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Royal College of Psychiatrists Northern Ireland Division

Consultation on Mental Health Legislation Department of Health

The Royal College of Psychiatrists welcomes the priority that the Minister for Health and his Department have given to the reform of mental health and capacity legislation.

The Royal College of Psychiatrists is the statutory body responsible for the supervision of the training and accreditation of psychiatrists in Britain and Ireland and for providing guidelines and advice regarding the treatment, care and prevention of mental and behavioural disorders.

The College has 255 members in Northern Ireland, as well as younger doctors in training. These doctors provide the backbone of the local psychiatric service, offering inpatient, day patient and outpatient treatment, as well as specialist care and consultation across a large range of settings.

The single most pressing concern of the Royal College of Psychiatrists is that legislation should be introduced combining capacity and mental health legislation in a single Act.

Reform is necessary because of developments in practice, because of the development of capacity legislation elsewhere, and to meet the requirements of human rights legislation. The College strongly believes that the best way forward would be a single Act encompassing mental capacity and mental disorder, which would obviate the need for a separate Mental Health Order. Learning Disability psychiatrists are of the view that for the Learning Disability group of patients in particular there may often be a dilemma about which piece of legislation to use in the event of there being two pieces of legislation.

DETAILED CONSIDERATIONS OF DEPARTMENT OF HEALTH PROPOSALS

This legislation will be fundamental to the role of psychiatrists, who have a duty to act at all times in the best interests of their patients, while giving due consideration to public safety. As such, we look forward to seeing more detail on the proposed legislation, and to working with the Department to shape legislation that is workable in practice.

Particular areas where we feel further clarification is required include:

(1) Restrictive Practice

We feel that more detail is required on advice with regard to restrictive practice, in particular, how and which professions or lay people are supported under the legislation to engage in restraint and how this is to be regulated and monitored, if and when this becomes necessary.

(2) Persons Lacking Capacity in the Community

With regard to section 5 (Powers And Safeguards To Protect Those Who Lack Mental Capacity) it is noted that many people with a learning disability will not be able to take advantage of the advanced decision making or lasting power of attorney provision. This is because their capacity for many decisions is likely to be impaired right from the outset. This will mean a high reliance of this patient group on the proposed High Court appointed Deputies and Public Guardians.

The Learning Disability psychiatrists would consider that the section at 5.5 which deals with people who come under the Bournewood judgement, i.e. lack capacity to consent, require care in a hospital or a care home and where it is in their own best interests to be deprived of their liberty, should be extended. There are a number of other related instances and settings that require to be included under the law. Chief among these is the care of people in homes in the community who may require some measure of restrictive practice such as locked outside doors or occasional physical

intervention procedures to keep them safe. At the moment such care is provided without the necessary legislative framework and this is an opportunity to put this right while avoiding the excessive bureaucracy of the Deprivation of Liberty Safeguards (DOLS) processes in England and Wales.

(3) Admission Process/Professional Roles

The Northern Ireland Mental Health Order, though out-moded in many ways, has the strength that psychiatrists are not involved in the initial Application for Admission for Assessment process. It is important that we do not lose this important principle. It is a protection for the rights of the patient, and also helps to minimise damage to the therapeutic relationship when a patient is detained.

Psychiatrists consider that it is in the patient's best interests to have the balance of health and social perspectives presently offered by the involvement of trained Approved Social Worker at the time of admission and that this could be usefully extended to support the more serious decision point of Detention for Treatment.

Psychiatrists consider that any health professional involved in application for assessment should have health based training equivalent to that of Approved Social Workers at present. Given the changes in GP working practice, this role might also be met by a Community Nurse who knows the patient well in liaison with the GP.

Currently psychiatrists are the only professionals who can take on the duties of Responsible Medical Officer. For all practical purposes it would seem likely that in the large majority of cases consultant psychiatrists, who are trained in all aspects of the bio-psycho-social model, are the most experienced practitioners in routinely managing acute disturbance and who provide 24 hour on-call rotas throughout the health service are the most appropriate people to act as the Responsible Clinician. In principle the College does not have a fundamental problem with other clinicians acting as Responsible Clinician in specific cases. Clearly it is important that any clinician taking on this major responsibility has appropriate training, expertise and experience and would be available to participate in a 24 hour rota. Our understanding is that in England there have been relatively few cases in which other professionals have taken on the role of Responsible Clinical Officer.

(4) Compulsory Treatment in the Community

The College is yet to be convinced that clear evidence has been produced to show that Community Treatment Orders enhance the quality of care for patients or provide protection for the public. There is emerging evidence from Britain that Community Treatment Orders are being used more extensively than anticipated and this is something about which we would have concern. The College is currently researching the experience of the use of Community Treatment Orders in Britain and we would suggest the value of obtaining advice from this work before making a definitive decision to proceed with this measure.

If it is decided to proceed with Community Treatment Orders then there would need to be very strong protections for patients for their review and monitoring.

The College would be opposed to Orders being used for patients who have not been admitted to hospital, in other words, they should only be a step down measure. If Community Treatment Orders are to proceed they should only be specifically for the purposes of administering medication as other issues can be dealt with by guardianship. We would welcome more information on the proposals for Guardianship powers in the new legislative framework, and where they will sit. Guardianship has proved to be a very useful, if limited, provision in the present 1986 Order.

(5) Assessment of Capacity

We would seek clarification about who decides on capacity and a clearer definition of capacity. New capacity legislation will require a major educational programme for all health professionals.

We believe that capacity legislation, as with mental health legislation, needs to be proportionate. In other words, there needs to be a higher test of capacity for decisions which remove liberty or result in risk and higher protections. We realise that many of the details will eventually be resolved by guidance at a later stage, but, so that patients do not come to harm, we would urge that the drafting of legislation should be as detailed as possible, and we would seek that the Royal College of Psychiatrists and other stakeholders should be involved closely throughout this process.

Our belief is that the role of psychiatrists in assessing capacity should mainly be for those patients who would normally be treated by a psychiatrist.

(6) Mental Health Tribunals

We welcome the earlier access to Mental Health Review Tribunals suggested in this reform, and we recognise that it will have major resource implications for the service. We would comment that ideally detention of individuals should itself be a judicial process, and some clarification is needed as to whether the proposed early Review Tribunals are for the purposes of authorising detentions or appealing against detentions. We advise that the present inquisitorial approach of the Tribunals is not allowed to become overtly adversarial, as this is not in patient's best interest.

(7) The Interface between Mental Health and Criminal Justice

There needs to be clarification of the interface between mental health professionals and the criminal justice system. The Royal College of Psychiatrists supports the principle of equivalence, namely that people who are subject to the Criminal Justice System should have access to treatment and care that is equivalent to that available to the rest of the community. We also favour an inter-agency approach that addresses both the needs of the Criminal Justice System and the mental health needs of the individual.

Psychiatrists and other mental health professionals need clear advice about when an individual's dangerous or illegal behaviour should be dealt with under mental health legislation, and when it should be dealt with under criminal justice legislation.

(8) Definition of ability to treat

The first law of clinical governance is that a doctor should not undertake any procedure for which they are not satisfied that they are clinically qualified. This applies to surgeons, but it equally applies to psychiatrists. Any proposed new legislation must be framed in such a way that no doctor is forced to take on the treatment of a patient, when they do not believe that the patient can be successfully treated against their will. If any clinician were to detain a patient that they did not believe they could successfully treat, they would simply be imprisoning them. Any new legislation, which involves restriction of liberty, should insist that the Responsible Clinician declares that they believe that the individual patient can be treated successfully without their consent.

(9) Personality Disorder

We have an issue about the inclusion of the diagnosis of personality disorder under any proposed new legislation. This is a broadening of the remit of the present Order and, although most psychiatrists believe that the suffering and distress resulting from personality disorders can successfully be treated and ameliorated, there is no evidence that personality disorder can be treated against the patient's will. In the same way that treatment of addiction problems requires the co-operation and motivation of the patient, the treatment of personality disorders is not a process which can be imposed on a patient who withdraws their consent. There are inconsistencies to including personality disorder but not addiction in any new legislation.

In other jurisdictions, capacity legislation always includes the statement that individuals are allowed to make unwise decisions. However, there is a danger of misuse of legislation in the event of an individual with a diagnosis of personality disorder making unwise decisions, if personality disorder is included in the legislation.

For similar reasons, it is essential that legislation is not applicable to individuals who are simply intoxicated and, therefore, temporarily lack capacity. They too can engage in unwise choices and behaviour.

Individuals who have a diagnosis of personality disorder do have access to services, whether their distress is due to personality disorder alone or due to other co-morbidity. This should not be confused with their need to have access to specialist personality disorder services which do need to be developed in Northern Ireland.

(10) Resources

We are concerned about the resource issues generally for implementing the proposed legislation. A major public and professional education programme will be required if the positive impact of new legislation is to be fully utilised. One of the merits of the Bamford process was the comprehensive approach to modernising services and reform of legislation in tandem. Legislative reform should support access to services and we would have concerns that if the Bamford service changes are not fully implemented this may result in use of the legislation having unintended consequences, such as difficulty for voluntary patients to access in-patient beds. If Community Treatment Orders were to be introduced, this will create additional demands and pressures for community services.

New legislation may thus result in more individuals being detained for protection of their own rights.

(11) Timescale

The Royal College of Psychiatrists is very concerned about the timescale for consultation of this important piece of legislation, and the timescale for drafting and implementation. Whether this is two Acts or one, legislation of this magnitude must not be rushed. We do not believe that twin legislation will be any faster or easier to draft, pass through the democratic process, or implement than one piece of legislation. We would like to see one piece of legislation that supports human rights, provides the best possible protections to people who lack capacity for any reason, and protects individuals and the public from harm. We think that many issues require further exploration, for example, Community Treatment Orders, Mental Health Review Tribunals, the use of Advance Directives for mental health and how people with learning disability will be affected etc, and recommend that these issues are broadly consulted upon and debated so that the Department can be informed by those stakeholders who will ultimately operate and be subject to the legislation.

(12) Advice

It would be very appropriate to include some General Adult Psychiatrists and Clinical Psychologists and other relevant professionals on the Steering Group when drafting new legislation. The strength of the Bamford process was in the voice of users and carers and their presence should be strengthened. Alternatively, consideration should be given to the establishment of a Reference Group of stakeholders which could guide the process, allow wider support for the changes and assist in their fuller implementation.

SINGLE ACT

Fundamentally we consider that both legislations are there to support others to intervene when mental disorder affects people's capacity to make decisions about their lives and treatment.

As we stand we are looking at introducing two pieces of legislation: one for "good" people with incapacity who primarily require protection and another for "bad" people who primarily need detention and treatment against their will. This effectively endorses the stigma that people with mental illness face every day, and which inhibits recovery and is a barrier to people living fully inclusive lives.

Similarly, two separate acts for capacity and mental health legislation may prove very difficult in practice, since individual professionals working with patients will be called to judge on a regular basis, which of these two pieces of legislation to invoke in a particular case.

There is a growing international consensus that favours amalgamation of mental health and capacity legislation into a single Act. Because Northern Ireland is introducing capacity legislation

and reviewing its mental health legislation at the same time it is uniquely placed to become the first country in the world to introduce a single Act.

Having observed the Scottish experience in particular over the last two years, we have concluded that most of the considerations mentioned above with the present proposals could be resolved by developing a single Act, encompassing mental health and capacity legislation. We do not under-estimate the difficulties that would be involved in drafting such an Act, not least the interface with the criminal justice system, but we believe that across services, professions, users and carers in Northern Ireland there is a commitment to resolve any difficulties, and succeed in producing world leading legislation.

The College and its members are committed to legislation based on the principles of autonomy, justice, benefit and least harm. Whatever form of legislation results from this review, these principles should support the dignity of the person and be written on the face of legislation as well as embedded throughout the Code of Practice.

There is a once-in-a-generation opportunity and a will to produce a radical innovation. Arguments that this has not been done anywhere else, and that it will prove very difficult, are arguments that would apply to any form of innovation. The Royal College is committed to helping at every stage of the development of new legislation, and to putting in all the necessary work so that this can be delivered on schedule.

It would be a sad indictment of us all if we fail to grasp this opportunity to innovate, so that we can improve the lives of our most vulnerable citizens and the safety of our society as a whole.

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