CORE
Metadata, citation and similar papers at core.ac.
vided by OAR@UM

A commentary on of the new mental health act for the Maltese Islands

Anthony ZAHRA & Nigel CAMILLERI

Legal notice 276, published in September 2013, has set out the time windows for the implementation of the Mental Health Act, which was approved by parliament in 2012. The changes are expected to be rolled out over a period of one year, with the totality of the Act being in force by 10th October 2014. The first set of changes, implemented last November, brings in effect the first half of the provisions of the Mental Health Act.

Overall the proposed Mental Health Act is much improved on the previous Act; it reads well and brings the law up to date with modern psychiatry practice. At first glance the Maltese Mental Health Act seems to stem from the basis of the UK 1983 Mental Health Act as amended in 2007, although the authors are not familiar with other EU Mental Health Acts, therefore they could not comment on whether there are resemblances to other Acts.

In the section below, the authors will discuss and make comments on some of the seminal parts of the new Mental Health Act.

Article 2 defines the many terms used in the Act. Of particular note is the term *mental disorder,* which has been pegged to disturbances of thought, mood, volition, perception, cognition, orientation or memory, to a degree that would be considered as pathological in international classifications. This is particularly useful in that it sets widely recognisable evidence-based standards, which are in turn supported by extensive field trials. However the authors point out in the definition of mental disorder, "... *considered pathological in accordance with internationally accepted medical and diagnostic standards*…." We believe that this leaves a definition which may be too broad in the determination of classificatory systems to be used. This may result in the possible idiosyncratic use of different diagnostic systems which have varying input of field tests and evidence-base. A specific reference to the International Classification of Diseases (WHO) or the Diagnostic and Statistical Manual of mental disorders (APA) may provide more definite guidance to the users of the Act as to which classificatory systems to refer to.

Part IV 7(2)(e): 'shall have a multidisciplinary care plan formulated in consultation with the patient and, or the responsible carer and finalised within 168 hours of admission.' One of the authors questioned what will the patient do and receive in the terms of care package in those seven days during admission to hospital? The authors are aware that the formulation of a care plan takes time to process, however a best practice suggestion could be that an initial care plan should be written up in the first 48 hours of the patients' admission into hospital, after which such care plan would be elaborated in more depth to meet all the needs of the in-patient over the following 5 days. As a result, the patient's management would commence as soon as possible, thus potentially reducing the acute impact of the condition and enabling his/her stay to be a short as possible. The outcome would be of benefit to both the in-patient and the service, as this will result in higher turnover rates of patients and lower mean number of days in hospital stays.

It is best clinical practice that a care plan and a discharge plan are formally drawn up in the immediate early phases of admission, whilst the law prescribes the maximum amount of time allowed for the formulation of such a plan. It should not be taken to mean that the law is prescribing the minimum number of days stipulated to write up a care plan, but the maximum. Further to this, the clinical focus of the clinicians remains upon devising a care plan formulation at the earliest, in the best interest of the in-patient, whilst being mindful of the legal parameters.

Part IV 7(3): This is a proviso which allows "in cases of voluntary admissions the nurse in charge of the patient may prevent self discharge for up to four hours to allow review by a medical practitioner if it is perceived that there are grounds for involuntary admission." This seems to be based on section 5.4 of the UK Mental Health Act. The Act specifies "*the nurse in charge of patient*"; does that mean there will be a named key worker/care coordinator

who will be responsible for the care of each patient (based on the Choice and Partnership Approach (CAPA)) model in the UK? If this is the case, if the appointed nurse is not on duty, then who becomes the nurse in charge? And what does 'nurse in charge' actually mean? In the UK, this falls within the remit of responsibilities of a registered mental health nurse. Shifted to the local context, would this be a nurse specifically trained in mental health or any nurse working on the ward who happens to be duty on the day? The authors feel that an action to detain a voluntary patient is a serious decision requiring formal mental health training, so limiting this responsibility to nurses who are specifically trained in the field would improve the standard of care.

Part IV 9(1). "Prior to an involuntary admission for observation, an initial medical assessment shall be made by two medical practitioners, one of whom shall be a specialist" Within the framework of the new Act, two doctors, one of whom being a specialist in mental health, need to provide a recommendation within 72 hours of each other. The application has to be signed by a responsible carer who is appointed by the patient, and in the absence of such, an approved mental welfare officer may apply for admission. In the case of disagreement between the two doctors responsible for the recommendation process, a third independent person, being also a specialist in psychiatry, will carry out an assessment, with the majority recommendation prevailing. This process promotes greater autonomy, in that the responsible carer nominated by the patient will be ultimately responsible for the application process. It is worth noting that provisions exist within the law for the substitution of carers through the Commissioner of Mental Health if there is reasonable doubt that the carer may not be acting in the patient's best interests.

In the UK it is the approved mental welfare officer (AMPH) who is responsible for organising the admission process. The AMPH is one of the three people needed to be present to organise and carry out the assessment to decide on whether or not the patient should be detained involuntarily. It is considered good practice for the three professionals to carry out the assessment together; this will result in asking a similar set of questions once and providing room for discussion following the same patient review. That way you get a medical perspective but also a social care perspective, which is also useful as there is a multidisciplinary approach adopted from the start. This system also helps to solve any problem which arise when you have two people who don't agree on an outcome; in this case, with three persons, there will always be a majority agreement. The two doctors have a responsibility to make a recommendation after which the AMPH takes a final decision.

Part IV 9(2): The presence of the emergency order has its advantages, especially when there is a lack of specialists who can assess potential admissions in the community prior to admission. In Malta, the emergency order is made use of frequently when it comes to admit a patient into a mental health hospital. This has been a loophole which has been used by many doctors, who refer patients for involuntary admission to a psychiatric hospital; however, as a result, this leaves the psychiatrists at the acute inpatient admission phase without any power to take an expert decision on whether or not the person needs to be admitted or not. The authors believe that basing the admission decision solely on one medical recommendation leaves room for potential misuse. As a matter of practice, there should be a best practice clinical direction making an emphasis that the observation order is to be used as first priority. That is the reason why an observation order gives both parties 72 hours to fill in both forms; from a practical side, two doctors, one of whom being a specialist in mental health, should be possible to find.

Part IV 10(2): The current role of responsible relative has been expanded to that of a responsible carer, and extends beyond marital and familial relationships to include persons of trust that are nominated by the patient. This allows a greater degree of autonomy. Whilst at prima facie it would appear that the trusted person will act in the patient's best interest, this clause leaves a lot of power in the hands of the trusted person which may not reflect the patient's intentions. After all, this is a decision about mental health, which is a medical disorder based on international diagnostic criteria, making it an objective decision. There is a complex issue of competence for a person with an acute mental disorder with lack of insight to choose a person of trust at that moment in time. Would this person of 'trust' be chosen beforehand using an advance directive? The authors agree that the nearest relative should be consulted for a collateral history and involved fully in the decision making process and care planning; however the application process may be safer if an approved mental welfare officer is involved.

Part IV 11(1): Whilst the observation order is valid for 10 days, there seems to be no clause on whether or not medication could be given during this time, unless in urgent situations and to prevent further deterioration. This period may not be sufficient to ensure the treatment of a mental disorder. It will be useful to audit the number of patients who will be converted to a treatment order and

determine any correlation with the newly implemented decreased length of time of the observation order.

Part IV 16: The community treatment order seems to be based on the UK Mental Health Act; it reads well and is practical.

Part V 24(2): The Act states: "Only a specialist may certify a person suffering from a mental disorder as having mental capacity or lack thereof.".

The law determines that the specialist needs to be a mental health specialist. All doctors should be trained in assessing capacity since a patient's health is the responsibility of any doctor; the doctor should be empowered to carry out an assessment of capacity in the first instance. However, if a second opinion is needed, then a psychiatrist is involved on a case by case basis. It is however noteworthy that within this Mental Health Act, capacity of understanding is mostly restricted for the management of civil matters, and issues of capacity falling within the remit of the mental health act need to be assessed by a specialist in mental health. It is necessary that further legislation is developed to fully regulate all aspects of the capacity and competence, including medical decision making.

The many other changes to be introduced in 2014, including the definition of the role of Commissioner for Mental Health, clear informed consent, services and treatment for underage persons, prescription of restrictive care, prisoners with mental health problems, the licensing of facilities for the provision of mental health care and commitment towards social inclusion will be addressed in later articles. Our impression is that the underlying drive and values in the 2012 Mental Health Act is to make the law more consonant with changes that have permeated the practice of mental health care, respecting autonomy, providing humane and expert care, whilst providing further checks and balances to ensure transparency and professional accountability.

WHAT ARE THE PRACTICAL IMPLICATIONS OF THIS MENTAL HEALTH ACT FOR PROFESSIONALS?

Many family doctors encounter the use of the Mental Health Act when faced with a situation where a person presents with an acute mental disorder which poses a threat to either the person or other parties. In circumstances where a period of containment and observation is warranted, even if such a measure is not acknowledged by the patient involved, the Mental Health Act specifies that an involuntary admission to a mental health setting may be invoked. Up to October 2014, there will be no changes in the period of time for which an emergency order will remain valid. The emergency order will remain for a period of 72 hours up to October 2014, with the new timeframes projected to be introduced at that point.

In conclusion, furthermore to the above, the authors suggest that the best practice for professionals would be to utilise the *admission for observation* in all circumstance unless there is truly an emergency; by this we mean a physical lack of doctors present to assess and make a recommendation for involuntary admission over a 72 hour period. We believe it would be useful for the Commissioner of Mental Health and/or the Malta Association of Psychiatrists to set up educational lectures or issue best practice guidelines, to be used by all professionals, furthering one's understanding of which section of the Mental Health Act should be used in specific clinical scenarios. In cases of encountered difficulties, it would be a safe and feasible option to approach the office of the Commissioner for Mental Health to seek clarification.

WHAT HAS CHANGED IN OCTOBER 2013?

- Within mental health services, informed consent for any form of therapy shall be formalised through the use of a standardised form
- The use of restraint, including the use of single rooms, shall be limited solely to periods of acute behavioural dyscontrol
- The use of electro convulsive therapy shall need the approval of two specialists, even when the patients are able to provide informed conset
- Introduction of terms and statutory offices aimed at introducing more checks and balances at a clinical and administrative level