

CONDITIONS FOR COMPULSORY ADMISSION AND TREATMENT

(July 2006)

Introduction

The following paper describes the: (i) principles which underpinned the work of the Group (ii) themes discussed by the Group (iii) outcomes of Group discussions on compulsory admission and treatment; (iv) recommendations and (v) references used. The Group's discussions have focused particularly on the periods before and immediately after admission to hospital

(i) Principles

1. The Group took into account the *Terms of Reference for the Review*, which recognise the need to:
 - enhance the personal dignity of service users and carers;
 - promote positive mental health;
 - consider issues of rights, discrimination and equality;
 - consider best practice at local, national and international levels;
 - collaborate with relevant stakeholders;
 - consider treatment and care for people with mental health and/or a learning disability needs; and
 - consider issues relating to incapacity.
2. The Group also considered the paper on *Ethical Issues* provided by Professor Roy McClelland. He identifies a number of principles:
 - recognition of autonomy, patient consent and participation wherever possible the upholding of the principles of beneficence and non-maleficence; and
 - upholding principles of justice, including: non-discrimination; equality and respect for diversity; reciprocity.

The paper helpfully identifies a number of themes where ethical principles are often tested in mental health law:

- a need to recognise the importance of a shift from paternalism towards rights perspectives in international law;
- the requirement of a stronger test for compulsory admission which recognised important issues of capacity and consent; and
- the tension between protecting the well-being of service users and their rights against an over-preoccupation with wider issues of public safety.

3. The Group considered the main points identified in the *Initial Submissions* document, which has been summarized by the Review's secretariat, with a particular focus on **Table 1** (DHSSPS, 2003).
4. The Group considered the main points identified in the Report published by the Northern Ireland Human Rights Commission (2003) *Connecting Mental Health and Human Rights* (Davidson et al, 2003), with a particular focus on chapter 2.
5. The Group considered aspects of mental health law review which was taking place in the Republic of Ireland, Scotland and England and Wales.
6. The Group considered a range of other papers submitted by members about aspects of policy and practice elsewhere in the United Kingdom and internationally.
7. The Group considered responses to drafts of the position paper provided by other groups or individuals involved in the review.
8. The Group considered the Legal Framework document produced by Dr McGinnity and her colleagues.

(ii) *Themes discussed by the Group*

9. The Group met on 13 occasions since July 2003. Jim Campbell met with representatives of GPs, ambulance service and police, along with Brian Hall, to discuss respective roles in relation to the admission process. Jim Campbell also met with Brian Hall and Maria McGinnity to discuss how the proposed Legal Framework document on possible capacity legislation would affect the deliberations of the Group. Jim Campbell met with the Review's service users' and carers' reference groups.
10. The Group began by engaging in a debate on the purposes of mental health legislation, and the principles which should underpin the drafting of such legislation. It was recognised that the events leading to compulsory admission and treatment are complex, often traumatic, and involve sometimes contradictory processes and principles. A balance had to be struck between protecting the rights of service users whilst acknowledging the need for the state, in exceptional circumstances, to take freedoms away. It was important therefore that any discussion of the area had to take account of the views of service users, carers and professionals.
11. The Group was mindful of the substantial changes that have occurred in policy, practice and engagement with service users since the Mental Health Order (MHO) became law in 1986 (Rogers and Pilgrim, 2002). The recognition of the right of people with mental disorders to live as normal a life as possible, the closure of long stay institutions, the development of community based facilities, the way in which service users and families and carers are increasingly involved in service planning and provision are features of systems in the United Kingdom, Europe, North America and Australasia. Over recent years we have witnessed the emergence of some

advances in aetiology, diagnosis, treatment and models of service for people who have a learning disability and/or mental health problems, alongside many opportunities for inter-disciplinary work in these areas. Yet there remains a perception that levels of service provision and the quality of skills and training of professionals should be improved. Concerns remain that the views of service users and carers are often not listened to and that aspects of law, policy and service delivery are not always sensitive to need.

12. The Group agreed that a number of prerogatives should inform the discussion about compulsory admission and treatment. The law, wherever possible, should support people with mental disorders in their own community, that more resources should be used to prevent compulsory admission and that the system should be more user and carer-centred. Where possible, changes to the existing law should continue to take into account the principle of the least restrictive alternative. In the event of compulsory admission and treatment there should be a multi-professional approach which overrides sectional interests and is geared towards the best interests of service users and carers. An essential element to this process was a properly trained and educated workforce that understood the needs of people with mental health problems and/or a learning disability and who were competent in applying skills and knowledge in sensitive and empowering ways. These themes informed the deliberations of the Group as it examined the strengths and weaknesses of current mental health legislation. The Group was conscious of the need to consider alternative perspectives in the context of changing local, national and international opinion. To this end the Group used the present MHO as a template, and then moved on to consider the relative merits of the legislation when judged against contemporary principles and practices in the field.

(iii) Outcomes of the Group discussion on Conditions for Compulsory Admission and Treatment

SECTION 1: COMMUNITY BASED INTERVENTIONS

1.1 Defining 'mental disorder' and related expressions (Article 3 (1))

The Group agreed that the term 'mental handicap' was outdated and should not be used in any new legislation. Before a decision was made about this, consideration should be made about usage in the European Union and elsewhere in the world. In addition the Group agreed that any new concept of mental disorder should be clearly and narrowly defined to be compliant with Article 5 of the ECHR, where compulsion is used.

1.2 Exclusions (personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs) (Article 3 (2))

There was a relatively long debate amongst Group members about these issues. It was agreed that some of the terminology was rather dated and in need of change (promiscuity or other immoral conduct; sexual deviancy) in any new legislation. The major debating

point was whether patients with a personality disorder should continue to be excluded. A general consensus emerged that, on principle someone should not be compulsorily admitted to hospital on grounds of personality disorder alone. However, we agreed that the process should be open enough to allow for an admission if someone with a personality disorder had a co-morbid mental disorder, or if the applicant was unsure about the nature of the mental distress. It should be left to the multi-disciplinary team members in the hospital to make a more detailed assessment and, if a personality disorder alone was diagnosed, then the person could be discharged. The proposed Legal Framework paper is less concerned with how the law defines mental disorder, and more concerned about the patient's capacity to make a judgement about well-being and risk. It suggests that a broad definition be used (impairment of mind or brain); the important point is that safeguards are built into the admission process which protects patients' rights (these are discussed later in the paper below). It may be that someone with a personality disorder could be compulsorily admitted to hospital if the conditions are met, however, there should be a transparent 'treatability' condition to this process. There was unanimous concern in the Group that many of the problems around the law in this area were created by a lack of adequate community based resources for people with a personality disorder. The Group wished to emphasise the urgency in providing such resources in order that this important, yet often neglected group are cared for (O'Kane, 2003).

1.3 Grounds for Application for Assessment (Article 4 (2))

It appeared to the Group that existing international laws tended to describe the grounds for compulsory admission, in terms of risk and the existence of a mental disorder. Some members of the Group felt that the focus of risk in existing Northern Ireland law – on physical harm – was rather narrow, and that a more explicit consideration of future risk might be permitted. Service users were concerned that a distinction should be made between risk to the self and risk to other people by those making an assessment (the latter being most stigmatizing and not necessarily evident in most situations).

The Group considered the proposal that any new law might permit, under tightly controlled and managed circumstances, detention in places other than hospitals as a way of enhancing the principle of the least restrictive environment. This may require a comprehensive multi-disciplinary assessment by relevant professionals and implies that resources can be made available to prepare such facilities. In addition some discussion took place about the need to change the law to allow practitioners to admit to hospital from, for example, outpatient facilities, in exceptional cases, where delay in going through normal processes would be unreasonable. Any changes in the law which would allow direct admissions to hospital by psychiatrists would need to establish strict conditions for this procedure, identifying the exceptional circumstances when it could be used. The Group believed that such proposals may deliver less restrictive environments but that the important views of service users and other Review groups should be acknowledged in discussions of these potential changes. For example, in the meeting with both service user and carer reference groups, service users felt that this was an unnecessary extension of the law and that existing powers of control were sufficient.

The important issue about how professionals would judge capacity (implied by the Legal Framework paper) will affect the way that people would be compulsorily admitted to hospital. This might be comparable to the new mental health law in Scotland where a person may be compulsorily admitted to hospital on the grounds that, "...because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired." (The Mental Health (Care and Treatment) (Scotland) Act 2003 Section 4 (b)). It was acknowledged that such judgements about capacity were complex and subject to a wide range of factors. It is, therefore, important that ground rules about how such judgements are to be made are as transparent and understandable as possible in future legislation for Northern Ireland.

1.4 Medical recommendation (Article 4 (3) and Article (6))

A number of proposals were considered by the Group in this area. It was argued that, because policy and practice had changed so much in the last two decades, it was unreasonable to expect the patient's own GP to always, or even some of the time, to be involved in carrying out the assessment/medical recommendation. The Group was aware of the new GMS contract which implies that GPs will not be required to visit patients in a location other than their registered address. In addition it was acknowledged that many GPs are inadequately trained, or have sufficient practice experience to carry out such assessments. After meetings and communications with GPs it was acknowledged that many GPs could still carry out this function during the 9-5 period, but that the out-of-hours service was more problematic because this was a generalized, trust-operated service where there is no expectation that the practitioner would know the patient.

For these reasons, the Group debated changes to the existing medical recommendation which differs to that recommended, for example, in the Scotland Act and England and Wales Bill. The Group thought that that well-trained and experienced community psychiatric nurses (CPNs) may be in a good position to offer a clinical judgement about mental disorder, and perform a role, similar to that of the GP. If the nurse was concerned about medical diagnoses beyond their skills and knowledge base, then access to medical opinion would be necessary. The Group were keen that GPs would continue to be involved in the process, but that they would have to be adequately trained for this legal function (for example there is a system in the Scottish law for the Approved Medical Practitioners), and, ideally, known to, or are able to find out about the patient and their carers. Where the person is unknown to the professional then the process should be carried out to ensure the dignity and human rights of the patient. In order that as full an assessment as possible is made, professionals should have access to appropriate places of safety to carry out these functions. The Group acknowledged that these substantive issues would have to be discussed with, for example, with the Royal College of General Practitioners and the Royal College of Nurses, providers of out-of-hours GPs services and tested against the European Convention on Human Rights (ECHR) and case law. The Group agreed that psychiatrists should normally continue to remain outwith the early part of the process and only become involved during the assessment period in hospital (apart, perhaps, from exceptional emergencies as described in 1.3 above).

The Group strongly felt that, regardless of which professional was carrying out these duties, practitioners should be adequately trained and approved to fit function. We should look to examples of good practice in Britain (for example Section 12 Approved practitioners) and elsewhere in the world, in these regards. It is the responsibility of the relevant authorities to ensure that such training is funded and managed.

1.5 Persons who may make application for assessment (Article 5 (1))

It was generally agreed that it was no longer appropriate for the nearest relative (NR) to be applicant. It seemed incongruous that the nearest relative should have the same legal powers as the Approved Social Worker (ASW) who is trained for function. In addition, it was sometimes the case that nearest relatives were uncomfortable with the coercive nature of this role and the impact that this might have on their relationship with patients. The Group was adamant, however, that carers and a 'named person' (as in the Scottish Act) should be closely consulted with, and informed, throughout the process. Provision for a second opinion if carers and/or the named person objected should be preserved in the new legislation. Although there were some merits in expanding the types of professionals who could be the applicant, the Group recommended that this role should remain with the ASW. It was felt that social workers would offer a social perspective to the process which might balance, and complement the more medical or clinical perspective brought by other professionals to the recommendation.

1.6 Application for assessment within two days (Article 5 (2)) and subsequent processes

The Group recommended that there should be a maximum of 48 hours during which a person should be seen and interviewed prior to compulsory admission. The Group also felt that processes identified in the Scottish Act were appropriate for our jurisdiction. In particular we recommend that an emergency detention order, which lasts up to 72 hours, should be used, involving a clinician (CPN or GP, depending on whether a clinician, other than a medic can perform this function) and an ASW. Thereafter a short-term detention could take place which would last a maximum of 28 days, when recommended by a consultant psychiatrist and agreed by an ASW (where possible).

1.7 Application for assessment in respect of patient already in hospital (Article 7)

The Group felt that the same process should follow as per community based admissions in any new legislation. It was, for example, important that the person who makes the recommendation and application is 'external' to the hospital system. The Group spent a considerable time in discussing the merits and otherwise of what have been described as 'holding powers', used by professionals to detain patients for a limited time subject to specialist opinion at a later date. There was particular concern about use or possible misuse of form 5As, primarily used in general hospital by less senior medical staff, some of whom may be unfamiliar with mental health legislation – there is some evidence to suggest that they are used inappropriately to 'force' patients to remain in hospital without follow through to the due legal process.

The Group believed that in any future law, such procedures are necessary for use in exceptional circumstances, but it was wholly inappropriate that professionals should have these powers if they were not trained/experienced in the use of mental health law. Additional guidance is needed in terms of professional codes of practice and the Group recommended that a method of monitoring this activity is necessary, for example through a process of registration of a document which is sent to the Mental Health Commission.

1.8 In the course of their deliberations the Group considered a number of issues which are highlighted in the review of mental health law in other UK jurisdictions – protective measures and Community Treatment Orders (CTOs)

The Group unanimously agreed that where a patient's liberty was being deprived, there should be strong measures which would help protect rights. The establishment of patient and peer advocates, a named person, lasting power of attorney and/or the use of advance statements in legislation as well as codes of good practice would be important in this respect. The Group welcomes a fuller discussion and exploration about how these arrangements can be operationalised and funded.

The Group spent a relatively long period discussing the pros and cons of CTOs. It was agreed that they may be appropriate in specific, closely monitored circumstances, a number of examples from professional practice were used to explain how the use of CTOs could protect the health and well-being of patients. There were, however some concerns expressed about CTOs. It was acknowledged that there a number of contested positions in the research literature about efficacy and outcomes (Campbell et al, 2006; James, 2006). In meetings with service user and carer reference groups, participants unanimously argued against the introduction of such forms of involuntary care and treatment in the community to Northern Ireland – viewing this as an unnecessary extension of professional and state powers. Some discussion took place about whether a modified version of existing laws – for example Guardianship. Recent proposed amendments to the 1983 Act in England in Wales are suggesting the use of supervised treatment in the community.

1.9 Police powers and the role of ambulance personnel (Articles 129-132)

The MHO currently requires a lay magistrate to issue a warrant if there is reasonable cause to suspect risk, neglect or harm. Any new legislation should ensure that such a legal process continues for the use of warrants in these circumstances.

In discussion with police representatives it was argued that police stations and cells were often not appropriate places of safety for disturbed patients. It was also noted that once a person has been moved to a place of safety, they cannot be transferred to a different place of safety (except in a medical emergency) until they have been examined by a medical practitioner and interviewed by an ASW. These issues are partly related to a perceived lack of adequate and appropriate accommodation for such assessments to take place. This issue of resource should be taken up by the Review's section on mental health service provision.

Although ASWs, medics, police officers and ambulance personal generally work well together in ensuring that transport to hospital is human and carried out in the least restrictive manner, there remains some lack of clarity of roles, particularly between police and ambulance personnel. These roles should be clarified in future legislation, and codes of practice.

SECTION II: HOSPITAL BASED INTERVENTIONS

2.1 Assessment by a medical practitioner (Article 9)

The Group felt that when a person is compulsorily admitted to hospital that they should be seen as quickly as possible by a medical practitioner. As with other aspects of mental legislation practice is determined and influenced by existing resources. The Group felt that tight time scales should remain, however, a question was raised about the requirement that a *consultant* psychiatrist needed to be so involve, given the resource implications for this group. It was agreed that this issue of staff resource should be included with other such resource implications raised by the current review of the law.

2.2 Disregard of assessment period for certain purposes (Article 10 (1-6))

The Group reflected upon the generally positive view about the 14 day period of assessment which exists under current legislation. We thought that, if a short-term detention order with a maximum period of 28 days was introduced then this would in effect extend this period. There was unanimous agreement that this was a good safeguard in terms of human and citizenship rights for the patient.

2.3 Rectification of applications, recommendations and reports (Article 11)

This article seeks to address circumstances where, within the proposed 28 day assessment period, if forms or reports are defective, there are opportunities to either discharge the patient or to requisition a new report. The Group felt that the existing provision which allowed for rectification within the assessment period would be reasonable in future legislation.

2.4 Detention for treatment (Article 12)

The Group considered the current process in detaining patients for treatment and considered whether, in any future law, there were sufficient safeguards for patients. The Group would like to take more time to consult and consider whether this process might be changed. Initial suggestions were that a quicker review of the decision might be valuable, that the multidisciplinary team be more explicitly involved and how, if in any way, carers and relatives can be included in the decision-making process.

2.5 Renewal of authority for detention (Article 13)

The Group considered the details of this article and proposed the following changes which may be incorporated into future legislation. They were very keen to ensure that a senior medical officer should see the patient within 48 hours in all cases and that weekend work and public holidays should not compromise this rule. This will have implications for resources, particularly in terms of psychiatric cover. Another suggestion was that a senior/experienced medical officer need not necessarily be a consultant (as is the case in England for example).

2.6 Discharge of patient from detention (Article 14)

The Group felt that existing procedures were reasonable but emphasized that there should be explicit guidelines in future legislation about how carers and/or 'named persons' can be involved at all stages in this process.

2.7 Leave of absence from hospital (Article 15)

This contains a number of quite complex sections which describe the conditions whereby detention can be renewed/extended. The Group were concerned that there was appeared to be substantial practice variations in terms of leave of absence. In current as well as future legislation is important therefore that guidelines for best practice in this area are drawn up. The Group believed that leave of absence can be beneficial, but only if planned and supported in the community. For example key workers should be identified, a hierarchy of risk established and an identified package of care including a 24 hour service. These safeguards are essential to ensure principles of reciprocity and legal control are matched alongside the treatment service that should be provided. In this way the rights of service users and carers can be preserved. A necessary aspect of regulating the use of leave of absence would be to have a system of registration and monitoring usage, including a record of clinical/professional judgement about why the leave is necessary, for how long and under what conditions, alongside the options available to support carers and service users throughout this period of absence.

Recommendations

1. The Group recommends that there should be careful deliberation about how professional judgements of capacity, as described in the Legal Framework paper, are made in ways that would be protective of patients rights. Service user and carer representatives should be involved in this discussion.
2. The Group recommends that, when needed, adequately resourced places of safety should be made available to professionals during the assessment process in the community.
3. The Group recommends that all professionals involved in substitute decision making should be trained and approved for purpose, including GPs, social workers and nurses.
4. The Group recommends that the role of the approved social worker (ASW) should be continued under mental health law.
5. The Group recommends that the review considers the use of an ‘approved clinician’ (either an approved GP or approved nurse) who may make the medical/clinical recommendation in the substitute decision-making process.
6. The Group recommends that a new emergency detention order which lasts up to 72 hours should be introduced.
7. The Group recommends that a new short term detention order lasting for a maximum of 28 days should be introduced.
8. The Group recommends that the nearest relative should no longer be applicant, but professionals should be required to thoroughly consult carers and/or ‘named persons’ during the process of compulsory admission.
9. The Group recommends that resources are used to sustain systems of peer and professional advocates, and arrangements made for the use of appointees and/or advanced directives.
10. The views of the Group were divided on the use of forms of involuntary care and treatment in the community. The Legal Framework paper is recommending the introduction of such powers in the form of Compulsory Welfare and Healthcare Orders. It is recommended that this issue is further discussed in consultation with service users, carers and professionals.

References

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