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932 Chapter 20 Legal issues Introduction Practising psychiatrists must be familiar with the laws in their country re lating to mental health. There are five broad areas of law of interest to psychiatrists: (1) common law as it relates to medical treatment decisions; (2) the law relating to incapable adults; (3) the law regulating the treat ment of patients with mental disorder; (4) laws and regulations relating to confidentiality; and (5) the criminal law in relation to mentally disordered offenders. In this book, the subjects of criminal law and mentally disordered of fenders are dealt with in E Chapter 16. The remaining topics are covered within this chapter. As has been noted in the chapter on forensic issues, law is both parochial and dynamic. The last two decades have seen significant changes in the laws relating to psychiatric practice, and further changes are likely over the decade to come. The current mental health and incapacity legislation covering the four legal jurisdictions within the British Isles is sum marized in Box 20.1. Although it is useful to have access to the relevant statute law, it is im possible to get a good understanding of how the law works in practice through reading the texts of the legislation. This develops through training, experience, and discussion with colleagues. The trainee psychiatrist should be aware of the current laws in their jurisdiction which affect their current area of practice. They should aim to have detailed knowledge of the parts of the legislation used day-to-day, and particularly in emergency situations. Alongside the Acts themselves, codes of practice and guidance notes are available that give practical advice on the use of the Acts. Beyond these, the trainee should know where to go for further information and advice (e.g. senior colleagues, hospital legal office, commissions). They should be wary of mental health ‘lore’. Much misinformation about legislation is prom ulgated without reference to what is actually correct. For example, some believe that UK legislation does not permit the detention of someone who is drunk, even if they are also depressed or acutely psychotic. It is important to remember that the law often cannot resolve clinical dilemmas. For example, if a detained patient takes an OD, mental health le gislation cannot be used to impose physical treatment. This does not mean that you can do nothing, knowing that you are acting (or not acting) legally. In this situation, common law may allow, and medical ethics may dictate, that

physical treatment be imposed.

Introduction Box 20.1 Legislation across the British Isles England and Wales Care and treatment of patients with mental disorder is regulated by the Mental Health Act 1983. Following failed attempts to produce a com pletely updated Act, the Westminster Parliament passed the Mental Health Act 2007 in July 2007. This amends the 1983 Act in several im portant areas. The majority of its provisions will be enacted between October 2007 and October 2008. The Mental Capacity Act 2005, which regulates decision-making on behalf of incapable adults, was implemented in 2007. Scotland The Mental Health (Care and Treatment) (Scotland) Act 2003 replaced the previous Mental Health (Scotland) Act 1984 in October 2005. It was later amended by provisions in the Mental Health (Scotland) Act 2015. The Adults with Incapacity Act 2000 consolidated and clarified the law relating to incapable adults, replacing a number of outdated legal instru ments which had previously been used for the role. Northern Ireland Care and treatment of patients with mental disorder are currently regu lated by the Mental Health (Northern Ireland) Order 1986, amended by the Mental Health (Amendment) (Northern Ireland) Order 2004. An in dependent and wide-ranging review of mental health law was initiated in 2002 under the chairmanship of Professor David Bamford. The resulting report was the basis for the Mental Capacity Act (Northern Ireland) 2016, which combines mental health and incapacity provisions in one statute. This Act was enacted in May 2016 but awaits implementation at the time of writing. Republic of Ireland The Mental Health Act 2001 replaced the Mental Treatment Act 1945 and various modifying Acts passed in 1953, 1961, and 1981. The Assisted Decision-Making (Capacity) Act 2015 was enacted in December 2016 and is being gradually implemented at the time of writing.

934 Chapter 20 Legal issues The development of mental health law Mental health legislation in the UK has its origins in the eighteenth century, which saw the passing of both the Vagrancy Law, allowing local magistrates to order the confinement of the ‘furiously mad and dangerous’, and the Act for the Regulation of Private Madhouses which allowed for licensing and inspection of private asylums and required a medical certificate of insanity before the confinement of ‘non-pauper’ patients. The former law primarily arose out of concerns about the risk posed to the general public by the mentally ill—the latter from concern to protect the interests of vulnerable patients. The Lunacy Act of 1890 gave magistrates authority to detain ‘lunatics, idiots, and persons of unsound mind’ within private asylums. The Mental Deficiency Act 1913 expanded and clarified these powers but also ex panded the role of the state in the regulation and supervision of the care of the mentally disordered by reorganizing the Victorian Lunacy Commission as the Board of Control for Asylums. This was established as a department of central government with powers to inspect asylums, review compulsory detention, investigate complaints about treatment of patients, and monitor the working of compulsory measures. In 1926, the Royal Commission on Lunacy and Mental Disorders pro duced a report which led to the Mental Treatment Act 1930. This Act was based on a view of mental disorders as similar to medical illness and envis aged treatment and rehabilitation, rather than preventative detention, as the goal of admission to hospital. It allowed for outpatient work by medical staff in mental hospitals and, for the first time, provided for voluntary treat ment in hospital. In 1957, the report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the Percy Report) was published. The Commission recommended that: ‘the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is ap plied to people who need care because of other types of illness’ and noted that: ‘the majority

of mentally ill patients do not need to be admitted to hospital as inpatients'. The subsequent Mental Health Act (1959) allowed most psychiatric admissions to occur voluntarily and changed the procedure for compulsory detention in hospital from a judicial to an administrative process. The Percy Report marked the turning point in official policy, from hospital-based to community-based systems of care. In England and Wales, the Mental Health Act 1983 narrowed the def initions of categories of mental disorder, excluding certain categories of patients from compulsory treatment. It also established regulations and safeguards governing treatment without consent. Similar Acts were passed for Scotland in 1984 and for Northern Ireland in 1986. At the end of the twentieth century, the UK government established the Richardson Committee to again review mental health legislation in England and Wales, and a draft bill followed in 2002. This attracted wide spread criticism for a perceived overemphasis on public protection and under-emphasis on the rights of individuals with mental disorder, seeming to reverse progress made over the previous century. An Act amending,

The development of mental health law rather than replacing, the 1983 Act was finally passed in 2007. In Scotland meanwhile, in 1999, the newly re-established Scottish Parliament tasked the Millan Committee with a wide-ranging review of Scotland's mental health laws. Its report was the basis for the complete replacement of the 1984 Act with the Mental Health (Care and Treatment) (Scotland) Act 2003. In NI, the Mental Capacity Act (Northern Ireland) 2016 will, when fully enacted, replace the Mental Health (Northern Ireland) Order 1986, as well as pro vide a legislative basis for incapacity law in the province. Since the turn of the century, a further innovation in mental health law has been the passage of Acts specifically covering the care and treatment of incapable patients—in Scotland in 2000, in England and Wales in 2005, the RoI in 2015, and NI in 2016.
A future challenge for lawmakers across the British Isles is the implementation of the rights specified in the European Convention of Human Rights and the United Nations Convention on the Rights of Persons with Disabilities into UK and Irish mental health law and incapacity law.

936 Chapter 20 Legal issues Consent to treatment A fundamental principle of medical care is that treatment of a patient should be with their consent. A patient has a right to decide for them selves which treatments to undergo and which treatments to refuse. This right is retained, even where refusal of treatment could result in death or significant deterioration in health. In the majority of cases, doctors should treat their patients according to this principle; treatment without consent (E Treatment without consent, p. 938) is possible only in certain circum stances, constrained by appropriate laws. Validity of consent For consent to be valid, the patient must have capacity to make medical treatment decisions, the consent must be informed (i.e. the patient has fully understood the details and implications of what is proposed), and it must be given freely (i.e. not given under duress). Capacity to make treatment decisions Capacity is a legal concept, meaning the ability to enter into valid contracts. It is gained on adulthood and is presumed to be present throughout the life span, unless permanently or temporarily lost. Under common law, there is a presumption of capacity in adults, i.e. it is to be assumed that an adult re tains full capacity unless there is evidence that it has been lost. Assessments of capacity are made on the balance of probabilities. Capacity is not an 'all-or-nothing' quality, i.e. one may have capacity for some decisions, but not others. Within incapacity law (E Mental Capacity Act: England and Wales, p. 942; E Incapacity Act: Scotland, p. 944), cap acity is divided into two broad categories: capacity for financial decisions and capacity for personal welfare decisions. A patient's capacity or incap acity should be judged in relation to the required decision, rather than being inferred from the presence

of any mental illness or disability. In order to have capacity to make medical treatment decisions, the pa tient must understand the decision, understand the alternative possible courses of action, assess the merits and risks of these choices, retain memory of the decisions and the reasons for them, and be able to com municate their intent. Informing consent Doctors have a duty to provide to the patient sufficient information about any proposed treatment to enable them to make an informed treatment decision. The amount and type of information provided will depend on the nature of the condition, the complexity and risks of the proposed treat ment, the clinical situation, and the patient's own wishes. The aim should be to provide the patient with a balanced and accurate view of their diagnosis and prognosis, the nature and purpose of the proposed treatment, any al ternative treatment options, and the likely risks and side effects, answering any questions honestly and only withholding information if its disclosure would cause the patient serious harm.

Consent to treatment Forms of consent Consent may be implied (i.e. the patient does not object to, and cooper ates with, the procedure) or may be express (i.e. oral or written permis sion is explicitly asked for and recorded, often on a detailed consent form). Generally, express consent is obtained for non-trivial or invasive proced ures, and for some interventions (e.g. operations), it is mandatory. Advance statements Sometimes, in cases where a patient has a progressive disease, although they currently lack capacity to consent or refuse treatment, they may have indicated, when greater capacity existed, their treatment preferences in an advance statement ('advance directive' or 'living will'). These wishes should be given due regard provided: • The decision in the advance statement is clearly applicable to the present circumstances. • There is no reason to believe that the patient has changed their mind. • If you act against an advance statement, then you should be able to justify this. Where such a statement is not available, the patient's known wishes should be taken into account using the common law principle of 'best interests' (E Common law, p. 940). The Montgomery case A significant recent change to the rules guiding consent in the UK resulted from the Montgomery v Lanarkshire case of 2015. This was an obstetric case where there was an alleged failure by the obstetrician to disclose risks associated with vaginal delivery. The ruling in the patient's favour refined the UK standards for informed consent. In future, doctors must make patients aware of any 'material risks' of a proposed treatment and of any reasonable alternatives. In the words of the Supreme Court: 'The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it'. 'You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.' General Medical Council (2013) Good medical practice, paragraph 17 https://www.gmc-uk.org/-/media/documents/Good_medical_practice___English_1215.pdf_51527435.pdf [M accessed 13 July 2018]

938 Chapter 20 Legal issues Treatment without consent In general, treatment of a patient can, and should, only proceed with their valid consent. There are, however, situations where treatment can take place without consent, and these situations (appropriately) have legal safe guards. There are four broad areas where treatment may take place despite lack of consent: (1) treatment undertaken under common law; (2) treat ment under the provisions of an Incapacity Act; (3) treatment under the provisions of a Mental Health Act; and (4) treatment authorized by a court. For psychiatrists, the majority of treatment decisions involving consid eration of non-consensual treatment will relate to psychiatric patients. However, in other fields of medicine, situations may

arise where decisions must be made regarding treatment without consent. Often a psychiatrist's opinion will be sought because, by the nature of their work, most psychi atrists will have greater knowledge of, and familiarity with, legal issues than their medical counterparts. Also, a patient's reasons for withholding con sent may be thought to be due to a (possibly undiagnosed) mental disorder. Where this is the case, other professionals may not feel they have the clin ical skills to make this diagnosis. Treatment undertaken under common law As noted in E Common law, p. 940, common law 'necessity' may pro vide a doctor with a defence against assault where non-consensual treat ment is given. There may be situations, e.g. the use of sedation in a patient with acute behavioural disturbance where there is a suspected physical or psychiatric cause, when the doctor has to act against a patient's wishes, in order to adequately carry out their duty of care. Treatment in these situ ations is given under common law, even if the patient fulfils the criteria for emergency detention under mental health legislation. Treatment under the provisions of an Incapacity Act The Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000 provide the legal framework guiding the care of incapable adults in England and Wales and in Scotland, respectively. The recently passed Assisted Decision-Making (Capacity) Act 2015 and the Mental Capacity Act (Northern Ireland) 2016 provide similar frameworks for the RoI and NI, respectively. These Acts define incapacity and establish processes and safe guards regulating decision-making on behalf of incapable adults. Treatment under the provisions of a Mental Health Act The majority of patients with a mental disorder receive treatment infor mally and with their consent. For a proportion, however, treatment is au thorized by a Mental Health Act. Four Mental Health Acts cover the four legal jurisdictions within the British Isles. These vary, but all allow for deten tion in hospital and for compulsory treatment of mental disorder. They all specify restrictions on the use of certain treatments (psychosurgery, ECT, and compulsory prescription of medication beyond a certain period) and describe processes of appeal and oversight of the treatment of detained patients. In general, treatment of unrelated medical disorders cannot be authorized by a Mental Health Act.

Treatment without consent Treatment authorized by a court In a small number of cases, doctors will ask for a court's decision regarding a decision to treat a patient without their consent. In general, these will be non-urgent, but potentially controversial, cases where statute law has no clear role and where there does not appear to be any relevant legal prece dent. Often the judgements in these test cases become important subse quently in guiding the approach to similar cases.

940 Chapter 20 Legal issues Common law Common law is that body of law which is derived from previous deci sions of the courts, in contrast with statute law—which is law created by legislative bodies (e.g. regional, national, and supranational parliaments). Common law can arise from: • Long-established custom and practice. • Clarification of the meaning and extent of statute by the courts. • Statements of law by judges ruling on cases where no applicable law exists or fits precisely. The common law is dynamic and changes and expands as cases are heard and judgements are handed down. For this reason, it is impossible to be aware of all potentially applicable judgements. Doctors should make every effort to be up-to-date with current debates and decisions within their own specialty. They should also seek clarification from senior colleagues, their hospital legal advisors, or their professional bodies in potentially contentious cases. Common law principles for medical treatment decisions • Act in accordance with the patient's wishes: a fundamental principle of the doctor–patient relationship. Doctors should, in general, respect the

patient’s autonomy in decision-making, only acting against the patient’s wishes in very limited circumstances. • Presume capacity in adults: a patient over the age of 16 is presumed to have capacity to make treatment decisions, unless there is evidence to the contrary (assessed on the balance of probabilities). • Apply ‘reasonableness’ test: a frequently used consideration in law is the test of what a hypothetical ‘reasonable man’ would do in the circumstances. For medical treatment decisions, the test is what the ‘reasonable doctor’ would have done in those circumstances. • Act in the patient’s ‘best interests’: in emergency situations, it may not be possible to obtain consent (e.g. in an unconscious RTA victim requiring drainage of an extradural haematoma); here, it is accepted that the doctor’s overriding duty is to preserve life. • Doctrine of necessity: ‘necessity’ provides a defence against a potential criminal charge that you have assaulted a patient by giving non- consensual treatment. A doctor may therefore give emergency treatment to preserve life and prevent significant deterioration in health. • Act in accordance with a recognized body of opinion: it is accepted in law that medicine is not an exact science—that in any situation, multiple courses of action may be potentially reasonable. However, there is an expectation that any treatment decision is considered suitable by a body of professional opinion (the ‘Bolam test’). • Act in a logically defensible manner: the Bolitho case (see Box 20.2) added consideration to the Bolam test by stating that medical decisions made, in addition to being in accordance with a recognized body of opinion, must be logically defensible in the circumstances.

Common law • Consider use of applicable law: the treating doctor should consider whether the provisions of any statute law provide guidance and additional protection for the patient. However, they should not delay urgent treatment to enact the provisions of statute law. • Consider request for court judgement: in difficult situations, consult more experienced colleagues; where appropriate, seek legal advice on whether it is appropriate to apply to the court for a ruling. Box 20.2 Significant rulings The Gillick case1 Victoria Gillick, a mother of five daughters, challenged the right of her Local Health Authority to advise doctors that contracep tives could be prescribed for under 16s without parental consent. The House of Lords ruled that, in relation to medical treatment, ‘the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is pro posed’. This ruling established the concept of ‘Gillick competence’, which applies to treatment decisions made by minors in England and Wales. Section 2(4) of the Age of Legal Capacity (Scotland) Act 1991 establishes the same principle within Scottish statute law. The Bolitho case2 Prior to this case, the standard of care expected in medical negligence cases had been judged according to the ‘Bolam test’.3 This established the principle that a doctor is not guilty of negligence if he has acted in accordance with a responsible body of professional opinion. This case centred on an individual who, as a child, had suffered brain damage as a result of a cardiac arrest induced by respiratory failure. The court’s finding was that, even if a body of professional opinion existed which held that the action was reasonable, the defendant could still be judged negligent if the judge held the opinion that no logical basis for the opinion had been shown to the court. The Ms B case4 As a result of a serious illness, a Ms B had been ren dered paralysed and dependent on artificial ventilation for survival. She re fused consent for continued ventilation, but in view of the inevitable fatal outcome, the hospital refused to accept her refusal. She was assessed by several consultant psychiatrists whose opinion was that she retained full capacity. She applied for a court decision where the ruling was that once her capacity had been established, any further treatment without con sent was unlawful. The court also gave the opinion that should doctors treating her feel unable to treat her in accordance with her wishes, they had a

duty to transfer her care to other doctors. Ms B was subsequently transferred to another hospital where, following withdrawal of artificial ventilation, she died. 1 Gillick v West Norfolk and Wisbech AHA All ER [1985], 3 All ER 402. 2 Bolitho v City and Hackney HA [1997] 3 WLR. 3 Bolam v Friern Hospital Management Committee [1957] 2 All ER 118. 4 Re B (Adult: Refusal of Treatment) [2002] 2 FCR1; [2002] 2 All ER 449.

942 Chapter 20 Legal issues Mental Capacity Act: England and Wales The Mental Capacity Act 2005 provides the legal framework guiding decision-making on behalf of those who lack capacity to make decisions for themselves. The Act applies to individuals over the age of 16 in England and Wales. Principles The Act is underpinned by a set of five key principles set out in Section 1: • Presumption of capacity—a person is assumed to have capacity unless it is established that they lack capacity. • All practical steps taken to allow autonomy—a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. • Allow unwise decisions—a person is not incapable merely because they make an unwise decision. • Best interests—an intervention under the Act on behalf of a person who lacks capacity must be in their best interests. • Least restrictive option—any intervention under the Act should restrict as little as possible their basic rights and freedoms. Assessment of incapacity Sections 2 and 3 set out a two-stage test for assessing incapacity: • A person lacks capacity if they are unable to make a decision for themselves in relation to any matter because of a permanent or temporary impairment in the functioning of the mind. • A person is unable to make a decision for themselves if they are unable: • To understand the information relevant to the decision. • To retain that information for a sufficient period to make a decision. • To use or weigh that information in making the decision. • To communicate their decision. Judgements about incapacity are to be made on the balance of probabilities. Lack of capacity is not to be presumed, based on a person's age or appear ance, on any aspect of their behaviour, or on any condition or disorder from which they suffer. The Act specifies certain decisions that cannot be made by one person on behalf of another. These are: agreeing to marriage, civil partnership or divorce, consent to a sexual relationship, and casting a ballot in an election. Techniques covered by the Act Lasting powers of attorney (LPA) A person may appoint an attorney to act on their behalf if they should lose capacity in the future. This is like the current enduring power of attorney (EPA) in relation to property and affairs, but the Act also allows people to empower an attorney to make health and welfare decisions. Before it can be used, an LPA must be registered with the Office of the Public Guardian. Court-appointed deputies The Act provides for a system of court- appointed deputies. Deputies will be able to be appointed to take deci sions on welfare, healthcare, and financial matters, as authorized by the new Court of Protection, but will not be able to refuse consent to life-sustaining

Mental Capacity Act: England and Wales treatment. They will only be appointed if the court cannot make a one-off decision to resolve the issues. Advance decisions The Act allows patients to make an advance decision to refuse treatment if they should lack capacity in the future. The Act sets out safeguards of validity and applicability in relation to advance decisions. An advance decision concerning life-sustaining treatment must be in writing, signed, and witnessed, and there must be an express statement that the decision stands 'even if life is at risk'. Protection from liability when providing care and treatment to an incapable adult Section 5 of the Act authorizes healthcare staff to carry out personal care, healthcare, and medical treatment in an incapable adult, without fear of liability. The care provider must establish that the patient lacks capacity and that the proposed treatment is in their best interest. If this is the case, then the care provider does not incur any

liability in relation to the Act that they would not have incurred if the adult had had capacity to consent in relation to the matter and had consented to the treatment. Bodies with powers under the Act Court of Protection This Court has jurisdiction relating to the whole Act. It has its own procedures and nominated judges. It is able to make declar ations, decisions, and orders affecting people who lack capacity and make decisions for, or appoint, deputies to make decisions on behalf of people lacking capacity. It deals with decisions concerning both property and affairs, as well as health and welfare decisions. The Public Guardian The Public Guardian has several duties under the Act and is supported in carrying these out by an Office of the Public Guardian (OPG). The Public Guardian and his staff will be the registering authority for LPAs and deputies. They supervise deputies appointed by the Court and provide information to help the Court make decisions. Deprivation of Liberty Safeguards The Deprivation of Liberty Safeguards (DoLS) are contained in an amend ment to the original Act and provide additional protections where an indi vidual is: 'under continuous supervision and control and is not free to leave'. They can be applied to individuals in a hospital or care home only; depriv ation of liberty elsewhere must be authorized by the Court of Protection. An application for authorization is made to the Local Authority that will appoint two trained assessors—one mental health assessor (a doctor ap proved under Section 12) and one 'best interests' assessor (often a social worker). They will confirm that six tests are satisfied: the person is over 18yrs, they have a mental disorder, they lack capacity, deprivation of liberty is in their best interests, MHA detention is not current or preferable, and deprivation of liberty is not in conflict with other decision-making authority (e.g. a valid advance decision). DoLS allows for legal representation, access to Independent Mental Capacity Advocates (IMCAs), and the right of ap peal to the Court of Protection.

944 Chapter 20 Legal issues Incapacity Act: Scotland The Adults with Incapacity (Scotland) Act 2000 provides the legal frame work regulating those who make decisions on behalf of adults with im paired capacity in Scotland. It covers financial and personal welfare decisions (which include decisions about medical treatment). The Act applies to indi viduals over the age of 16yrs. Principles Those making decisions on behalf of another are required to take account of the following fundamental principles, as in Section 1: • Benefit—any intervention in the affairs of an incapable adult must benefit the adult concerned, and this benefit must not be reasonably achievable without the intervention. • Least restrictive option—any intervention must restrict the freedom of the adult as little as possible. • Consider the adult's wishes—decisions made on behalf of an incapable adult must take account of their currently and previously expressed wishes on the subject. • Consultation with relevant others—anyone making decisions on behalf of an incapable adult must take account of the views of the adult's nearest relative or primary carer, and of the adult's guardian, welfare attorney, or continuing attorney (if they exist). • Encourage residual capacity—the adult should be encouraged to exercise whatever capacity is still present. Assessment of capacity Under the Act, incapacity means to be incapable of: • Acting; or • Making decisions; or • Communicating decisions; or • Understanding decisions; or • Retaining the memory of decisions. Capacity is task-specific and must be judged in relation to the decision under consideration. In assessing capacity under the Act, the practitioner should consider for this particular decision whether the individual: • Understands what is being asked and why. • Understands that the information is personally relevant to them. • Is aware of the alternative choices available. • Can weigh up the risks and benefits associated with the alternative choices. • Has sufficient memory ability to retain the relevant information. Additionally, the practitioner should consider whether the decision is con sistent with the patient's background, beliefs, and

previously expressed wishes when greater capacity existed. It is important to note that a person is not incapable simply because they have a mental or physical illness or a learning disability.

Incapacity Act: Scotland Techniques covered by the Act Powers of attorney A capable adult can provide for eventual incapacity by granting power of attorney to another person. A continuing power of at torney relates to financial decisions; a welfare power of attorney relates to personal welfare decisions. The latter becomes active only when the adult loses capacity in relation to the welfare decision in question. Intromission with funds An individual can apply to the Public Guardian for authority to gain access to the adult's finances, in order to fund the adult's living expenses. Management of residents' finances Following review by a medical practi tioner certifying incapacity in relation to financial affairs, registered establish ments (e.g. nursing homes) can manage the financial affairs of residents with impaired capacity up to a prescribed limit. Guardianship and intervention orders Following application, supported by at least two medical recommendations, the Sheriff Court can grant an in dividual ongoing authority to make financial or personal welfare decisions on behalf of an adult. The former is financial guardianship, and the latter welfare guardianship. For decisions which require a 'one-off' intervention, the Sheriff can grant a financial or welfare intervention order covering the proposed intervention. Medical treatment Under Part 5 of the Act, if a medical practitioner re sponsible for the medical treatment of an adult is of the opinion that the adult is incapable in relation to a decision about the medical treatment in question, he may issue a certificate of incapacity authorizing the treatment. The certificate must state the nature and likely duration of the incapacity and the proposed treatment. Bodies with powers under the Act The Office of the Public Guardian Supervises individuals authorized under the Act to make decisions on behalf of another. It maintains a register of continuing and welfare powers of attorney, guardianships, and intervention orders; authorizes access to funds; has powers to investigate complaints on matters related to the financial affairs of an incapable adult. The Mental Welfare Commission for Scotland (MWC) In addition to its duties under the MHA, the MWC guides and supervises the actions of those appointed to make welfare decisions on behalf of an incapable adult. The Sheriff Court Applications for guardianships or intervention orders are made to the Sheriff Court. This court is also the forum for appeals against medical treatment decisions. Local authorities The local authority has a duty to investigate circum stances where the personal welfare of an adult in the community may be at risk due to incapacity, to supervise appointed attorneys and guardians, and to investigate complaints in relation to those exercising welfare powers. Additionally, they have a duty to apply for intervention or guardianship or ders and to subsequently act as welfare guardian where necessary and no- one else is applying to do so.

946 Chapter 20 Legal issues Incapacity Act: Northern Ireland The Mental Capacity Act (Northern Ireland) 2016 received Royal assent in May 2016 but, at the time of writing, has not yet come into force. It is a combined incapacity and mental health law, unique in this respect in the British Isles, and will introduce incapacity law to NI and eventually replace the Mental Health (Northern Ireland) Order 1986 for those over 16yrs. Principles The principles are detailed in Sections 1 and 2 of the Act and must be ap plied where determinations under the Act are made on behalf of those who lack capacity. • Decision specific: a person should not be treated as lacking capacity, unless it is established that they lack capacity in relation to the decision in question. • All possible support: patients are not considered as lacking capacity, unless all possible assistance has been given to enable independent decision-making. • Presumption of capacity: patients are not considered as lacking capacity on the basis of age, any physical or mental health condition, or personal

characteristics. • Allow unwise decisions: patients are not considered as lacking capacity simply because they make unwise decisions. • Best interests: substitute decisions must meet the best interests principle. The Act follows the English and Welsh approach, rather than the Scottish approach, to incapacity powers, in that rather than specifying legal powers to act, it provides protection for criminal or civil liability, provided its prin ciples and procedures are followed. Test of incapacity A person over 16yrs lacks capacity if they are ‘unable to make a decision’ for themselves ‘because of an impairment of, or a disturbance in the func tioning of, the mind or brain’. ‘Unable to make a decision’ means they are unable to: • Understand the relevant information. • Retain in memory the relevant information. • Appreciate the personal relevance of the information and weigh it in the decision-making process. • Communicate the decision (by verbal or other means). Powers under the Act Advance decisions Individuals with capacity can make an advance decision to refuse specified treatments. There is then no protection from liability for medical practitioners if they carry out or continue treatment which conflicts with an effective advance decision. Lasting Power of Attorney (LPA) Individuals with capacity can appoint an other person as an LPA holder. This can delegate decisions on property and affairs to the LPA holders and authorize them to make decisions on care and treatment and personal welfare after the point at which the individual loses capacity.

Incapacity Act: Northern Ireland Court Appointed Deputy The High Court is given powers to make deci sions as to the presence of capacity and to appoint court-appointed dep uties with similar powers to an LPA. Criminal Offences The Act creates a number of offences, including ill treat ment or neglect, and unlawful detention of incapable patients. Short-term detention The Act will allow for detention in hospital for up to 28 days after application by an ‘appropriate healthcare professional’ (usually an approved social worker) with a medical report. Bodies with powers under the Act The Act creates a Public Guardian who maintains a register of LPAs and court-appointed deputies and will supervise their activities via court visitors. It also places a requirement on Health and Social Care Trusts to establish Independent Advocacy services for their patients.

948 Chapter 20 Legal issues Incapacity Act: Republic of Ireland The future legal framework for decision-making with, or on behalf of, those who lack capacity in the RoI is the Assisted Decision-Making (Capacity) Act 2015. This Act has replaced the previous nineteenth-century legislation [Marriage of Lunatics Act 1811 and Lunacy Regulation (Ireland) Act 1871] and the former system of Wards of Court. It is intended to provide modern incapacity legislation, in line with the United Nations Convention of the Rights of Persons with Disabilities. The Act uses a functional definition of incapacity—capacity is assessed in relation to the decision in question and is no longer viewed as an ‘all-or- nothing’ phenomenon. There is a presumption of capacity in adults and a graded approach to assistance in those with impaired capacity. Supported decision-making The Act adopts a graded approach to supported decision-making and en visages three forms of assistance. Former ‘wards of court’ are to be dis charged from wardship and instead directed towards the most appropriate support option under the new Act. Assisted decision-making Here the person appoints a ‘decision-making as sistant’ via a formal ‘assistance agreement’ to aid them in gathering and understanding information and to assist them in expressing their decision. They retain decision-making responsibility. Co-decision-making Here the person appoints a ‘co-decision-maker’, again via a formal ‘assistance agreement’ to aid and share their decision-making. The responsibility for decisions is shared jointly. Decision-making representative Where the person is unable to make sup ported decisions, the Act allows the Circuit Court to appoint a ‘decision- making

representative’. They must make decisions on the person’s behalf, in line with their expressed wishes, where possible, and according to the principles of the Act. Powers under the Act At the time of writing, the Act has received Presidential assent and a phased commencement is planned over the coming years—therefore, as yet, there has been no clinical experience of its use. Enduring Powers of Attorney (EPA) Previously, EPAs could be granted under the Powers of Attorney Act 1996. The new Act extends their role to potentially include health decisions, as well as financial and welfare deci sions. They do not operate until the person lacks capacity in relation to the specified decision. They must be in writing and registered with the Director of the Decision Support Service. Advance healthcare directives The Act allows capable adults to make ad vance healthcare directives, which will then come into effect after a future loss of capacity. These directives can stipulate future healthcare preferences and can specify refusal of life-sustaining treatment. They are not legally binding on medical practitioners, but the practitioner must be prepared to justify non-compliance with their stipulations.

Incapacity Act: Republic of Ireland Criminal offences The Act introduces a number of criminal offences in relation to incapable adults, including using fraud or coercion in relation to supported or proxy decision-making, making a false statement in relation to an intervention under the Act, and ill treatment or wilful neglect of an incapable adult. Bodies with powers under the Act The Act sets up a Decision Support Service, headed by a Director, within the Mental Health Commission. This body is tasked with overseeing assistants, co-decision makers, decision-making representatives, and EPAs and has the power to investigate complaints. Additionally, it is tasked with promoting the legislation and the future preparation of a code of practice.

950 Chapter 20 Legal issues Mental Health Act: England and Wales 1 Introduction The MHA 1983 governs the care and treatment of patients with mental dis order within England and Wales. The Act was amended in several significant areas by the MHA 2007 (see Box 20.3). Principles The 1983 Act did not contain a statement of principles. Section 8 of the 2007 Act directed the Secretary of State to include a statement of prin ciples in a future revision of the code of practice. The five ‘overarching principles’, as stated in the 2015 revision of the code, are: • Least restrictive option and maximizing independence—informal treatment is the preferred option. Where a patient is detained, their ongoing independence should be supported as far as possible. • Empowerment and involvement—patients and their relatives and carers should be fully involved in decisions about their care. • Respect and dignity—professionals should treat patients and their relatives and carers with respect and dignity. • Purpose and effectiveness—care should be patient-centred, recovery-focused, and in line with current best practice. • Efficiency and equity—the provision of services for patients with mental health needs should be equitable with that for physical disorders. Definition of mental disorder The 2007 Act defines mental disorder as ‘any disorder or disability of the mind’, replacing four subdivisions of mental disorder in the 1983 Act. The code of practice gives a non-exhaustive list of conditions: affective dis orders, schizophrenia and delusional disorders, neurotic, stress-related, and somatoform disorders, organic mental disorders (dementia, delirium, or brain injury or damage), personality disorders, disorders caused by psycho active substance use, eating disorders, learning disabilities, and behavioural and emotional disorders of children and young people. Other definitions Approved doctor—under Section 12(2), the Secretary of State may approve a registered medical practitioner as having special experience in the diag nosis and treatment of mental disorder. This is done in practice through the regional health authority. Responsible clinician—the practitioner in charge of the patient’s treat ment, usually a consultant

psychiatrist [previously referred to as the respon sible medical officer (RMO)]. Approved mental health professional (AMHP)—a professional (usually a social worker) who has undergone specific training and assessment and is appointed for the purposes of the Act as having competence in dealing with individuals with mental disorder [previously referred to as the approved social worker (ASW)]. Nearest relative—determined by who is first on the following list: spouse or civil partner, child, parent, sibling, grandparent, grandchild, uncle or aunt, nephew or niece. If two relatives are of equal standing, then the elder

Mental Health Act: England and Wales 1 prevails. If a patient lives with a relative or has lived with a non-relative as a spouse for 6mths, then that person is the nearest relative. Mental Health Review Tribunal (MHRT)—legal forum to which a patient or a nearest relative can appeal against detention. The MHRT has three mem bers: a legally qualified chair, a medical practitioner, and a lay member. It must discharge a patient if the criteria for detention no longer apply. Mental Health Act Commission (MHAC)—the MHAC monitors the use of the MHA and the care of patients subject to it. It also investigates certain complaints, appoints second opinion doctors, and maintains the code of practice. It produces a biennial report. Second opinion appointed doctor (SOAD)—an independent doctor ap pointed by the Secretary of State (in practice by the MHAC), who gives a second opinion regarding treatment which can be given without the patient's consent under Section 57 or section 58. Box 20.3 Changes to the 1983 Act in the 2007 Act • Definition of mental disorder A single definition of mental disorder applies throughout the Act, which abolishes the previous four subcategories of disorder. • Criteria for detention The previous 'treatability' and 'care' tests are abolished and replaced by a new 'appropriate medical treatment' test applying to the longer-term powers of detention. This does not allow continued compulsory detention, unless medical treatment which is appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient. • Broadened professional roles Approved social workers (ASWs) are replaced by approved mental health professionals (AMHPs), and non- social workers can enter this role, subject to appropriate training. The responsible medical officer (RMO)'s role is replaced by that of the responsible clinician, allowing non-medical staff, such as psychologists, social workers, and nurses, to undertake this role. • Nearest relative (NR) Patients are given the right to make an application to change their NR, and courts are enabled to displace an NR where there are reasonable grounds for doing so. The list of NRs is amended to include civil partners. • Supervised community treatment The 2007 Act introduces supervised community treatment (SCT) which is described in E Supervised community treatment, p. 955. • Mental Health Review Tribunal (MHRT) The Act introduces a single tribunal for England, alongside one in Wales, and introduces order-making power to reduce the time before a case has to be referred to the MHRT by hospital managers. • Age-appropriate services Hospital managers must ensure that patients aged under 18yrs admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age. • Advocacy There is a right to independent mental health advocacy. • Use of ECT New safeguards are introduced.

952 Chapter 20 Legal issues Mental Health Act: England and Wales 2 Compulsory measures The main procedures allowing compulsory detention in hospital are Section 2 (admission for assessment), Section 3 (admission for treatment), Section 4 (emergency admission), and Section 5(2) (emergency detention of informal inpatient). Compulsory admission should usually be under Section 2 or 3; Section 4 is only used rarely, in a genuine emergency where an approved doctor is not available soon enough. Emergency detention—Section 4 allows the emergency detention of pa

tients who have not yet been admitted to hospital (this includes those in A&E, outpatient departments, and day hospitals); Section 5(2) is similar but applies to patients who have already been admitted to hospital (whether in a psychiatric or non-psychiatric ward). • For Section 4, the application is made by the nearest relative or AMHP and requires recommendation from one registered medical practitioner. • For Section 5(2), the medical recommendation must be by the responsible clinician or his nominated deputy; this will usually be the duty psychiatrist, but the nomination should be made before the relevant period of duty. Involvement of the nearest relative or AMHP is not required for Section 5(2). • The duration of detention is 72hrs, during which an assessment must be undertaken to determine if detention under Section 2 or 3 is warranted. • Section 5(4) allows nurses (of the prescribed class) to hold an informal inpatient in hospital for up to 6hrs to allow for a medical assessment. Admission for assessment—an application for detention under Section 2 may be made by the nearest relative or AMHP and requires two medical recom mendations, one of which must be by an approved doctor. Duration of detention is 28 days. Following Section 2, an application may be made for detention under Section 3. Alternatively, the patient may remain in hospital informally or be discharged. Admission for treatment—an application for detention under Section 3 is made in a similar manner to Section 2. Duration of detention is initially 6mths, which may be renewed for a further 6mths, and then 12-monthly thereafter. Treatment of patients subject to compulsion • A patient detained in hospital (except under emergency provisions) may be given medication for mental disorder for up to 3mths, whether they consent and/or have capacity or not. • Under Section 58, medication for over 3mths or ECT requires the patient's consent (the responsible clinician completes Form 38) or, if the person refuses or is incapable of consenting, agreement of a SOAD (who issues Form 39). • Under Section 62, treatment that is urgently necessary may be authorized by the responsible clinician without consent or a second opinion; this is usually used for giving ECT to severely ill and at-risk patients, while awaiting a second opinion.

Mental Health Act: England and Wales 2 • Under Section 57, the patient's consent and agreement of a SOAD are required if any patient (whether detained or informal) is to receive neurosurgery for mental disorder or surgical implantation of hormones to reduce ♂ sex drive. Leave, absconding, and transfer Procedures allow for patients to be granted leave of absence with the au thorization of the responsible clinician (Section 17); for patients to be taken into custody and returned to hospital if they abscond (Section 18); and for patients to be transferred between hospitals (Section 19). Review Patients subject to emergency detention have no right of appeal. Patients detained under Section 2 or 3, or subject to guardianship under Section 7, may appeal to an MHRT. The nearest relative may also appeal against Section 3 or 7. One appeal is allowed during each period of compulsion. The responsible clinician may terminate a patient's detention at any point.

954 Chapter 20 Legal issues Mental Health Act: England and Wales 3 Aftercare following detention Care programme approach and Section 117 aftercare Section 117 places a statutory duty on health and social services to pro vide aftercare for patients who have been discharged from detention under Sections 3, 37, 47, or 48 (the last three are sections used for mentally dis ordered offenders; E Chapter 16). The framework within which this after care is planned and implemented is the CPA, which was introduced in 1991 but has since been significantly modified. The CPA should be used for all patients where appropriate, even if they have not been detained in hospital. For patients in hospital, the CPA process should start well before discharge. The key aspects of the CPA are: • A coordinated assessment of the patient's health and social care needs. • The development of a

care plan addressing the identified needs, which will be agreed by the patient and any carers who are involved. • An identified care coordinator (e.g. CPN, social worker, psychiatrist) who will be the main contact and will monitor the care plan. • Regular reviews of the care plan, with changes as necessary (at a minimum, there must be an annual review). • The CPA should be integrated with care management (the process of care coordination used by social services). There are two levels of CPA—standard and enhanced: • Standard CPA—may be appropriate for patients who: require the support or intervention of one agency or discipline; require only low- key support from >1 agency or discipline; are more able to self-manage their mental health problems; have an active informal support network; pose little danger to themselves or others; and are more likely to maintain appropriate contact with services. • Enhanced CPA—may be appropriate for patients who: have multiple care needs requiring inter-agency coordination; are only willing to cooperate with one professional or agency but have multiple care needs; may be in contact with a number of agencies (including the criminal justice system); are likely to require more frequent and intensive interventions; are more likely to have mental health problems coexisting with other problems such as substance misuse; are more likely to be at risk of harming themselves or others; and are more likely to disengage with services. Supervision registers, which identify patients particularly at risk to themselves or others, have been abolished, with the introduction of enhanced CPA. A patient may not be compelled to accept or participate in any aspect of aftercare under Section 117. When aftercare services are no longer re quired, Section 117 duty ends.

Mental Health Act: England and Wales 3 Supervised community treatment The 2007 Act introduces supervised community treatment (SCT) as an op tion for patients following a period of detention in hospital. The stated aim is to address the mental health needs of that group of patients who recover following a period of compulsory hospital treatment but repeatedly leave hospital, discontinue treatment, and relapse, requiring further compulsory treatment (so-called ‘revolving door’ patients). Community Treatment Order—Section 32 of the 2007 Act introduces the Community Treatment Order (CTO), a new power to discharge a patient detained under Section 3 from hospital, subject to them being liable to re call. A CTO is authorized by the responsible clinician, with the agreement of an AMHP. To be valid, a CTO must be in writing and the relevant criteria must be met: • The patient is suffering from mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment. • It is necessary for their health or safety, or for the protection of other persons that the patient should receive such treatment. • Subject to the patient being liable to be recalled, such treatment can be provided without them continuing to be detained in a hospital. • It is necessary that the responsible clinician should be able to exercise the power under Section 17E(1) to recall the patient to hospital. • Appropriate medical treatment is available for the patient. A CTO may specify conditions to which the patient is subject, and a patient can be recalled to hospital if the conditions are not met or if there is a risk of harm to the patient or to other persons if the patient were not re called. The conditions must be for the purpose of ensuring that the patient receives medical treatment or of preventing risk of harm to the patient or to other people, and should be kept to a minimum number consistent with achieving their purpose. The responsible clinician can vary and suspend conditions. A CTO lasts for 6mths and can be renewed for a further 6-mth period and yearly thereafter.

956 Chapter 20 Legal issues Mental Health Act: Scotland 1 Introduction The Mental Health (Care and Treatment) (Scotland) Act 2003 replaced the Mental Health (Scotland) Act 1984 in 2005. The 2003 Act emphasizes the protection of the rights of mentally disordered patients and shifts the em

phasis from detention in hospital to treatment for mental disorder, whether in hospital or in the community. The 2003 Act was amended in several areas by the Mental Health (Scotland) Act 2015; the following text reflects these amendments. Principles Anyone using the Act must take account of the ten guiding principles: • Non-discrimination—patients with mental disorder should retain, wherever possible, the same rights as those with other health needs. • Equality—powers should be exercised without any direct or non-direct discrimination on any grounds. • Respect for diversity—patients should receive care and treatment sensitive to their individual backgrounds and needs. • Reciprocity—where an obligation is placed on a patient through the Act, there is a parallel obligation on the health service to provide an appropriate service for the patient, including ongoing care following discharge from detention. • Informal care—wherever possible, care and treatment should be provided without use of compulsory powers. • Participation—patients should, as far as they are able to, be involved in planning all aspects of their care and support. • Respect for carers—those who provide informal support to patients should receive appropriate support and advice and have their views taken into account. • Least restrictive alternative—patients should receive care in the least restrictive manner, which is compatible with safe and effective care, taking appropriate account of the safety of others. • Benefit—any intervention under the Act should be likely to produce a benefit for the patient, not achievable without use of the Act. • Child welfare—the welfare of any child with mental disorder is paramount in any interventions imposed on a child by the Act. Definition of mental disorder Section 328 defines ‘mental disorder’ as ‘any mental illness, personality dis order or learning disability’ however caused or manifest. None of these terms is further defined. A person is not mentally disordered solely by reason of sexual orienta tion; sexual deviancy; transsexualism or transvestism; dependence on, or use of, alcohol or drugs, ‘exhibiting behaviour that causes or is likely to cause, harassment, alarm, or distress to any other person’, or ‘acting as no prudent person would act’.

Mental Health Act: Scotland 1 Other definitions Approved medical practitioner (AMP)—under Section 22, these are doctors with the necessary qualifications and experience, who have undertaken training, and are approved by a Health Board as having special experience in the diagnosis and treatment of mental disorder. Responsible medical officer (RMO)—the registered medical practitioner in charge of the patient’s treatment, usually the consultant. Mental health officer (MHO)—a social worker, with the necessary regis tration, experience, education, training, and competence in dealing with individuals with mental disorder; appointed under Section 32 of the Act. Designated medical practitioner (DMP)—a medical practitioner appointed by the MWC to give second opinions regarding the medical treatment of patients subject to compulsion. Named person—someone nominated by a person to support them and protect their interests. Entitled to be informed about certain decisions and to act on the patient’s behalf in certain circumstances. There is no ‘default’ named person—individuals must give written agreement to take on the role—and the patient can decline to appoint one. Advance statement—these must be made in writing, with a witness, at a time when the person has capacity. Those carrying out duties under the Act must ‘have regard to the wishes specified in the advance statement’. If acting against these wishes, this must be recorded in writing, with reasons, and a copy of this record must be sent to the patient, named person, wel fare attorney, guardian, and MWC. There is a duty on Health Boards to file advance statements with the patient’s other health records. Advocacy—under Section 259, every person with mental disorder has the right of access to independent advocacy, and it is the duty of the Local Authority and Health Board to ensure availability of this. Mental Health Tribunal for Scotland (MHTS)—the legal forum for making decisions regarding applications for certain

compulsory orders and pro posals to amend or appeal compulsory orders. Consists of three mem bers: one legal, one medical, and one general. Mental Welfare Commission (MWC)—a body with the statutory duty to protect individuals with mental disorder, whether they are liable to deten tion or not. It has a responsibility to visit and inspect services and the power to conduct enquiries into deficiencies in care, as well as duties to monitor the operation of the Acts and promote best practice.

958 Chapter 20 Legal issues Mental Health Act: Scotland 2 Compulsory measures Nurses' holding powers (Section 299)—allows a registered mental health nurse (RMN) or a registered nurse in learning disability (RNLD) to detain an informal current inpatient for a period of up to 3hrs to allow for medical assessment. Emergency detention—under Part 5, Section 36, a fully registered medical practitioner may grant an Emergency Detention Certificate (EDC), author izing the detention of a person in hospital for 72hrs. Consent from an MHO is necessary (unless impracticable); the situation must be urgent, such that making arrangements for short-term detention under Part 6 would involve 'undesirable delay'. As soon as practicable, the patient should be assessed by an AMP to determine if detention under Part 6 should be applied or if the patient should be dealt with informally. Short-term detention—under Part 6, Section 44, any AMP may grant a Short-Term Detention Order (STDO), authorizing the detention of a person in hospital for 28 days. Consent from an MHO is necessary in all cases. At the end of the order, the patient may be discharged, remain as an informal patient, or may be placed on a CTO. Compulsory Treatment Order (CTO)—under Part 7, an application may be made to the MHTS for a patient to be made subject to a CTO, authorizing compulsory treatment in hospital or in the community for 6mths. The appli cation is made by an MHO and has three components: two medical reports (one by an AMP and the other by the patient's GP or another AMP), a report prepared by the MHO, and a proposed care plan (prepared by the MHO in consultation with the RMO and others who will be involved in the care and treatment of the patient). The MHTS must be satisfied that criteria for a CTO are met; if there are issues that require clarification, the MHTS may grant an interim CTO instead. A CTO in the community may make requirements as to residence, attendance for treatment and other services, access of staff to the patient's home, and acceptance of medication. A CTO may be renewed for 6mths, then annually thereafter, without further application to the MHTS unless variation to the order is proposed. If a patient on a community CTO refuses medication, then they may be taken to hospital and detained for up to 6hrs to receive this. If the patient is non-compliant with other aspects of the order, then detention in hospital for up to 72hrs can be authorized by the RMO; this may be extended to 28 days, with approval of the RMO and MHO, to allow assessment as to whether to apply for the CTO to be varied. Criteria for compulsory intervention The criteria for compulsion under a CTO are: • The person has a mental disorder. • Medical treatment is available, which would be likely to prevent that disorder fro worsening or be likely to alleviate the effects of the disorder. • There would be significant risk to the patient's health, safety, or welfare, or the safety of another person, if treatment were not provided.

Mental Health Act: Scotland 2 • The patient's ability to make decisions about the provision of medical treatment is significantly impaired because of their mental disorder. • The making of the order is necessary. These criteria are less stringent for emergency and short-term measures than they are for longer-term measures. For short-term or emergency de tention, it only has to be likely that the criteria apply, and the second cri terion above regarding treatability does not need to be considered. Treatment of patients subject to compulsion (Part 16) • A patient subject to compulsion

(except under emergency provisions) may be given medication for a mental disorder for up to 8wks, whether they consent and/or have capacity or not. Patients in the community cannot be given medication using physical force. • Medication for over 2mths requires the patient's consent or, if the person refuses or is incapable of consenting, authorization by a DMP. • ECT may only be given if a patient can and does consent, or—if incapable of consenting—with the authorization of a DMP. ECT cannot be given, even in an emergency, to a patient with capacity who refuses. • Treatment that is urgently necessary may be authorized by the RMO without consent or a second opinion, e.g. giving ECT to severely ill and at-risk patients lacking capacity while awaiting a second opinion, giving medication to acutely disturbed patients on emergency detention. • To receive neurosurgery for a mental disorder, there must be an independent opinion from a DMP that the treatment will be beneficial, two opinions from lay people appointed by the MWC that the person has capacity and consents or, if they do not have capacity, that they do not object. If the person is incapable but is not objecting, the treatment must be authorized by the Court of Session. Leave, absconding, and transfer Procedures allow for 'suspension of detention' of patients detained in hospital—CTOs or compulsion orders can be suspended for a maximum of 200 days in any 12-mth period. There are provisions covering the taking into custody and return of patients who abscond from hospital or the residence specified in a community-based CTO, and for patients to be transferred to other hospitals. Review A patient or their named person may appeal to the MHTS against being subject to a CTO or short-term detention (but not emergency detention), against transfer to another hospital, and, for patients in the State Hospital and in medium-security units, against being held in conditions of excessive security. An RMO must refer a case to the MHTS if a variation is proposed in an order. If the MHTS has not reviewed a case for 2yrs, then it must do so without a specific referral being made. The MHTS must cancel an order if the criteria for compulsion are no longer met. The RMO and MWC also have the power to cancel an order at any point if these criteria are no longer met.

960 Chapter 20 Legal issues Mental Health Act: Northern Ireland 1 Introduction At the time of writing, the current mental health law for NI remains the Mental Health (Northern Ireland) Order 1986, described in this section. The Mental Capacity Act (Northern Ireland) 2016 will provide the future legal framework for incapacity law and mental health law in NI. The provi sions of this joint Act will come into force over the coming years and will eventually replace the former Order. Definition of mental disorder Article 3 defines 'mental disorder' as meaning 'mental illness, mental handicap and any other disorder or disability of mind'. There are further definitions of the types of mental disorder: • Mental illness—defined as 'a state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he requires care or medical treatment in his own interests or the interests of other persons'. • Mental handicap—defined as 'a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning'. • Severe mental handicap—defined as 'a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning'. • Severe mental impairment—defined as 'a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'. The following are excluded if they are the only 'conditions' present: per sonality disorder, promiscuity or other immoral conduct, sexual deviancy, or dependence on alcohol or drugs. Other definitions Mental Health Review Tribunal for Northern Ireland (MHRTNI)—legal forum to which a patient or a nearest relative can appeal against detention. The MHRTNI has three members: a legally qualified

chairperson, a medical prac titioner, and a lay member. It must discharge a patient if the criteria for detention no longer apply. Mental Health Commission for Northern Ireland (MHCNI)—like the MWC in Scotland, it has a broader remit than the MHAC in England and Wales. Appointed doctor—the MHCNI appoints medical practitioners for the purposes of Part II (compulsory admission to hospital and guardianship). These doctors are analogous to approved doctors in England and Wales. Doctors may also be appointed for the purposes of Part IV (consent to treatment). The term 'appointed doctor' on these pages is used to refer to Part II. Responsible medical officer (RMO)—the registered medical practitioner in charge of the patient's treatment, usually the consultant.

Mental Health Act: Northern Ireland 1 Approved social worker (ASW)—a social worker who has undergone spe cific training and assessment and is appointed for the purposes of the Order as having competence in dealing with individuals with mental disorder. Nearest relative—the person caring for the patient who is first on the fol lowing list (Article 32): spouse, child, parent, brother or sister, grandparent, grandchild, uncle or aunt, nephew or niece. If there was no carer, then the first person on the list is the nearest relative. If two relatives are of equal standing, then the elder prevails. Criteria for compulsory intervention The criteria for compulsory intervention are less stringent for emergency and shorter-term measures (i.e. Articles 4 and 7(2)) than they are for longer-term measures (i.e. Article 12). The criteria for compulsion under Article 12 are: • The patient is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment. • Failure to so detain the patient would create a substantial likelihood of serious physical harm to themselves or other persons. • Consideration has been given to whether other methods of dealing with the patient are available and to why they are not appropriate. For Article 4, the type of mental disorder does not need to be specified, and for Article 7(1), it must appear that the Article 4 criteria are met.

962 Chapter 20 Legal issues Mental Health Act: Northern Ireland 2 Compulsory measures Article 4 allows detention in hospital for assessment, which may be fol lowed by detention for treatment under Article 12. Article 7(2) allows for the detention of a patient already in hospital. Admission for assessment—an application for detention under Article 4 may be made by the nearest relative or ASW and requires one medical rec ommendation. This should be by the patient's GP or a doctor who knows the patient, if this is practicable, and should not be, except in urgent cases, by a doctor on the staff of the admitting hospital. Immediately on admis sion to hospital, the patient must be examined by the RMO, an appointed doctor, or another doctor, who must submit a report to the responsible authority. They may then be detained for 7 days from the point of admis sion (this is limited to 2 days where the examination is not by the RMO or an appointed doctor, during which the RMO should examine the patient). Detention may be extended by a further 7 days on one occasion, following a further report from the RMO. Following detention under Article 4, a pa tient may be detained under Article 12, remain informally, or be discharged. Assessment of patient already in hospital—under Article 7(2), where a person is a voluntary inpatient, if it appears to a doctor on the staff of the hospital that an application for assessment ought to be made, then a report may be furnished to the responsible authority, allowing detention for 48hrs. This may be followed by detention under Article 4. Detention for treatment—where a patient has been detained under Article 4, they may be further detained for 6mths under Article 12. This requires a recommendation from an appointed doctor (not the doctor who made the assessment recommendation). This may be renewed for a further 6mths and annually thereafter. Guardianship—Article 18 allows for guardianship. The application is made by the nearest relative or

ASW, and there must be two medical recom mendations and an ASW recommendation. The patient must be suffering from mental illness or mental handicap, and guardianship should be neces sary in the interest of the patient's welfare. Renewal is as for Article 12. Nurses' holding powers—Article 7(3) allows nurses (of the prescribed class) to detain an inpatient in hospital for up to 6hrs, to allow for a medical assessment regarding detention. Detention under Article 7(3) ends when the doctor arrives. Treatment of patients subject to compulsion—Articles 62–69 set out very similar provisions regarding consent to treatment to those set out for England and Wales by the 1983 Act (E Mental Health Act: England and Wales 1, p. 950). Leave, absconding, and transfer—procedures allow for patients to be granted leave of absence with the authorization of the RMO (Article 15); for patients to be taken into custody and returned to hospital if they ab scond (Article 29); and for patients to be transferred between hospitals (Article 28).

Mental Health Act: Northern Ireland 2 Review The MHRTNI operates in a very similar way to England and Wales but must review a detained patient if they have not been reviewed for 2yrs. After reviewing a case, the MHCNI may refer a patient to the MHRTNI or may recommend that the patient be discharged. The RMO may discharge a patient at any point. The nearest relative may also discharge a patient if not opposed by the RMO. Mental Health Commission for Northern Ireland The functions of the MHCNI are very similar to those of the MWC in Scotland—the duty to protect individuals with mental disorder whether they are liable to detention or not; the power to recommend discharge of patients subject to compulsion; the responsibility to visit and inspect services; and the power to conduct enquiries into deficiencies in care.

964 Chapter 20 Legal issues Mental Health Act: Republic of Ireland 1 Introduction The Mental Health Act 2001 replaced the Mental Treatment Act 1945 and various modifying Acts passed in 1953, 1961, and 1981. The new Act was implemented in November 2006. Principles Section 4 sets out some principles to be considered in operating the Act. The best interests of the person should be the principal consideration, with due regard being given to the interests of others who may be at risk of serious harm; the person should be notified of proposals and should be al lowed to make representations regarding these, which should be given due consideration; any decision should give due regard to the right of a person to dignity, bodily integrity, privacy, and autonomy. Definition of mental disorder and criteria for compulsion Section 3 sets out the definition of mental disorder, which also includes the criteria for compulsory detention. 'Mental disorder' is defined as 'mental illness, severe dementia, or signifi cant intellectual impairment where: (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) (i) because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and

(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.' 'Mental illness' means a state of mind of a person which affects the person's thinking, perceiving, emotion, or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons. 'Severe dementia' means a deterioration of the brain of a person, which significantly impairs the

intellectual function of the person, thereby affecting thought, comprehension, and memory and which includes severe psychi atric or behavioural symptoms such as physical aggression. ‘Significant intellectual disability’ means a state of arrested or incomplete development of the mind of a person, which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person. Under Section 8, the following are excluded if they are the only condi tions present: personality disorder, being ‘socially deviant’, and being ad dicted to drugs or intoxicants.

Mental Health Act: Republic of Ireland 1 Other definitions Approved centre—hospitals or other inpatient facilities for the care and treatment of people suffering from mental illness or mental disorder. Must be registered with the Mental Health Commission (MHC). Review tribunal—the legal forum which reviews the making of every ad mission and renewal order. Has three members: a legally qualified chair person, a consultant psychiatrist, and another member. Mental Health Commission (MHC)—the body responsible for monitoring the standards of mental health services and protecting detained patients. Has a more direct role in the latter than similar bodies in the UK. Inspector of Mental Health Services—consultant psychiatrist appointed by the MHC to visit and inspect approved centres and to review mental health services. Will also review individual cases when visiting centres. Mental Health Commission The MHC was established in April 2002. Its main purpose is to promote, encourage, and foster the establishment and maintenance of high stand ards and good practices in the delivery of mental health services and to protect the interests of detained patients. It is notified of every episode of detention and renewal, appoints tribunals, maintains a panel of consultants to undertake independent examinations, appoints an Inspector of Mental Health Services, maintains a register of approved centres, makes regulations as to the use of seclusion and restraint, and prepares codes of practice and other documents.

966 Chapter 20 Legal issues Mental Health Act: Republic of Ireland 2 Compulsory measures Application for involuntary admission (Section 9) An application for admission may be made under Section 9 by a spouse or relative, an authorized officer (of the Health Board), a garda, or any other person (with certain exclusions applying). The applicant must have seen the person within the last 48hrs. Medical assessment (Section 10) Within 24hrs of the application being made, a medical practitioner (who does not work at the approved centre where the person may be admitted) should examine the person. The doctor should inform the person about the purpose of the examination, unless this would be detrimental to the person. If the doctor considers the person to be mentally disordered, then a recommendation may be made, allowing involuntary admission to an ap proved centre. This remains in force for 7 days. Power of the garda to detain and apply for involuntary admission (Section 12) The garda may take a person into custody if they have reasonable grounds to believe that the person is mentally disordered and, because of this, there is a serious likelihood of the person harming themselves or others. They may forcibly enter premises, if necessary. The garda would then follow the usual application for an involuntary admission procedure (Section 9). If this application is granted, the garda must take the person to an approved centre. Removal to an approved centre (Section 13) The applicant is responsible for getting the person to an approved centre. If not possible, then the doctor making the recommendation may request that staff from the centre do this. The garda may be asked for assistance. Admission to an approved centre (Sections 14 and 15) When the person is admitted to an approved centre, a consultant psych iatrist must examine them as soon as is practicable (Section 14). They may be held for 24hrs to allow this examination. If this psychiatrist is satisfied that the person is suffering from mental disorder, then

an ‘admission order’ is made. Under Section 15, an admission order authorizes the detention and treat ment of the patient in the centre for 21 days. This may be renewed (as a ‘renewal order’) for 3mths initially, then 6mths, and then annually there after. The consultant responsible for the patient must make the renewal, following an examination in the week, before making the renewal order. When an order (admission or renewal) is made, the consultant must send a copy to the MHC and a written notice to the patient (Section 16). Voluntary patients wishing to leave an approved centre Previously, a voluntary patient had to give 3 days’ notice of intention to leave. Under Section 23, a voluntary patient may leave hospital at any point, unless a consultant psychiatrist or doctor or nurse on the staff considers that they suffer from a mental disorder. If this is the case, they may be detained for up to 24hrs. During this period, the responsible consultant

Mental Health Act: Republic of Ireland 2 must either discharge the patient or arrange an examination by another consultant. If this consultant is of the opinion that the patient is mentally disordered, then they issue a certificate and the patient is detained as they would be under an admission order (Section 14). Treatment of patients subject to compulsion (Part 4) • The consent of a patient to treatment is required, except where the consultant psychiatrist considers that the treatment is necessary to safeguard the life of the patient, to restore their health, to alleviate their condition, or to relieve their suffering, and the patient is incapable of giving such consent because of mental disorder. • Neurosurgery for mental disorder may not be performed, unless the patient consents and it is authorized by a tribunal. • ECT may not be given, unless the patient gives consent in writing or where the patient is unable or unwilling to give consent, the therapy is authorized by the responsible consultant psychiatrist and another consultant psychiatrist. • Medication for amelioration of the mental disorder for >3mths cannot be given, unless the patient consents in writing, or, where the patient is unable or unwilling to give consent, the continued medication is authorized by the consultant psychiatrist responsible for the patient and by another consultant psychiatrist. This must be renewed every 3mths. Review When the MHC receives a copy of an order, it must refer the case to a tribunal, assign a legal representative to the patient if they do not have one, and direct that a member of the panel of consultant psychiatrists appointed by the MHC reviews the case (Section 17). Within 21 days of the making of the order, the tribunal must review the detention. The tribunal may affirm or revoke the order, depending on whether the criteria for detention are met (Section 18). An appeal against a tribunal’s decision may be made to the Circuit Court (Section 19). Leave, absconding, and transfers Procedures allow for patients to be allowed to be absent from the approved centre, with the authorization of the consultant responsible for their care (Section 26); for patients to be taken into custody and returned to an ap proved centre if they abscond (Section 27); and for patients to be trans ferred to other approved centres and hospitals (Sections 20, 21, and 22).

968 Chapter 20 Legal issues Issues of confidentiality ‘Whatever . . . I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.’ Hippocratic Oath Patients’ right to confidentiality Patients have a right to expect that information about them will be held in confidence by their doctors. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to give doctors the information they need in order to provide good care. If you are asked to provide information about patients, you should: • Seek patients’ consent to disclosure, wherever possible, whether or not you judge that patients can be identified from the disclosure. • Anonymize data where this will serve the intended purpose. • Keep disclosures to the minimum necessary. • Always

document and be prepared to justify your decisions. Protecting information • Doctors have a professional responsibility to ensure patient information is effectively protected against improper disclosure at all times. • Many improper disclosures are unintentional—do not discuss patients where you can be overheard or leave patients' records, either on paper or on screen, where they can be seen by other patients, unauthorized healthcare staff, or the public (E Confidentiality expectations: the reality, see opposite). • Allowing for issues of personal safety, ensure that, as far as possible, your consultations with patients are private. Sharing information with others providing care • Ensure that patients are aware that personal information about them will be shared within the healthcare team and of the reasons for this. • Respect the wishes of any patient who does not wish specific information to be shared in this way, unless to do so would put others at risk of death or serious harm. • Where patients have consented to treatment, express consent is not usually needed before relevant personal information is shared, to enable the treatment to be provided safely and ensure continuity of care (e.g. medical secretaries typing letters to GPs, referrals for further investigations, referrals to other specialists).

Issues of confidentiality Medical reports This includes both specific requests for a particular report on current med ical problems and disclosure of information from existing medical records for a third party (e.g. court report, insurance claim, benefits claim). In these circumstances: • Satisfy yourself that the patient has been told about the purpose of the examination and/or disclosure, the extent of the information to be disclosed, and the fact that relevant information cannot be concealed or withheld. (Showing the form or letter of request to the patient may assist in ensuring they understand the scope of information requested.) • Obtain evidence of written consent to the disclosure from the patient or a person properly authorized to act on the patient's behalf. • Disclose only information relevant to the request made. • Include only unbiased, factual information that you can substantiate. • Always check whether the patient wishes to see their report (the Access to Medical Reports Act 1988 entitles patients to see reports written about them before they are disclosed, in most circumstances). Disclosures without consent to employers, insurance companies, or any other third party can be justified only in exceptional circumstances (e.g. to protect others from risk of death or serious harm; E Breaking confiden tiality, p. 970). Recent developments In 1997, the Caldicott Committee Report made a number of recommenda tions aimed at improving how the NHS handles and protects patient infor mation. A key recommendation was the establishment of organizational guardians to oversee access to patient-identifiable information. These 'Caldicott Guardians' have been established and are responsible for internal protocols and policies on the use of such information and on its disclosure. A key principle is that of 'the need to know'. Confidentiality expectations: the reality Despite confidentiality being one of the main foundations of the 'privileged' doctor–patient relationship, expectations about where personal informa tion may be reasonably disclosed varies among patients and medical pro fessionals at different stages of their training. According to a JAMA study,1 only 23% of patients believed they should be identified by name to other physicians, compared to 60% of house staff and 55% of medical students. Seventy per cent of medical students and 51% of house staff accepted talking about patient information with a spouse or friend, compared to only 17% of patients. 1 Weiss B (1982) Confidentiality expectations of patients, physicians, and medical students. JAMA 247:2695.

970 Chapter 20 Legal issues Breaking confidentiality Personal information should not be disclosed to a third party (e.g. relative, partner, solicitor, police officer, or officer of a court) without the

patient’s express consent, except in the circumstances described in this section. If you decide to disclose confidential information against a patient’s wishes, you must document this decision in the patient’s notes and be prepared to explain/justify your decision (and communicate this decision to the patient). Disclosures to protect the patient or others • In some cases, the risk to third parties is so serious that it outweighs the patient’s privacy interest, and the appropriate person or authority should be informed without undue delay. Examples of such circumstances include: • To assist in the prevention or detection of a serious crime (i.e. where someone may be at risk of death or serious harm) (e.g. threats of violence; see Box 20.4) or suspected child abuse (E Child maltreatment 1: general issues, p. 712). • Where a colleague, who is also a patient, is placing patients at risk as a result of illness or other medical condition. (If you are in doubt about whether disclosure is justified, consult an experienced colleague or seek advice from a professional organization. The safety of patients must come first.) Box 20.4 The Tarasoff case On 27 October 1969, Prosenjit Poddar killed his ex-girlfriend Tatiana Tarasoff. Two months earlier, Poddar had declared his intentions during an outpatient appointment with his psychotherapist Dr Lawrence Moore at the University of California at Berkeley’s Cowell Memorial Hospital. Dr Moore tried to have Poddar confined to a mental institution for ob servation (including asking the university police for assistance). When law enforcement agents decided that Poddar was harmless and released him, Moore’s director Dr Harvey Powelson requested that all evidence of con tact between Moore and the police department be destroyed. No one pursued the case further. After the murder, Tatiana’s parents became aware of this prior know ledge and sued the university regents, hospital, and police department, claiming that, at least, a warning should have been issued to her. On 1 July 1976 (>6.5yrs after the murder), the Supreme Court of California found that the defendants had breached their duty to exercise reasonable care. In other words, physicians and therapists have a duty to warn third parties of threatened danger arising from a patient’s violent intentions. As a final statement, the Court stated that ‘protective privilege ends where public peril begins’. Note: although often quoted when discussing issues of confidentiality, this case has no legal bearing in the UK. Even in the USA, the impact of the Tarasoff case has been less dramatic and intrusive than one might expect.

Breaking confidentiality • Where a patient continues to drive, against medical advice, when unfit to do so. In such circumstances, you should disclose relevant information to the medical adviser of the DVLA without delay. Fuller guidance is given in E Fitness to drive, p. 972. Disclosure in connection with judicial or other statutory proceedings Under certain circumstances, disclosure of information is required by law: • Notification of a known or suspected communicable disease. • If ordered to do so by a judge or presiding officer of a court (unless the information appears to be irrelevant, e.g. details of relatives or partners of the patient not party to the proceedings). • To assist a coroner, procurator fiscal, or other similar officer in connection with an inquest or fatal accident inquiry (only relevant information should be provided). • An official request from a statutory regulatory body for any of the healthcare professions, where disclosure is necessary in the interests of justice and for the safety of other patients. Difficult situations • Children and other patients who may lack competence to give consent (E Consent to treatment, p. 936). • Always try to persuade them to allow an appropriate person (e.g. individual with parental responsibility) to be involved in the consultation. • Always inform the patient (and their relative or carer) prior to passing on information to another responsible person or statutory agency (e.g. social services). • Document in the patient’s records the steps you have taken to obtain consent and the reasons for deciding to disclose information. • Where a person lacks capacity, disclosure should be in that

person’s best interests and follow the other basic principles regarding confidentiality. • Situations of dual responsibilities (i.e. contractual obligations to third parties such as companies or organizations, e.g. occupational health services, insurance companies, benefits agencies, police forensic medical advisors, armed forces, prison services), as well as obligations to patients. Always ensure patients are aware of the purpose of the consultation and to whom you are contractually obliged to release information. • If in doubt, consult (in the UK): • GMC: guidance may be found online (M https://www.gmc-uk.org/ ethical-guidance/ethical-guidance-for-doctors/confidentiality [accessed 13 July 2018]. • Royal College of Psychiatrists: guidance may be found at M https:// www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/ cr209.aspx [accessed 13 July 2018]. • Consider seeking the advice of your medical defence body.

972 Chapter 20 Legal issues Fitness to drive Principles and legal definitions The DVLA in the UK sets out minimum medical standards of fitness to drive and the requirements for mental health in broad terms. A clear distinction is made between the standards needed for Group 1 (cars and motorcycles) and Group 2 (lorries and buses) licences, the latter being more stringent due to the size of vehicle and the greater time spent at the wheel. ‘Severe mental disorder’ is defined by Section 92 of the Road Traffic Act 1988 as ‘mental illness, arrested or incomplete development of the mind, psychopathic disorder or severe impairment of intelligence or social functioning’. The standards set reflect not only the need for an improvement in the mental state, but also a period of stability, such that the risk of relapse can be assessed, should the patient fail to recognize any deterioration. The standards for patients with misuse of, or dependency on, alcohol or drugs are detailed in E Legal issues related to drug and alcohol misuse, p. 642. Notes on medication Section 4 of the Road Traffic Act 1988 states that ‘any person who is driving or attempting to drive on the public highway, or other public place whilst unfit due to any drug, is liable to prosecution’. All drugs acting on the CNS can impair alertness, concentration, and driving performance. This is particularly so at initiation of treatment or soon after and when dosage is being i. Driving must cease if adversely affected. When planning the treatment of any patient (particularly professional drivers, e.g. of taxis, lorries, buses, or construction vehicles), always con sider adverse side effect profiles which may impair driving ability: • Antidepressants—anticholinergic/antihistaminic effects (sedation). • Antipsychotics—both sedation and EPSEs (assess regularly). • BDZs—the most likely psychotropic medication to impair driving performance; avoid long-acting compounds. • For all psychotropics—consider the epileptogenic potential. Duties and other considerations Duty of care—doctors have a duty to advise their patients of the potential dangers of adverse effects from medication and interactions with other sub stances, especially alcohol. Confidentiality—when a patient has a condition which makes driving un safe and the patient is either unable to appreciate this or refuses to cease driving, GMC guidelines advise breaking confidentiality and informing the DVLA (see Box 20.5). Patients detained under the MHA—similar rules as for informal patients (i.e. drivers must be able to satisfy the standards of fitness for their re spective conditions and be free from any effects of medication which will affect driving adversely).

Fitness to drive Further advice on fitness to drive • Doctors may write to the DVLA or may speak to one of the medical advisors during office hours to seek advice about a particular driver (identified by an M number) or about fitness to drive in general. • All DVLA advice is available online at M http://www.dvla.gov. uk (including an email facility for use by medical professionals only) [accessed 13 July 2018]. Box 20.5 GMC guidance for informing the DVLA* • The DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when driving licence holders

have a condition which may, now or in the future, affect their safety as a driver. • Therefore, where patients have such conditions, you should: • Make sure that the patients understand that the condition may impair their ability to drive. If a patient is incapable of understanding this advice (e.g. because of dementia), you should inform the DVLA immediately. • Explain to patients that they have a legal duty to inform the DVLA about the condition. • If the patient refuses to accept the diagnosis or the effect of the condition on their ability to drive, you can suggest that the patient seeks a second opinion and make appropriate arrangements for the patient to do so. You should advise patients not to drive until the second opinion has been obtained. • If patients continue to drive when they are not fit to do so, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin. • If you do not manage to persuade patients to stop driving or you are given or find evidence that a patient is continuing to drive, contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical advisor at the DVLA. • Before giving information to the DVLA, you should inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient to confirm that a disclosure has been made.

- Source: data from the GMC M https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---patients-fitness-to-drive-and-reporting-concerns-to-the-dvla-or- dva/patients-fitness-to-drive-and-reporting-concerns-to-the-dvla-or-dva [accessed 13 July 2018].

974 Chapter 20 Legal issues DVLA requirements for specific psychiatric conditions Anxiety or depression without significant memory or concentration problems, agitation, behavioural disturbance, or suicidal thoughts • Group 1 drivers—DVLA need not be notified, and driving may continue. • Group 2 drivers—very minor short-lived illnesses need not be notified. Severe anxiety or depression with significant memory or concentration problems, agitation, behavioural disturbance, or suicidal thoughts • Group 1 drivers—driving should cease, pending the outcome of medical enquiry. A period of stability, depending upon the circumstances, will be required before driving can be resumed. Particularly dangerous are those who may attempt suicide at the wheel. • Group 2 drivers—driving may be permitted when the person is well and stable for a period of 6mths. Medication must not cause side effects which would interfere with alertness or concentration. Driving is usually permitted if the anxiety or depression is long-standing but maintained symptom-free on doses of psychotropic medication which do not impair. DVLA may require psychiatric reports. Acute psychosis (any cause) • Group 1 drivers—driving must cease during the acute illness. Relicensing can be considered when all of the following conditions can be satisfied: • Has remained well and stable for at least 3mths. • Is compliant with treatment. • Is free from adverse effects of medication which would impair driving. • Subject to a favourable specialist report. Note: drivers who have a history of instability and/or poor compliance will require a longer period off driving. • Group 2 drivers—driving should cease, pending the outcome of medical enquiry. The person must be well and stable for a minimum of 3yrs, with insight into their condition, before driving can be resumed. At that time, the DVLA will usually require a consultant examination. Any psychotropic medication should be of minimum effective dosage and not interfere with alertness and concentration, or in any other way impair driving performance. There should be no significant likelihood of recurrence. Hypomania/mania • Group 1 drivers—driving must cease during the acute illness. Following an isolated episode, relicensing can be reconsidered when all the following conditions can be satisfied: • Well and stable for at least 3mths. • Compliant with

treatment. • Insight has been regained. • Free from adverse effects of medication which would impair driving. • Subject to a favourable specialist report.

DVLA requirements for specific psychiatric conditions Note: hypomania or mania are particularly dangerous to driving when there are repeated changes of mood. Therefore, when there have been four or more episodes of mood swing within the previous 12mths, at least 6mths' stability will be required, with evidence of treatment compliance and a fa vourable specialist report. • Group 2 drivers—driving must cease, pending the outcome of medical enquiry. The person must be well and stable for a minimum of 3yrs, with insight into their condition, before driving can be resumed. At that time, the DVLA will usually require a consultant examination. Any psychotropic medication should be of minimum effective dosage and not interfere with alertness and concentration, or in any other way impair driving performance. There should be no significant likelihood of recurrence. Schizophrenia or other chronic psychoses • Group 1 drivers—the driver must satisfy all the following conditions: • Stable behaviour for at least 3mths. • Adequately compliant with treatment. • Free from adverse effects of medication which would impair driving. • Subject to a favourable specialist report. Note: for patients with continuing symptoms, even with limited insight, these do not necessarily preclude licensing. Symptoms should be unlikely to cause significant concentration problems, memory impairment, or distrac tion while driving. Particularly dangerous are those drivers whose psychotic symptoms relate to other road users. • Group 2 drivers—driving must cease, pending the outcome of medical enquiry. The person must be well and stable for a minimum of 3yrs, with insight into their condition, before driving can be resumed. At that time, the DVLA will usually require a consultant examination. Any psychotropic medication should be of minimum effective dosage and not interfere with alertness and concentration, or in any other way impair driving performance. There should be no significant likelihood of recurrence. Dementia or any organic brain syndrome It is extremely difficult to assess driving ability in those with dementia. Those who have poor STM, disorientation, and lack of insight and judgement are almost certainly not fit to drive. The variable presentations and rates of progression are acknowledged. Disorders of attention will also cause im pairment. A decision regarding fitness to drive is usually based on medical reports. • Group 1 drivers—in early dementia, when sufficient skills are retained and progression is slow, a licence may be issued, subject to annual review. A formal driving assessment may be necessary. • Group 2 drivers—refuse or revoke licence. Intellectual disability • Group 1 drivers—severe learning disability is not compatible with driving, and the licence application must be refused. In milder forms, provided there are no other relevant problems, it may be possible to hold a licence, but it will be necessary to demonstrate adequate functional ability at the wheel.

976 Chapter 20 Legal issues • Group 2 drivers—recommended permanent refusal or revocation if severe. Minor degrees of learning disability when the condition is stable, with no medical or psychiatric complications, may be compatible with the holding of a licence. Persistent behaviour disorder Includes post-head injury syndrome, psychopathic disorders, and non- epileptic seizure disorder. • Group 1 drivers—if seriously disturbed (e.g. violent behaviour or alcohol abuse) and likely to be a source of danger at the wheel, the licence should be revoked or the application refused. Licence will be issued after medical reports confirm that behavioural disturbances have been satisfactorily controlled. • Group 2 drivers—recommended refusal or revocation if associated with serious behaviour disturbance likely to make the individual a source of danger at the wheel. If the person matures and psychiatric reports confirm stability, consideration would be given to restoration of the licence, but a confirmatory psychiatrist report would be required.