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ABSTRACT

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The provisions of the Mental Health Act 1983 (for England and Wales) are under review, with a draft bill now published, paving the way for a new act. The bill proposes a much simpler three-step process to replace the current orders for detention and/or treatment, which are discussed here to familiarise nurses with what takes place now. Society has demanded in recent years that changes in society should be reflected in mental health legislation although, to date, there have been many critics of the draft bill's proposals.

Care and treatment under the Mental Health Act 1983

ALL HEALTHCARE professionals will encounter people who are suffering from mental illness or learning disabilities: people with all forms of mental disorder will be found not just in departments or services for mental health care but also in surgical wards, labour suites and outpatient departments. A small percentage of those encountered will have their care and treatment governed by the provisions of the Mental Health Act 1983, and although the act is under review, with a draft bill now published (Department of Health, 2002), paving the way for a new act, it is essential that all nurses and midwives have an understanding of the law pertaining to mental health.

The function of the Mental Health Act 1983

The act was passed to protect patients, the wider community and those who work with patients suffering from a mental disorder. It is supported by the *Code of Practice on the Mental Health Act 1983* (DoH and Welsh Office, 1999). The code interprets the act and defines how it should be implemented in practice. Although the code is not a law it is expected that health care professionals will adhere to the guidance it offers: non-adherence could lead to disciplinary measures. It is essential, therefore, that nurses who regularly work with patients who have mental health problems, and are subject to the provisions of the Mental Health Act 1983, ensure that they have access to the Code of Practice.

Definition of terms of the 1983 Act

The act has 10 parts, each relating to a specific function. Part I (Application of the act); Part II (Compulsory admission to hospital and guardianship), and Part III (Patients concerned in criminal proceedings or under sentence), are discussed below. It is important, first, to define some of the terms used in the act, in particular what is meant by 'mental disorder'.

The act defines who can be subject to its provisions. In Part I the term 'mental disorder' is used to categorise those to whom the act applies and the term is defined as: 'Mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'. This definition is broad and the terms 'mental illness' and 'any other disorder or disability of mind' are not further defined. However, the Department of Health and Social Security issued some broad guidelines after the act was passed (DHSS, 1998), which stated that mental illness means having one or more of the following characteristics:

- More than temporary impairment of intellectual functions, shown by failure of memory, comprehension and learning capacity;
- More than temporary alteration of mood, such as to

give rise to the patient having a delusional appraisal of his situation, his past or his future, or that of others or to the lack of any appraisal;

- Delusional beliefs – persecutory, jealous or grandiose;
- Abnormal perceptions associated with delusional misinterpretation of events;
- Thinking that is so disordered as to prevent the patient making a reasonable communication with others.

This range of definitions is still not without its critics but it is an attempt at clarification. But there are other terms that warrant interpretation within the act:

- 'Severe mental impairment': this means a state of arrested or incomplete development of mind, which includes severe impairment of intelligence and social functioning – it is usually associated with abnormally aggressive or seriously irresponsible behaviour on the part of the individual concerned;

- 'Mental impairment': this has the same meaning as 'severe mental impairment' but there is a difference of degree; thus, those with a mild degree of mental impairment would not be detained under the act unless they also suffered from a mental illness that caused them to be a risk to themselves or others;

- 'Arrested or incomplete development': these are terms that exclude those whose condition arose as a result of an accident, illness or injury after the full development of the brain, for example brain injury to an adult, or senile dementia (Jones, 2003);

- 'Psychopathic disorder': this is a term that has been the subject of much controversy since its inclusion in the Mental Health Act 1959. It is not a clinical diagnosis but a legal term. What exactly constitutes psychopathic disorder, and how it should be treated or managed has been the subject of rigorous debate, yet little agreement has been reached on a definition.

Although the 1983 act does not refer to the treatability of psychopathic disorder or mental impairment, sections 3 (Part II), 37 and 47 (Part III) state that a patient may not be compulsorily admitted to hospital for treatment unless it can be shown that the medical treatment is likely to alleviate or prevent a deterioration in the patient's condition. This is often referred to as the 'treatability clause'.

In the proposals for the reform of the 1983 act (that is, proposals before the bill was drafted), the term 'psychopathic disorder' was not used. However, a new term, 'dangerous severe personality disorder' appeared in the draft bill and the 'treatability clause' disappeared. This means that someone with a severe personality disorder could be detained without the need for proof that the period of detention would improve that person's condition or prevent its further deterioration. Furthermore,

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TABLE 1. CRITERIA FOR COMPULSORY ADMISSION TO HOSPITAL, AND RIGHTS OF APPEAL (PART II)

Section	Duration	Purpose	Remarks	Rights of appeal
2	28 days	Assessment only	Section 2 generally used if the person has no history of admission or if the diagnosis/prognosis is unclear	To the hospital managers or to the MHRT* within 14 days of admission
3	6 months; renewed for 6 months then for 1 year	Treatment		To the hospital managers or to the MHRT every 6 months
4	72 hours	Emergency admission for assessment	Used only when delay in waiting for application for Section 2 would be undesirable owing to the serious nature of the person's illness	None
5(2)	72 hours	Detention of people who are already voluntary patients	Used as an emergency holding power to allow for a Section 2 or 3 application to be completed	None
5(4)	6 hours	Emergency detention if patient becomes a risk to self or to others should an attempt be made to leave hospital	To be used only when the patient requires detention and no doctor can be summoned immediately	None *Mental Health Review Tribunal

in the draft bill (DoH, 2002), there is no separate provision for those with 'dangerous severe personality disorder', which means that those who have personality disorder will be treated in the same way as any other patient with a mental disorder. Despite this, there have already been two specialist units created to care for such patients, and two more are planned.

Particular aspects of the 1983 act

There is no provision within the 1983 act to compel someone to receive treatment for a physical disorder, even when the refusal to accept treatment appears to be aberrant. The act also makes it very clear that the conditions for which patients may be detained do not include promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

Part II: Compulsory admission to hospital and guardianship

While the majority of admissions to a psychiatric hospital today are informal, about 10 per cent of patients are compulsorily detained, some of whom may also be subject to compulsory treatment.

Part II of the act details the conditions under which an individual can be detained. It stipulates the length of the period of detention and indicates that it must be made clear whether the patient is being detained just for

assessment or whether he/she will also be subject to compulsory treatment.

Table 1 outlines the purpose for which certain sections of the act are used and indicates whether an order is for assessment or treatment. Under the act the term 'treatment' includes medical treatment, nursing care, habilitation and rehabilitation under the supervision of a responsible medical officer.

All patients detained for more than 72 hours have the right to appeal against their detention and/or treatment. One of the innovations of the 1983 act was that patients who were detained for more than six months had an automatic appeal to the Mental Health Review Tribunal. This is an independent body that reviews a patient's condition and the care and treatment that is being received. It has the power to discharge a patient from a detention order or even to authorise discharge from hospital.

There is a variety of provision under the act for the detention of people who are unwell and still in the community. There is also provision for detaining those who have been receiving care for a mental health problem in a mental health hospital but have expressed the wish to leave. In the case of patients who, it is thought, are a danger to themselves or to others, it is possible for a doctor to detain them using section 5 (2) for 72 hours. If a doctor is not available immediately, a registered nurse

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(trained in either mental health or learning disability but practising in his/her own specialty) can use the power of section 5(4) until the doctor arrives, for a maximum of six hours. The choice of section is, therefore, dictated by circumstance. All patients so detained must be informed of their status under the act: they must be told the length of time of the detention order, and their rights, including the right to appeal and the right to refuse certain forms of treatment.

When the detention order has expired, unless provision for further detention has been made, the patient is entitled to leave hospital or to remain there as an informal patient for further care and treatment. But discharge from detention does not necessarily mean discharge from hospital.

Some patients do not require admission to hospital, but their condition demands that they have some kind of compulsory control over their lives. Such patients usually have some form of learning disability or have a form of dementia: they are able to live in the community, but for their continued safety they are subject to an order for guardianship (section 7). Initially this lasts for six months, after which time it may be renewed for a further period of six months and then renewed annually. The patient may appeal to the Mental Health Review Tribunal to have the order reviewed after the first six months. The guardianship order places that patient in the care/control either of a body such as a local social services authority or a named individual who has agreed to act as guardian. The named guardian has rights and responsibilities regarding the safety and care of the patient. The guardianship order can specifically state where the patient is to stay and give details of places where he/she is to attend for treatment, employment or education. The order ensures that the guardian has the right of access to the patient. This last condition is very useful when a patient could be at risk from abuse or exploitation of others.

Section 17 of part II of the act allows for a patient to be given permission to have leave of absence from the hospital for a specified time. It also specifies that the patient is to be the responsibility of a named person. If the patient fails to return from the period of leave, he/she can be apprehended and returned.

After-care as it applies to Parts II and III of the Mental Health Act 1983

The power of the act does not end with a patient's discharge. Those who have been detained under section 3 must be thoroughly assessed as to their health and social care needs, and are entitled to after-care. Patients detained under sections 37, 47 and 48, all of which are sections of part III of the act, are also entitled to after-care. These entitlements are part of the Care Programme Approach, and bring together the health and social services agencies as well as appropriate voluntary agencies as a means of offering the best possible care and support for that patient in the community. Preparation for discharge begins as soon as a patient is admitted. After-care services continue until members of both the

health and social services agree that the patient no longer requires the service.

In the draft bill, a much simpler, but still flexible, three-step process will replace the various orders for detention and/or treatment of the 1983 Act. But Eldersgill (2002), perhaps one of the fiercest critics of the bill, has gone so far as to state that no rational, humane person could support such a set of proposals!

Part III: Patients concerned in criminal proceedings or under sentence

The flexible approach to assessing and treating patients who are unwell in hospital or in the community applies also to individuals who are involved with court proceedings and are suspected of having a mental disorder. Similar provision is available for those who are already serving a sentence and who are suffering from a mental disorder to such a degree that they need to be transferred from the criminal justice system into the health system so as to ensure they receive adequate assessment or treatment.

Consent to treatment

Part IV of the act is concerned with 'consent to treatment', and allows for patients who are detained under orders for treatment to be treated without their consent if necessary. Safeguards have been built in to the act on this issue; thus details are given of what treatment may be given without the patient's consent. The act also stipulates when a second, independent opinion is to be sought before the administration of compulsory treatment. Thus the doctor giving the second opinion must first consult two other individuals who have been directly involved in the care of the patient. One of these must be a nurse and the other must be neither a nurse nor a doctor.

A patient's capacity to consent to admission and treatment lies at the root of a controversial argument put forward by Gunn and Holland (2002), that it is not really necessary to have a Mental Health Act at all: what would be more relevant is a Mental Incapacity Act. This would, they argue, determine whether patients were able to make decisions about their own care and treatment, and if they were deemed as not being capable of such decisions, steps could be taken on their behalf. This idea formed part of the discussions surrounding proposals for the draft bill.

Conclusion

Society has demanded in recent years that mental health legislation should balance the needs of both the patient and the wider public. When the 1983 Mental Health Act came into being it was thought to have made huge strides towards achieving that difficult balance. Twenty years on it is clear that a new act is required – one that reflects present care and treatment needs. Whether the proposals contained within the draft Mental Health Bill will make the situation for patients better or worse remains to be seen. ■