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Mental Health Act in Acute Care: a practical guide

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"They're excellent - they're very professional and very experienced."

Chambers

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Introduction

- Presenters
  - Stephen Evans
  - Niloo Bozorgi
- Second of two webinars: both will be available on our website soon
- This webinar
  - review key legal principles of MHA use
  - commons scenarios – practical advice
- Previous webinar
  - governance and organisational issues in MHA use in acute settings

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Overview

- The Mental Health Act and its key provisions
- Who's who – roles and responsibilities
- Detention
- Treatment
- Emergency Department, s.136 and the police
- When not to use MHA
- Practical issues
- Questions and discussion

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What the MHA does

- A legal tool to authorise detention, assessment and treatment of mental disorder and its manifestations
- It might allow patients to:
  - be kept in hospital against their wishes
  - have care for self-inflicted injuries
  - be transferred to/detained in acute hospital for other care eg obstetric
- It does not:
  - authorise treatment for purely physical needs
  - negate other rules e.g. Mental Capacity Act
  - exclude voices of family/carers
- Practice may vary with local services but the law as set out here will apply

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Key provisions (1)

- **Guiding Principles**
  - least restrictive principle
- **Section 2 or 3**
  - most common detention provisions
  - authorise detention for assessment/treatment for up to 28 days/6 months
  - requires MHAA (assessment) by two doctors (one with certification), AMHP (social worker) and input from NR
- **Section 17**
  - provision for a patient under s.2/3 to be allowed leave
  - can include escort or custody eg RMNs, restraint
  - transfer of the place of detention is under s.19

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Key provisions (2)

- **Section 136**
  - power held only by the police to take someone to a place of safety for up to 24 hours for assessment and to make arrangements for their care

- **Section 5(2)**
  - power of doctors to hold an admitted inpatient ie prevent self-discharge, for 72 hours for MHAA

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Who's Who

- **AMHP** – usually a social worker with special accreditation to assess under MHA
- **NR** – nearest relative (not NOK) determined by statute and to be consulted by AMHP
- **Section 12 doctor** – usually a psychiatrist who has accreditation to assess under MHA
- **AC/RC** – s.12 doctor responsible for care
- **MHAO** – staff who run MHA administration
- **Liaison teams** – in-reach teams providing assessment and advice in ED and on wards
- **Security staff** – valuable especially in ED to prevent absconding (within the law)

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Detention (MHA) and Deprivation of Liberty (MCA)

- Detention under MHA is lawful only with correct actions and paperwork
- Purpose can only be assessment/treatment of mental disorder to manage risk to health/safety or others
- Patient can appeal to a Tribunal or AHM
- Deprivation of liberty under MCA is matter of fact on the *Cheshire West* acid test
- No DoLS authorisation if has capacity, under 18, objecting, or MHA is applicable
- Neither is “better”, rare that both are available

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Treatment

- Under s.63, detained patients can be treated for mental disorder or its manifestations
- This can cover:
  - psychiatric medication
  - nursing care
  - containment
  - treating effects of self harm e.g. cuts or OD
  - providing feeds/hydration to those with eating disorders or self-neglect
- It doesn't usually cover:
  - diabetes management
  - elective surgery
  - reproductive care
  - although MHA detention may help facilitate

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Emergency Department (1)

- Know the patient's legal status on arrival:
- Leave/transfer/informal from psychiatric care
  - primary unit should give guidance at the time
- Section 136
  - imposed by police anywhere other than private residence on basis they have concern about MH
  - allows for MHAA and making arrangements
  - clock starts on arrival at place of safety
  - 24-hour clock cannot be extended by you
  - can only be extended if condition prevents MHAA and only for max 12 hour i.e. 36 total
  - 136 can be imposed in the ED (if police present)
  - not necessary for police to remain on site
  - ends when not needed (no MD) or runs out

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Emergency Department (2)

- Assessment
  - preliminary assessment may identify need to review/treat both physical and mental health
  - ED/acute Trust retain responsibility for the patient even with liaison psychiatry involved
- Admission
  - detention under MHA (e.g. s.2 or s.3) can be used in acute hospitals, on transfer or directly
  - can admit with consent or under MCA
- Treatment
  - requires capacitous consent, MHA or MCA+BI
  - there may be a combination of these regimes
- Consider local processes

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When MHA is not the answer

- Emergencies:
  - acute medical emergency
  - immediate risk of very serious harm to others
  - when necessary to act first, then review
- But that is the limit on “common law”
- Mental Capacity Act is always relevant if the patient lacks capacity and assessment and consideration of best interests is necessary alongside MHA
- With under 18s, other provisions may be more suitable

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Practical points

- Always know how/where to escalate
- Risk assess situations where you may need advice and if so, get it early
- Correct completion of MHA forms is crucial
- Cooperation between services is very important but often difficult
- Bear in mind that others eg police officers, may not have much understanding of MHA
- Especially if patient is under 18, must consider other duties eg safeguarding

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Questions/ discussion

Thank you for your time

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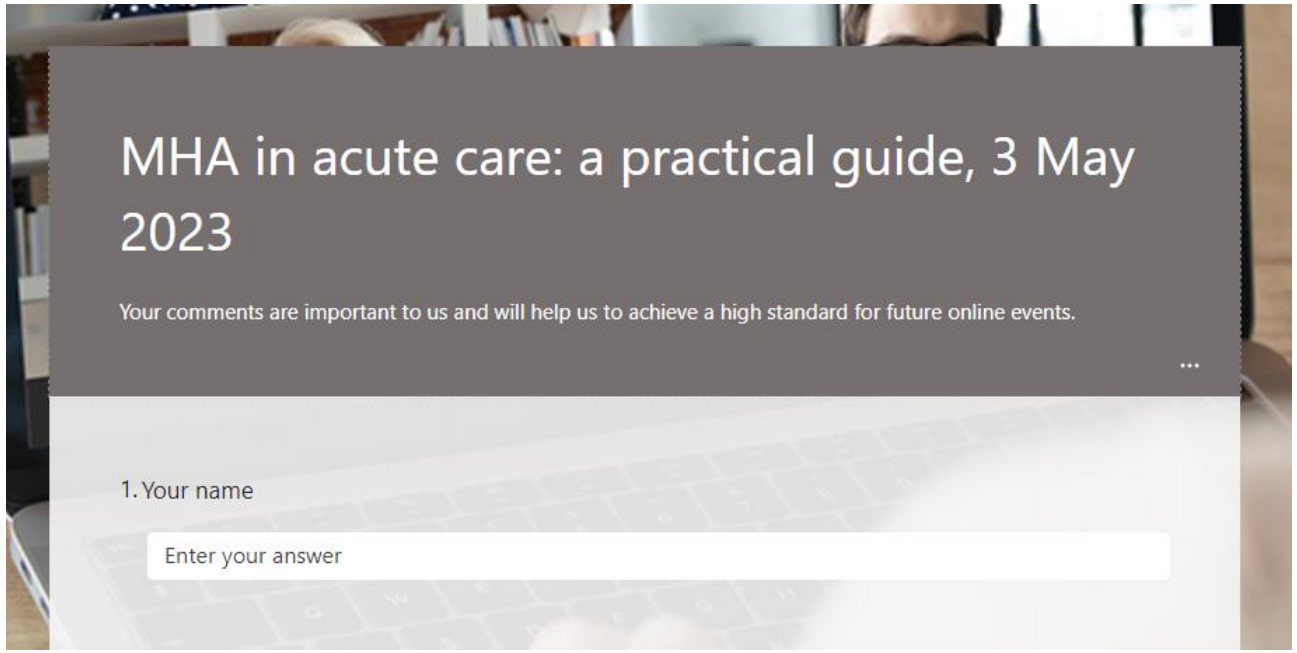
Thank you.



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