Psychiatric Bulletin (1990), **14**, 502–504

The College

Public policy statement on consent to medication

The College has recently received an enquiry about explanations concerning medication which should be given to patients. As a result of this, the Public Policy Committee has produced a revised statement.

In normal clinical practice in all medical specialties an explanation must be given to the patient about the illness and the suggested treatment as well as possible alternatives. The doctor and patient should then be able to agree on a proposed treatment plan. Foreseeable consequences should be discussed and any necessary precautions stated. Verbal explanation accompanied by discussion with the patient will suffice in the majority of cases.

It is good practice to record in the notes that an explanation has been given and that the patient's agreement to the treatment plan obtained. Recent Department of Health guidelines specify that if the treatment can carry substantial or unusual risk, both the giving of an explanation by the health professional and giving of consent by the patient must be formally recorded on a consent to treatment form.

In cases of drugs where particular precautions have to be taken, a written, sometimes printed explanation, is given to the patient to keep as a reminder, Such written information should be given to the patient only after verbal explanation has taken place and consent given.

Consent of non-volitional patients, including minors, to treatment has been already dealt with by the College's paper 'Consent of Non-Volitional Patients and *De Facto* Detention of Informal Patients' approved by Council in October 1989.

As stated in Appendix C of the Department of Health draft guidelines 'Consent to Treatment or Examination', the capacity to understand the information given will be influenced by both the intellectual state and by the nature of mental disorder, but may also vary from time to time.

Approved by
Executive and Finance Committee,
May 1990

Patients' monies

Recent reports by The Mental Health Act Commission[1,2] have addressed issues concerning financial arrangements for hospital in-patients, particularly those long-stay patients whose income is often derived solely from statutory benefits. The Commission was specifically interested in the possible underclaiming of benefit, the power of the RMO to limit a particular patient's income under DHSS memorandum HM(71)90, and the apparent lack of a co-ordinated approach by hospital administrators in the use of patients' monies for the benefit of individual patients, especially those incapable of making decisions for themselves.

The Executive and Finance Committee of The Royal College of Psychiatrists in October 1988 recommended that the Public Policy Committee prepare a policy statement on Patients' Monies and Welfare Benefits in the light of the Commission's reports. This draft policy document is produced for consideration by the Public Policy Committee in this regard.

For clarity, these three issues will be taken in turn.

(a) Under-claiming of benefit

No statistics are available concerning the proportion of patients likely to be underclaiming benefit. Concern has been expressed that it may be significant. The Social Services Committee (Session 1984–85)[3] reported that "Evidence suggests that take-up of benefits is low among both mentally handicapped and mentally ill people and their families".

Although under-claiming of statutory benefit is not confined to those in psychiatric care, patients are often poorly equipped to utilise the complexities of benefit schemes to their best advantage. Initiatives

such as 'Benefit Take-up Exercises' and basing Citizens' Advice Bureaux staff in psychiatric hospitals have been reported as being useful. However, hospitals with policies designed to help all patients with benefits are uncommon. Bradshaw & Davis reported that a National Survey of all hospitals showed only 1 in 270 offered to new admissions a benefit check and advice on claiming.[4]

It is therefore recommended that:

(1) The College recognises that under-claiming of benefit by some patients and their families is a problem, and further encouragment should be given to research in this area, in order that the extent of the problem be quantified.

(2) Hospital practices which attempt to ensure that, where relevant, all patients are receiving optimum statutory and voluntary benefit are to be commended. In this regard, particular note is made of innovations such as Benefit Take-up Schemes.

(3) The important role of Social Workers and Community Psychiatric Nurses in advising patients on statutory benefit matters is recognised.

(4) All hospitals develop, in conjunction with the local DSS offices, procedures to expedite benefit claims by patients to prevent any hardship consequent upon avoidable administrative delays.

(b) The authority of the Responsible Medical Officer to limit benefit

DHSS memorandum HM(71)90,[5] Paragraphs 5 and 6, states that certain sources of income, namely the Hospital Personal Allowance, National Insurance & Supplementary Benefits may be reduced by the RMO if the full standard weekly allowance cannot be used by or on behalf of the patient for his personal comfort or enjoyment.

Although the last policy document of the Royal College of Psychiatrists concerning patients' finances in 1981[6] indicated that these powers were suspected to be "rarely used", they have been heavily criticised on the basis that no patient should be deprived of the right to receive benefit because of his/her mental state, and that the discretion to stop benefit should end.[7]

For practical purposes it would be difficult to envisage a scenario whereby, notwithstanding the severity of a patient's mental disorder, finances cannot be used to improve on an individual's quality of life. Nineteen years after the issuing of this memorandum, the authority invested in the RMO appears now theoretical and to be used only in most unusual circumstances. The problem, if one exists, appears to be how income can assist a patient, not if a patient can be assisted.

Paragraphs 5 and 6 of the memorandum, which awards powers to limit a patient's income, should not be confused with paragraph 11, where the amount of cash a patient should receive at any one time may be restricted if a patient's mental or physical condition makes him/her unable to handle more than a limited amount of cash. It also invests similar powers to the RMO if it is considered necessary on therapeutic grounds to restrict the amount which a patient should handle while in hospital.

It is therefore recommended that:

(5) A patient's right to benefit must be regarded as an entitlement to be used as appropriate by, or when incapable on behalf of, the patient for his/her security, comfort or enjoyment.

(6) It is recognised that there may be circumstances that, for clinical or therapeutic reasons, such as mania or part of an agreed behavioural management programme, it may be in the patient's best interests that the amount of cash he/she handles at any one time should be temporarily limited.

(c) The use of patients' monies

The basic allowance for long-stay patients is currently £8.70 a week. A few patients, however, with income from other sources can accrue significant savings. To suffer from a psychiatric illness does not necessarily of itself prevent a patient from making reasonable judgement on how finances should be used, but particularly with those suffering profound mental handicap or other organic conditions, problems may arise. The present administrative system allows for safe investment of patients' assets, and is not geared towards the utilisation of an individual's finances to meet his/her requirements. Again, the extent of the problem is not known, but many severely handicapped patients, unable to manage their finances, will have delegated power of attorney or have direct assistance from the Court of Protection.

Patients' monies should not subsidise the responsibility of the Health Authority to provide basic occupational therapy and recreational activities in the institutional setting which, for patients, is their home. The ultimate responsibility for the clothing of patients also rests with the Health Authority. Although patients should not be discouraged from purchasing their own clothes, indeed this can be therapeutic, those with little income will require assistance, and communal clothing is an out-moded practice.

Various schemes have been proposed to spend allowances to enhance a patient's quality of life, including arranging holidays, mobility aides, transport hire, and patients' clubs. However, no general guidelines can cater for the specific requirements of each individual patient.

Furthermore, other than involving the Court of Protection, there are no statutory mechanisms allowing the Responsible Medical Officer to have access to a patient's money to meet his/her needs, although it appears to be a common local practice for small sums to be spent by the nursing staff on behalf of severely disabled patients. The climate of decision making may change substantially when Section 1 of The Disabled Persons Act 1986 is implemented enabling patients' advocates to be appointed. It is recommended that:

(7) A key worker be nominated from the multidisciplinary team to advise on the finances and needs of each individual patient, liaise with involved parties, and act, as necessary, on his/her behalf.

It is understood that the Department of Social Security is reconsidering the issue of long-stay patients unable to manage their financial affairs, and it is anticipated that the recommendations made in this document be considered for inclusion in the Department's revision of DHSS Memorandum HM(71)90.

Approved by Council, March 1990

References

(1) The Second Biennial Report, Mental Health Act Commission 1985–87.

(2) The Third Biennial Report, Mental Health Act Commission 1987–89.

(3) House of Commons (1985) Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People. Second report from the Social Services' Committee Session 1984–85 (Chairman – Mrs Renee Short). London: HMSO.

(4) Not a Penny to Call My Own: poverty amongst residents in mental illness and mental handicap hospitals. Bradshaw & Davis, Kings Fund Publishing Office, 2 St Andrew's Place, London NW1 4LB.

(5) Hospital Memorandum on Patients' Monies. HM(71)90, Department of Health & Social Security, Alexander Fleming House, London SE1 6BY.

(6) Report to Council from Public Policy Committee on DHSS Consultative Document: Patients' Money. Accumulation of Balances in Long-stay Hospitals. PPC 29/81.

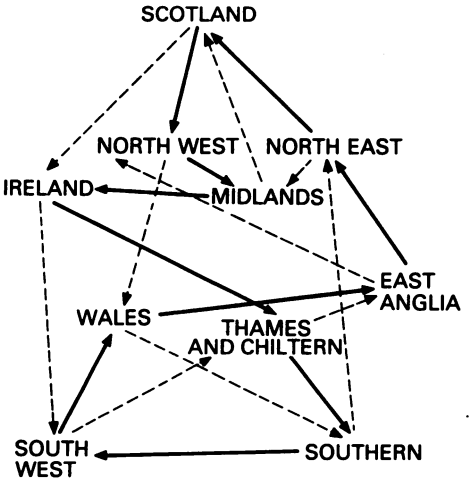
(7) Mind Policy Paper No. 1: Money in Hospitals: the incomes of people living in long-stay hospitals. MIND, National Association for Mental Health, 22 Harley Street, London W1N 2ED, 1983.

Approvals Exercise

Fellows and Members will know that the Approvals Exercise depends on teams comprising the convenor, a consultant and a senior trainee from one Division of the College, making visits to training schemes in another Division.

It was decided soon after the institution of the Approvals Exercise that for a number of reasons there should be a change of Divisional visiting every few years. It is now more than a decade since the last change and so it has been agreed by the Central Approval Panel and ratified by the Court of Electors, that there should be a change of Divisional visiting as from 1 January 1991. The diagram right shows the existing scheme of visits and also the proposed change. We hope that implementing this change will not cause any difficulties for the recipients of College Approval Visits which have in general, been so successful in raising training standards in hospitals and schemes in the United Kingdom and Ireland.

Professor A. C. P. Sims
Dean, July 1987–July 1990



Interrupted lines – existing arrangements
Heavy lines – proposed system