a Independent Mental Capacity Advocate or a deputy appointed by the Court of Protection
Best interest

- The person or body that intervenes on behalf of the person must believe that their act or decision is in that person’s best interests and that belief must be reasonable.

- It is advisable when considering mechanical restraint to make decisions within a multidisciplinary context with relatives/carers.
Independent Mental Capacity Advocates

• Becomes involved if there are no relatives or in disputes where serious medical treatment is to be provided.
• Can interview the person
• Must act in the person’s best interest
• May seek second opinion
• Cannot make the best interest decision
• If advice not accepted may go to Court
Court of Protection

- Has jurisdiction over those who lack capacity
- Can make an order making a decision on the person’s behalf
- Appoints deputies to make decisions on the person’s behalf
- Makes decisions on a person’s capacity to make a particular decision.
Section 5 provides protection for acts done if the person is established as being mentally incapacitated and the act is in the person’s best interest.

However, this does not effect criminal liability arising from negligence.
Restraint

MCA Section 6 defines restraint as the use or threat of force where the person resists, and any restrictions on the persons liberty of movement, whether or not the person resists.
Restraint is only permitted if the person using it:-

• Believes that it is necessary to prevent harm to the person; and

• If the restraint is a proportionate response to the likelihood and seriousness of the harm.
Deprivation of liberty

Restraint which results in the person being deprived of his liberty within the meaning of Article 5 (1) of the Human Rights Act cannot be an act which Section 5 of the Mental Capacity Act provides any protection.
Best Interest and Best Practice

In day to day practice best interest decisions must be consistent with best practice

Best practice guidance has been provided by BILD
Best practice in Restraint

- Restraint should only be used as part of a behavioural support strategy/plan
- Based on MDT assessment
- There is no alternative
- It should reduce the risk of harm
- The restraint should be proportionate
- A plan should be in place to ensure the of restraint to be kept to a minimum.
- Staff/carers should be trained in the use of the procedure/device
- It should not restrict the person's liberty
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