College of Psychiatrists of Ireland
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Submission to Department of Health

Prepared by the Law Committee

Comment on Preliminary Draft Heads of Bill on Deprivation of Liberty – Safeguard Proposals

Part 13 of the Assisted-Decision Making (Capacity) Act 2015

09 March 2018

The College, formed in 2009, is the professional and training body for psychiatrists in the Republic of Ireland. It is the sole body recognised for training of doctors to become specialists in psychiatry and for providing career long competence for specialists in psychiatry, as regulated by the Medical Practitioners Act 2007 through the Medical Council. The mission of the College of Psychiatrists of Ireland is to promote excellence in the practice of Psychiatry.

The College welcomes this consultation and the opportunity to contribute to the consultation.

The format of this submission is by comment under the relevant questions on each of the heads of the preliminary draft Bill as requested. We have made efforts to provide concise responses in our response to this Consultation.

Head 1

1.1 Do you have any views on the definitions currently included in the draft Head?

The definition of a relevant facility needs further discussion. We do not understand the reasoning that excludes acute medical wards in general hospitals but includes acute psychiatric units in the same general hospitals. A legal framework already exists which regulates involuntary admissions under the Mental Health Act 2001 and acts to protect patients interests.

1.2 In particular do you have any views as to the types of healthcare professionals that should be include within the definition of "other medical expert"?

We take the view that medical experts are by definition medically trained professionals on the appropriate specialist register maintained by the Irish Medical Council and/or other medical regulatory authorities.

However, if the Head is looking for the contribution of other Healthcare professionals that is a different matter.

We note however that the ECJ has ruled that detention on medical grounds must be certified by medical as opposed to non-medical healthcare professionals.

1.2 Do you have any other views specific to Head 1?

The term 'Chemical Restraint' is a politicised and non-clinical term and is never used by any clinician to describe clinical practice. The standard international classification systems, such as DSM-5, recognise that behavioural, other symptoms exist in particular as part of all neurocognitive disorders, and that medications may sometimes attenuate these symptoms, to the benefit of patients and their carers.

There exists a developing professional literature to support practice in this area.

Head 4

4.1 Do you think that the term "under continuous supervision and control" should be defined? If so, what should this definition include?

We take the view that the current description is adequate.

4.2 When the person in charge has reason to believe that a relevant person may lack the capacity to decide to live in a particular facility, who should be notified with a view to affording them an opportunity to make an application under Part 5 of the Act?

If the relevant person has nominated a next of kin or if they already have a co decision maker or decision-making representative appointed under the Act, an easily assessable register of agreements and decisions under the Act needs to be held by the Decision Support Structure and available to those working in this area.

Head 5

In subhead 5.1 what are your views on the proposed circumstances in which an urgent admission can be made?

We are in broad agreement with these criteria.

5.2 ***In subhead 2 (b) should a health professional other than a registered medical practitioner be able to provide medical evidence?***

If so, what type of healthcare professional? This issue also arises at Head 6(2).

Our comment in relation to Head 1.2 is relevant to this question.

5.3 ***In subhead (7) who should make an application to the court if no else does so? Do you have a view on the proposed role of the Director of the Decision Support Service? This issue also arises in Heads 7(6), 7(11), and 8(3).***

We are in agreement with the proposed role of the Decision Support Service. It would appear reasonable that the Service develop a panel of persons qualified to make applications in these instances.

Head 6 Procedure for Making an Admission Decision

6.1 Is the evidence of one medical expert sufficient?

Routinely we suggest that this should suffice.

Head 7 Persons living in a relevant facility.

7.1 ***In subhead 02 do you have any views on how the issue of fluctuating capacity should be addressed?***

We are in agreement broadly with the treatment of this issue in the Heads of Bill.

7.2 In subhead (2) do you have a view on the length of time that would be considered a "short period? This issue also arises in Head 7(8), 7(12), and 8(5).

The term "short period" would be extremely difficult to specify owing to the diversity of circumstances in which these provisions may apply to.

Head 8 Transitional arrangements for Existing Residents on Commencement of this Part.

8.1 Do you have any view specific to Head 8?

We are of the view that the time-frame for the transitioning from current practice to adherence to the Assisted-Decision Making (Capacity) Act 2015 needs to be more timely than is suggested here.

All patients concerned should see this process commence for them within six months of the commencement of the Act and their status regularised within 12- 18 months. We are cognisant of the investment in resources to the Decision Support Service and the Court Service that are required for this to happen.

Head 9 Review of Admission Decisions

9.1 Do you have any views specific to Head 9?

We are broadly in agreement with Head 9, as written.

Head 10 Chemical Restraint and Restraint Practices.

10.1 Do you have any views specific to Head 10?

This Head needs to reflect the realities of working in the early 21 century and therefore needs to be re written.

Chemical restraint is a politicised and non- clinical term, which is never used by any clinician to describe clinical practice. The standard international classification systems such as DSM-5 recognise that behavioural and other symptoms exist in particular as part of all neurocognitive disorders and that medications may sometimes attenuate these symptoms, to the benefit of patients and their carers.

There exists a developing professional literature to support practice in this area. The College suggests that it would be more appropriate to have a Head titled **'Medication and Restraint'.**

Head 11 Records to Kept

11.1 Do you have a view on the types of records that must be kept under this Head?

All records mandated and usual in any medical facility must be maintained.

Head 12 Regulations

12.1 In subhead (10, do you think that the Minister should be empowered to make regulations on any other aspects of the Heads?

In agreement. This is usual custom and practice in this area.

Head 13 Offences

13.1 Do you have a view on the proposed offences set out in this Head?

In agreement

Head 14 General Questions

We would like to make some general points in conclusion.

The College welcomes the Assisted-Decision Making (Capacity) Act 2015 and is committed to the practice of medicine in a framework of rights and obligations regulated by law, and within a modern framework informed by human rights legislation internationally.

We see the utility of the Assisted-Decision Making (Capacity) Act 2015 as supporting the recognition of and effective validation of the expressed will and preferences of patients in the care of the Health Services that we practice in and we are committed to a parity of esteem and resourcing for somatic and mental health.

We suggest that these measures should assist to regularise the status of those persons who are unable to make effective decisions for themselves in relation to their care. Specifically, that means that these regulations should assist in the management of those patients who cannot make decisions in relation to their care, irrespective of how this situation has come about.

The reference in the text at 14.2 of the consultation paper "the draft heads apply to older people, persons with disabilities and people with a mental health illness" is incorrect and discriminatory. For example, what about a young adult person with an acquired brain injury that leaves them lacking capacity to make decisions in respect of their ongoing care?

The College is aware of the very significant additional resources that will have to be made available if the Assisted-Decision Making (Capacity) Act 2015 is to be commenced and has significant concerns that these resources will not be available.

The College is clear that the Assisted-Decision Making (Capacity) Act 2015 and specifically the provisions regarding the deprivation of liberty should not apply to acute psychiatric units and mental health hostels.

We note that the effective operationalisation of the Assisted-Decision Making (Capacity) Act 2015 and the Deprivation of Liberty safeguards in particular will require attention to areas such as escorting and transfer of patients between residential and hospital facilities that prove difficult to organise for local services.