The new Mental Health Act and the Family Doctor

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INTRODUCTION

The new Mental Health Act (2012), is expected to enter fully into force in October 2014. This Act will completely replace the Mental Health Act which we have known and worked with over the last 30 years. Essentially this new Law will bring with it challenges and opportunities for all health care professionals involved in the care of persons with mental disorders.

The new Mental Health Act follows the trend of modern legislation, which essentially adopts an individual human rights approach and places an emphasis on the protection of such rights in vulnerable groups in society, in this case persons with a mental disorder. The Act also mirrors the wider changes in knowledge, perception and attitudes towards mental diseases and mental health which have taken shape over the past decades.

WHAT IS NEW?

For the large part, the old legislation focuses on three broad sections:

(1) Compulsory Hospital Admission,
(2) Institutions providing mental health services, and
(3) Patients concerned in criminal proceedings.

The new Act still covers these three themes but also introduces seven new concepts with sections that deal with:

(1) the rights of users and carers,
(2) the establishment of a Commissioner to safeguard those rights,
(3) compulsory treatment within the community (Community Treatment Order),
(4) the certification of lack of Mental Capacity and the additional functions of curators,
(5) issues pertaining to minors receiving care in mental facilities or as dependent children of parents receiving such care,
(6) special treatments, restrictive care, and clinical trials or other research involving persons with mental disorder, and
(7) the promotion of social inclusion and elimination of all forms of discrimination on the basis of mental health status.

WHOSE REMIT IS IT?

One could argue that the Mental Health Act falls within the remit of psychiatrists and other mental health care professionals and that the role of the family doctor exists somewhere on the boundary of this "inner sanctum." This viewpoint could not be more wrong! Why?

First of all the Mental Health Act, 2012 is about all persons with mental disorder, whether residing in the privacy of their own homes, receiving care in the community or in residential accommodation, or in-patients within mental health facilities. It encompasses care provided both privately as well as within the public health service.

Secondly it is an Act which looks beyond the manifestations of the illness and emphasises the person with the illness. This is at the very core of the family doctor-patient relationship. The family doctor treats the person and not the illness and therefore will welcome the listing, for the first time, of nineteen separate rights for all persons with mental disorder. Merely by browsing through this list of rights, family practitioners may quickly understand how their role is indeed a crucial one for the mental health patient.

Under the new Act emphasis is made to select the least restrictive treatment option for the patient. Hence wherever possible, treatment in the community is to be preferred over treatment within a licensed facility (hospital).

Where care in the community cannot be selected as a primary treatment option, the emphasis then turns to aftercare and rehabilitation in the community. In both these scenarios, the family doctor is strategically placed to provide or supervise the necessary treatment in the community, and to act as the bridge between the patient and the specialist mental health services. The family doctor can be the patient's advocate, ensuring that the patient is provided with adequate information

about the illness and treatment options, and has access to appropriate services as required. The family doctor can be pivotal in actualising the right for patients to actively participate in the formulation of their own care plans and to provide informed consent as necessary. The family doctor is also well placed to encourage and guide the patient in identifying a responsible carer of his or her own choice, and to provide support and guidance to the latter. In other words the family doctor can make a big difference as to whether persons with mental health problems and their carers can actualise the rights that have been granted to them under this Act.

VOLUNTARY INPATIENT TREATMENT IN A LICENSED FACILITY

In line with the least restrictive treatment approach envisaged in the new Act, voluntary treatment is to be preferred over involuntary treatment.

Therefore should hospital in-patient treatment be considered necessary, the family doctor should in the first instance consider eliciting informed consent for a voluntary admission, provided the patient is also informed that should circumstances change and certain criteria be met, such admission could be converted to an involuntary one.

INVOLUNTARY TREATMENT IN A LICENSED FACILITY

The family doctor is often a key participant in the involuntary admission of a patient to a mental health licensed facility. Whilst an emergency involuntary admission will still be possible on the strength of one medical signature only (which is usually that of the family doctor), it is advisable for family doctors to utilise the preferred route of admission which requires a specialist psychiatric assessment and recommendation prior to admission. In either case the medical recommendation is to be done by filling in **only one form - the Second Schedule**. The Second Schedule will also include the application for admission by the responsible carer or the mental welfare officer.

There are three (3) criteria which must all be met throughout the course of an involuntary admission. These are: (a) the presence of a severe mental disorder which (b) is posing a serious risk of physical harm to self or others, and (c) failure to admit or detain the person will likely lead to a serious deterioration in his or her condition or will prevent the administration of appropriate treatment that cannot be provided safely in the community.

Involuntary admission shall always be for Observation for a maximum period of 10 days, at the end of which there can be one of four outcomes:

(1) discharge to the community,
(2) conversion to a voluntary inpatient admission,
(3) an application for an involuntary Treatment Order, or
(4) in application for a Community Treatment Order.

The last two options will necessitate the assessment of the request by the Commissioner and a final decision by Day 15 from date of admission for Observation. The maximum validity of a Treatment Order is for 10 weeks. This may be followed by an Extension of Treatment Order for a maximum of 5 weeks and eventually a Continuing Detention Order for a maximum of 6 months, renewable. At each stage the Commissioner for persons with mental disorder will need to be involved for approval. An independent peer review will be necessary for approvals of Continuing Detention Orders.

In the case of minors the maximum equivalent periods of involuntary admission which may be approved by the Commissioner are much reduced.

COMMUNITY TREATMENT ORDER

The Community Treatment Order is the preferred treatment option for a person suffering from a severe mental disorder requiring treatment in the interest of self or for the protection of others, where there is a serious history of previous failure of compliance, and where such treatment can be safely provided in the community with some extra safeguards. The family doctor is ideally placed to be an active participant in this novel treatment option which enables persons who depend on regular psychiatric treatment to be able to live safely in the community.

A community treatment order provides a family doctor with the possibility of working in tandem with a psychiatrist who remains the responsible specialist for the patient and other health care professionals within a multidisciplinary team approach. The family doctor can either sign the medical recommendation for the application for the community treatment order together with the responsible psychiatrist (Seventh Schedule) or else join the specialist team at a later stage by signing an agreement to provide the required care (Eighth Schedule).

If at any time during the validity period of the Community Treatment Order (maximum 6 months) it becomes necessary to involuntarily admit the patient to a mental facility (hospital), the Order provides the ability to admit the patient for a maximum period of Observation

of 10 days. The person can then be discharged back to the community for the continuation of the remaining validity of the Community Treatment Order. The Order also has safeguards that enable forceful conveyance of the patient for psychiatric assessment if required. The police may be asked for assistance if necessary.

MENTAL CAPACITY AND THE LACK OF IT

A person suffering from a mental disorder shall be deemed able and competent to make decisions unless certified by a psychiatrist as lacking mental capacity to do so.

The practical issue with mental capacity or the lack of it, is the fine balance between autonomy and protection. For this reason the law introduces three levels of certification of lack of mental capacity

(1) a transient lack of mental capacity for a maximum period of 14 days which can be documented in the clinical file;
(2) longer periods up to 26 weeks which require approval by the Commissioner following the advice of an independent specialist; and
(3) certification of lack of mental capacity expected to last longer than 26 weeks which will need to be accompanied by applications for incapacitation or interdiction.

OTHER MATTERS

The family doctor should be aware of a few other various provisions under the new Act. These include

(1) the requirement of eliciting informed consent from minors who are deemed to have sufficient maturity and understanding to provide such consent and acting on such consent even without involving parents,
(2) the special safeguards applicable for research in persons with mental disorder and in the application of restrictive care or special treatments including electro-convulsive therapy (ECT), and
(3) restrictions in assuming a professional capacity with patients related to the third degree.

All decisions taken by the Commissioner can be appealed to in the Court of Voluntary Jurisdiction.

CONCLUSION

The new Mental Health Act provides the family doctor with a modern legislative framework which promotes the rights of the person with mental disorder whilst ensuring the required level of protection. It focuses upon abilities and maximisation of potential of the patient and his or her responsible carer and emphasises the role of multidisciplinary professional involvement. It widens the remit of mental health care away from the strict confines of the mental health institution to the wider community wherein the person with mental disorder can live and integrate as a full and inclusive member of society, be protected from all forms of discrimination, and enjoy full and equal opportunities. Indeed the Mental Health Act (2012) sets the stage upon which the family doctor can take a central and active role. It should also motivate family doctors to further develop their knowledge and skills to provide better mental health care for their clients in the community.

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