



Mental Health Alliance

3 Month Rule for Second Opinion Briefing

This briefing has been prepared by the Royal College of Psychiatrists
for the Mental Health Alliance

To move the following clause

- (1) Section 58 of the 1983 Act is amended as follows
- (2) in subsection (1) (b) leave out "three months" and insert "two months".

Purpose of the amendment

To reduce the period of time before a second medical opinion is required for medication from 3 months to two months. .

Given the serious effects of medication and the possibility of patients being given too high doses without their consent, even despite their active opposition to the medication, this is too important a safeguard to be jettisoned. The Human Rights Committee expressed its serious concern about this issue in its recent Reports and called for a change in the law.

Reason for the amendment

The 1983 Act entitles the medical practitioner to treat a patient with medication for his/her mental disorder without the person's consent, indeed despite his or her opposition to it, for a period of 3 months.

Before the end of this period Section 58 of the Act requires that a second medical opinion must be sought from a doctor before treatment can continue. A second opinion is required in two circumstances – either when the patient with capacity does not consent or where the patient lacks capacity and the responsible clinician considers treatment should be given.

The role of the SOAD¹

The second opinion doctor is required to examine the patient and decide whether the general class of medication is appropriate and the levels of that medication. S/he does not specify a particular drug and leaves the clinician the right to make changes to that in the light of the patient's reactions to it. In deciding upon treatment SOADs should take into consideration the patient's observations upon his/her illness and its impact upon his/her presentation, behaviour and relationships and the current treatment, including any side effects. The views of the responsible clinician and of other members of the clinical team are also relevant.

Treatment without consent for 3 months

The Act gives an exceptional power to override the choice of those patients who retain the capacity to make his/ her own choices, which is not available to treatment for physical illness. Although the responsible clinician should seek the consent of the patient and listen to his/ her views this often does not occur. As the MHAC has reported

“too many patients feel that they are excluded from decision-making and the exercise of choice in their hospital treatment, and unable to discuss their subjective experiences of therapeutic effect or adverse side-effects. This is likely to exacerbate the likelihood of non-compliance after discharge and may contribute to the problems of ‘revolving door’ readmissions”².

The Mental Health Act Commission finds, in its visits to hospitals, that the issue of medical treatment is a key one for patients. It is an area in which complaints are frequently made to them. Patients are reported as dissatisfied with the side effects of their medication and with the medication which has been prescribed without their own preferences being taken into account³.

¹ The SOAD's own conclusions should, as set out by the Mental Health Act Commission, cover:

- “(i) the patient's mental disorder and its impact upon his/her presentation, behaviour and relationships; the patient's insight (if any);
- (iii) the need for medication in general and for this medication in particular, and the likely consequences were it not to be administered to the patient;
- (iv) any possible alternative forms of medication and why (it is assumed) they are not appropriate (or not as appropriate) in this case;
- (v) the danger (if any) that the patient represents to others, including (but not exclusively) other patients and staff;
- (vi) the appropriateness both of the means by which it is proposed to administer the medication and of any alternative means of administration”.

² Biennial Report 2003-2005 p 227 and following

³ The Commission lists among its ten common problems with the administration of the treatment provisions (Part IV) of the Act : (i) No record of discussion with patient regarding proposed treatment; (ii) No record of assessment of patient's capacity to consent to treatment; (iii) Patients telling visiting Commissioners that they

Medication for mental illness involves powerful and potentially toxic chemicals. They have significant side effects. Common side-effects include: serious weight gain leading to obesity (with the associated health risks); diabetes; impotence; disabling, embarrassing, and at times painful, movement disorders and lethargy and feeling 'drugged-up' all the time⁴.

A patient's diagnosis is not straightforward and may change several times over a period of detention. Particular medication or particular dosages may need to be changed. Furthermore there are known pitfalls in the practise of prescribing psychiatric drugs. These involve different issues of judgment (what medication, what dosage level, the compatibility of different drugs with each other for instance) and errors or poor practise can occur.

The problem of 'off-label prescribing'⁵, the use of unlicensed medicines, exceeding dosages above BNF limits and polypharmacy are all significant problems. These can have a serious impact on the patient's physical and mental health.

All of these factors contribute to the case for careful and prompt oversight of medication. Three months of being treated without consent, or with a lack of capacity to consent to treatments which may be causing harm is simply too long.

In 2004-5 18% of patients had their plan changed as a result of SOAD intervention but as the MHAC reported this is not an accurate indicator of the importance of the role.

"The SOAD provides a check on the RMO's practice, and by the very nature of the oversight provided by the Second Opinion ensures that RMOs give careful thought to their decisions. We believe that if this provision had not been available there would have been no check on the appropriateness of treatment, and many more treatment plans could have been the subject of formal complaint⁶.

The 1983 Act provides a safeguard for medication beyond a 3 month period. In recognition that this was a lengthy period the Act included a power for the Secretary of State to reduce the period by order. The government points to that as an objection to the amendment - but in 24 years it has not been used! If it is the right thing to do it should be done. Under the 2004 draft a tribunal would have authorised medication by the end of **28 days**.

are not happy taking their medication when this is covered under a Form 38 certifying their informed consent;(ix) Medication prescribed or administered outside of limits authorised on prescribed forms (Form 38 or 39);(x) Forms completed with no reference to the upper limits of dosage.

⁴ Parkinsonism, dystonia, akathisia, tardive dyskinesia, hypotension, hypothermia, hyperthermia, neuroleptic malignant syndrome (which may be fatal), drowsiness, apathy, agitation, excitement, insomnia, convulsions, dizziness, headache, gastro-intestinal disturbances, nasal congestion, dry mouth, blurred vision, difficulty with micturition, acute urinary retention, constipation, tachycardia, arrhythmias, (including sudden death), menstrual disturbances, galactorrhoea, gynaecomastia, impotence, weight gain, agranulocytosis or leucopenia, (both of which may be fatal), photosensitization, contact sensitisation, rashes, jaundice, corneal and lens opacities, and pigmentation of the skin, cornea, conjunctiva and retina (which may cause blindness).

⁵ This problem is reported in the National Patient Safety Agency Report *Building a memory: preventing harm, reducing risks and improving patient safety*. Examples of 'errors' according to this report include 'the use of psychotropics above recommended levels and the use of anti-epileptic drugs as mood-stabilisers'.

⁶ 11th Biennial Report 2003-5 , p235

The Mental Health Act Commission has stated

We believe that the current Act provides insufficient protection to patients in the first three months of their treatment under detention, when they may be forcibly given medication in doses or combinations that are outside of product guidelines and recommendations without the oversight of a Second Opinion Appointed Doctor. Some RMOs appear to share our unease: we receive (but have to decline) occasional requests for statutory Second Opinions in relation to such patients⁷.

The main argument put by the government in favour of a 3 month period before there is a need for a second opinion is that this is required for the person's condition to stabilise. We do not accept this argument. Nor it seems did the government in the 2004 Bill where only 28 days was deemed necessary before there was a review of the care plan by the new Tribunal.

They further state that

“Three months provides an opportunity for the treating psychiatrist to reflect on the medications that are to be used on the patient”.

Patients almost invariably receive medication within hours of arrival in hospital. A diagnosis and treatment plan will be formulated within days albeit that it may change over time. As the statement below, from the Minister, makes clear, the treatment plan evolves over a number of weeks - not months. It is after a few weeks, therefore, that the SOAD should be required. It is true that for a small number of patients with long histories and many admissions the diagnosis may still be revised after many years. To wait until there is a final decision is made would be nonsense.

“The likely efficacy of some individual medications can be determined in less than three months, but while a particular medication may have been started soon after the patient was detained, it is often a number of weeks into detention that the overall treatment plan evolves”.

The efficacy of a particular treatment is not the issue. The SOAD certifies medication by BNF category. Once a diagnosis is made medication, if appropriate, should be prescribed from particular categories. If, for example, the patient suffers from depression then the categories will include anti-depressants and, perhaps, mood stabilizers. The SOAD would usually authorise that any anti-depressant and mood stabilizer may be given (and other medication if indicated). The SOAD certificate would, however, limit the dose range (usually to that in the BNF), the number of medications from each category, the route of administration, and prevent other medications be prescribed without a further review.

Where people are treated without their consent there is also an advantage in an early second opinion. Having come to a decision as to the nature of the mental disorder the medical practitioner will be treating that with medication from a particular group of medications appropriate for that mental disorder. The second opinion doctor does not authorise a particular treatment but a group of treatments, leaving the practitioner the role of selecting and if necessary changing the particular drug that is prescribed.

⁷ 11th Biennial Report p.236

The Minister at Committee stated that there was” no evidence to show that the current period is not the right amount of time for ensuring that medication is taking effect and if the medication has changed for ensuring that it has taken effect”.

What evidence would demonstrate the “right amount of time”? The purpose of the SOAD is not to confirm, or refute, that the medication is “taking effect”. It is to reduce the risk of harm coming to a patient by the inappropriate use of medication and to ensure that alternative medical treatments, including non-pharmacological interventions, are considered. There is considerable evidence of polypharmacy, use of medications in doses significantly above their licensed dosage and use of medications for purposes for which they have no licence at all.

Resource implications. Up to 8,000 more SOAD hours.

While this may be an accurate figure it is hard to accept that the government is really concerned about this since their own amendments for treatment of community patients will greatly increase the number of SOAD hours (everyone will get a SOAD) while the amendment proposed by the Alliance will reduce the number of SOAD hours. (CTO patients will get a SOAD only in the same way as do those who are detained – that is if they stop consenting to treatment or become incapacitous)

Human Rights issues

The Draft Code of Practice reminds clinicians of their obligations under Article 3 and Article 8 in the following terms:

- “•compulsory administration of treatment which would otherwise require consent is invariably a breach of Article 8 of the Convention (right to respect for physical integrity as an aspect of private life). Such a breach can be justified where it is in accordance with law, and it is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person’s mental disorder and the improvement of their health.)
- compulsory treatment is capable of being inhuman treatment .. contrary to Article 3, if its effect on the person concerned reaches a sufficient level of severity.

The Government however claimed in Committee that this is not a human rights issue. The Joint Committee on Human Rights in its recent Reports on the Mental Health Bill disagree. They state⁸

“There is now a recognition that the effects of some psychiatric drugs may be as unacceptable to patients as ECT, and that the likely efficacy of a particular antipsychotic medication may be assessed within one month rather than three. The Mental Health Act Commission Eleventh Biennial Report expresses the view that the 1983 Act provides insufficient protection to patients’ Article 8 rights in relation to drug treatment without consent, ... **Three months is a long time to be in receipt of compulsory psychiatric treatment without the opportunity for review and supervision of the responsible clinician’s decision to impose that treatment, and we consider it is doubtful whether the Government’s obligation under**

⁸ Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill, Fourth Report of Session 2006-07 p.23.

Article 8 to provide effective supervision and review of treatment without consent is discharged by such a long waiting time.

In its later Report the Committee has reiterated its concern on this issue and called for the period of 3 months to be reduced⁹. They remain unconvinced by the government's arguments and state

“It seems to us that the issue is not how long it takes the medication to take effect or the psychiatrist to arrive at an effective treatment plan, but how long it is reasonable to expect a patient to endure treatment which he or she is resisting without any opportunity to seek review of the need for that treatment. We recommend that the waiting period be reduced to one month in line with the provisions relating to second opinions for treatment in the community”.

⁹ Fifteenth Report of Session 2006-7 p.9