The Coronavirus Act 2020 was introduced in March, creating emergency legislation to ease pressure on the NHS and mitigate the impact on both patients and staff. It might have been easy to assume mental health services would be among the least affected because the perceived focus is on acute physical care. However, the act allows amendments to the Mental Health Act 1983 (MHA), which will lead to significant changes for mental health treatment. The legislation, along with current social distancing measures, will change the way patients are detained in hospital, how treatment is monitored and how easily they can exercise rights of appeal against detention.

Like many other mental health charities, Mind has raised questions about how patients can be kept safe under this new legislation. The emergency legislation comes at a time when a long-overdue white paper in response to the MHA was expected to address pre-existing injustices in the way people are sectioned and treated in hospital.

It is fundamental to the patient-nurse therapeutic relationship to not only safeguard patients’ rights but to advocate for and encourage patients to exercise such rights, regardless of the circumstance (Jugessur and Iles, 2009). Mind has also acknowledged the urgent need to alleviate pressure on the mental health care system.

**Effects on existing legislation**

The Coronavirus Act 2020 allows changes to the way the MHA operates in England and Wales, and makes similar provisions to temporarily amend the mental health laws in Scotland and Northern Ireland. According to the Department of Health and Social Care (2020), the emergency changes, “would only be used if demand pressures and workforce illness during the pandemic meant that local authorities were at imminent risk of failing to fulfil their duties and only last the duration of the emergency”.

The key changes under these emergency laws are:
- The decision to detain a person under the MHA can be made using a single doctor’s opinion, rather than the two normally required.
- Time limits on how long someone can be detained might be extended or suspended.

The DHSC has made clear that these changes will not be introduced as a blanket approach but only if necessary. The legislation will be in place for up to two years, and powers can be switched on or off by each of the following:

- A second opinion is no longer needed to section someone or to review detention after three months.
- Mental health tribunal hearings are now performed by phone, which can be difficult for detained patients.
- Mind has raised concerns about these changes and suggests how nurses can support patients.
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Discussion

the four UK devolved administrations. The
UK government has also said it will publish
an accurate and up-to-date account on its
website of the legal provisions that exist and
the plans it has to review or change them.

It is crucial to note that the MHA and its
accompanying code of practice (Department of Health, 2015) continue to apply as
usual, unless and until the emergency
changes permitted by the Coronavirus Act
2020 are switched on. Even then, the MHA
and its code of practice will still apply; the
changes will be allowed where justifiable.

At the time of writing, further NHS guid-
dance is due to be published for local systems
on when it would be appropriate to use
emergency powers. Mind is also feeding into
dr the DHSC guidance about what the powers
mean, which will be published if the powers
are switched on (Bit.ly/MindCovidResponse).

As a nurse, you will have to know the
usefulness of holding power, they rarely use it.

Doctors also have holding power under
section 5(2) of the Mental Health Act 1983.
The professionals who usually use it are
doctors on psychiatric wards who believe a voluntary patient needs to be
detained to be assessed under section 3 of
the act. The emergency legislation extends
doctors’ holding power from 72 to 120 hours.

Both holding powers are defined by the
MHA code of practice as emergency meas-
ures: doctors are required to attend and
make an assessment as a priority. Using a
holding power is not to be used as an alter-
native to beginning a patient’s detention
under section 2 or 3 (DH, 2015).

In relation to the extended section 5(2),
Mind is concerned that five days is a long
time for a patient to be held without suffi-
cient safeguards, including:

A senior medical review;
A responsible clinician in charge of
overseeing their treatment;
An appeal to the Mental Health
Tribunal to be discharged or seek a
change in treatment;
The statutory right to an independent
mental health advocate.

Second opinion appointed doctors
At present, patients can be given medica-
tion for the first three months of detention
without an independent second opinion.

After that, a second opinion appointed
documents (SOAD) must approve treatment if
the patient cannot give consent or refuses
to do so. The emergency legislation removes
the need for a SOAD to review medication if
the approved clinician thinks it would be
impractical or cause undesirable delay.

Mind hopes that, if the legislation is
switched on, the statutory guidance that
would be published by the DHSC will define
the term ‘undesirable delay’. The organisa-
tion had pre-existing questions about the
role of the SOAD in relation to human
rights law (Mind, 2009), and therefore finds
this change particularly concerning. It is
also concerned this emergency legislation

be held either until they see a psychiatrist
or for up to six hours, whichever is soonest.
The emergency legislation allows this to be
extended to 12 hours (Table 1).

The use of this power is always at the
professional discretion of the nurse, as
they are ultimately accountable for its use.
Nurses should, therefore, never simply
follow orders to use their holding power if
directed to do so by more senior nurses or
doctors. Ajetunmobi (2001) found that,
although nurses mostly agree on the use-
fulness of holding power, they rarely use it.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Existing legislation</th>
<th>Emergency legislation</th>
</tr>
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<tbody>
<tr>
<td>A nurse can hold a patient on a ward for psychiatric analysis</td>
<td>6 hours</td>
<td>12 hours</td>
</tr>
<tr>
<td>A doctor can hold a patient on a ward for psychiatric analysis</td>
<td>72 hours</td>
<td>120 hours</td>
</tr>
<tr>
<td>Police can detain someone in a place of safety</td>
<td>24 hours</td>
<td>36 hours</td>
</tr>
</tbody>
</table>

Table 1. Changes to detention times
could compromise patient safety, especially in high-risk prescribing.

Nurses have a key role in this situation, as they can speak out in the multidisciplinary team and advocate for best practice by seeking a second opinion. This would provide assurance for both the patient and their own practice within the Nursing and Midwifery Council code (NMC, 2015).

Mental health tribunals
Under the European Convention on Human Rights, an appeal against detention in hospital is a human right. The NMC compels nurses to uphold this and psychiatric nurses are required to prepare reports for the Mental Health Tribunal (in England and Scotland), the Mental Health Review Tribunal (in Wales), or the Review Tribunal (in Northern Ireland).

Although the tribunals try to dispense with as much formality as possible, hearings can be difficult and might damage the therapeutic relationship when patients hear staff give evidence about why they should be detained. Conversely, by the end of a tribunal patients can gain a greater understanding of why they are detained, because the same level of detail might not be discussed with them in the ward round. Nurses can also learn a lot about patients through the evidence they give to the tribunal, for example, how they feel about their detention and what course of treatment they feel would most benefit them.

Telephone hearings
Patients who are detained have the right to a fair trial under the European Convention on Human Rights. Having a specially trained lawyer representing them can help patients understand the process and for them to be able to trust us to make their case. That’s not possible to do properly without privacy and face-to-face contact to take instructions on what can often be very distressing material in clinical reports. This is especially the case when the client is new to the solicitor and when an element of their illness might be paranoia or confusion.

However, people managing tribunals for hospitals have expressed that they see telephone reviews as a necessary alternative. Kevin Towers, head of mental health law at West London NHS Trust, said: “Like everyone else, we have never experienced anything like this and are adapting ways of working and sharing resources where possible. Broadmoor, which opened as a new hospital in December 2019, has held video tribunals, which I understand went very well. Other hospitals have had telephone hearings, which we recognise are not ideal but better than no review at all.”

Taking away someone’s liberty is a serious matter and any appeal must be treated as equally serious, even in times of crisis. Nurses have a key role to play here, as nursing managers and staff can advocate for more phones on the wards and private places to use them. Another possibility is that, where pandemic safety measures allow, senior nurses and ward managers could arrange ‘clean’ visiting rooms (with strict infection-control procedures) that are large enough to allow social distancing. Nurses can also speak up if they think a patient does not have the necessary support to go ahead with a tribunal and needs their lawyer present. The NMC code sees this as very much within the remit of a nurse: it requires nurses to “provide leadership to make sure people’s wellbeing is protected and to improve their experiences of the health and care system” (NMC, 2015).

Conclusion
Mind is concerned that the emergency legislation has removed important safeguards and rights for people detained against their will for treatment, at a time when a long-overdue reform was expected to address significant issues with the way people are sectioned and treated in hospital. Being detained under the MHA at any time can be distressing, but it is even more so when wards are on lockdown during a pandemic. However, nurses can step in where the law has exposed a vulnerable client group. The psychiatric nurse theorist Peplau defined nursing as “an interpersonal process of therapeutic interactions between an individual who is sick or in need of health services and a nurse especially educated to recognise [and] respond to the need for help” (Peplau, 1991). Respecting and advocating for patients’ rights, even in such difficult times, can only improve the therapeutic patient-nurse relationship.

The long-term impact of the coronavirus pandemic on the mental wellbeing of the nation remains to be seen. In the meantime, Mind will monitor the introduction and effects of these emergency measures and represent people with mental health problems. Backed up by the NMC code, nurses can use their voice to make sure admission to a psychiatric ward under the amended MHA is not unnecessarily traumatic and that patients’ rights and dignity are continuously prioritised during treatment.

References