The College

The Public Policy Committee—A Decade On

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Following the establishment of the College, the Public Policy Committee held its first meeting in March 1972. It evolved from the Parliamentary Committee of the RMPA and at that meeting its terms of reference were agreed and are still current. They are: 'That it shall take note of and consider legislation, existing and prospective, and departmental, regional and local administrative practice with a view to commenting on matters touching upon the affairs of the College. In this respect it is empowered to take immediate action, if public statements about psychiatric affairs are urgently required, but normally will report to Council any measures which it recommends. It shall concern itself with the education and enlightenment of the public in matters relating to the prevention and treatment of mental disorder and the work of the College and its members.'

So the Public Policy Committee has a function to review all legislation relevant to the practice of psychiatry internationally, nationally and at more local levels. It also has a responsibility to act as the public relations vehicle of the College, commenting on issues of public interest as well as having a remit to inform the public about psychiatry, the College and indeed mental health matters generally.

The membership is drawn mainly from Council with additional members co-opted in order to give a balanced representation of regional and specialist interests. A useful arrangement has been the attendance of a senior medical representative from the DHSS (currently Dr Pamela Mason) in the capacity of observer. She is able to provide information on Departmental policy and to present the Committee's views informally to her colleagues, so acting in an effective liaison role.

The current Chairman is Professor Gerald Timbury; his predecessors were the late Dr Martin Cuthbert, Dr Arthur Bowen and Dr Donal Early, who were each in office for approximately three years. The first secretary, Dr Morris Markowe, relinquished his position in 1973 and Dr Brian Ward has held this post since.

A review of the minutes over the past decade reveals the large number of issues over which the Committee has deliberated. From the beginning it was appreciated that the work would be dealt with most effectively by establishing working parties which would report to the main Committee when a particularly important subject was being considered. It might be of interest to the reader to hear of some of the important issues discussed by the Committee. For several years it was involved in the controversies arising from the recommendations of the various Committees of Inquiry which took place in various psychiatric hospitals and on the many issues relating to patients' rights and liberties, which developed from these investigations. This soon led into further controversial matters such as the College's relationship with MIND, the status of psychiatrists and the developing role of our 'non-medical' colleagues in the disciplines of psychology, social work, nursing and occupational therapy. Working parties reported on such subjects as Death Certification and Coroners, the Butler and Nodder reports, various ethical issues and discussions leading to the College's recommendations on the Mental Health (Amendment) Bill. A variety of topics relating to patient care have been discussed such as clothing allowances, patients' money and travelling expenses, and hospital shops as well as the problems arising from a history of psychiatric illness in relation to driving licences, electoral registration and life insurance.

Documents published by other bodies have been reviewed and the Committee's opinions forwarded for consideration by Council. These have included the COHSE Document on *The Management of the Violent Patient,* the Criminal Law Revision Committee on Sexual Offences, various Royal Commissions and DHSS reports on such subjects as Patient Transport. This list, by no means comprehensive, I hope, provides an impression of the subjects and issues tackled.

As the decade progressed, alterations in emphasis have occurred. Firstly, the growth of specialist sections in the College have made them an obvious source of first opinion on specific matters on which they have specialist knowledge and experience. Secondly, certain issues have such continuing significance that special standing committees have been formed reporting directly to Council dealing with the new Mental Health (Amendment) Bill, ethical standards, confidentially issues and the political abuse of psychiatry. It has also become clear that the PPC is not an appropriate vehicle able to deal with public relations issues which call for a rapid response from the College and there are now alternative arrangements for either a senior officer or a recognized expert on a particular subject to make such a response. The PPC remains responsible for monitoring the media on topics of psychiatric interest.

The College has not thus far had an established policy about publishing material, or developing other methods for the enlightenment of the public on the prevention and treatment of mental illness. Information on the work of the College and its members is disseminated through the *Bulletin,* which has a wide distribution.

The work of the PPC is of great importance, but in my

view its terms of reference need to be re-defined and some of its original functions should be formally assigned to other College bodies, which, to a considerable extent, is already the *de facto* position.

Meanwhile, the Committee prospers albeit deliberating mainly on issues which come to it because they do not readily fall within the terms of reference of other College bodies. It has most recently been putting its final views on the Mental Health (Amendment) Bill to the Special Standing Committee, establishing working parties on the subjects of the Court of Protection and Lord Chancellor's Visitors, and the Management of Attempted Suicide, as well as commenting on DHSS documents on In-patient Facilities for the Mentally Ill and the Registration System for Accommodation Registered under the Residential Homes Act.

The range of subjects discussed clearly varies from those of widespread interest and controversy to trivial topics which nevertheless merit consideration, and range from lively and exciting to dull and tedious. This broad variety makes being a member of this Committee stimulating and informative. However, I consider that too wide a range of subjects reduces effectiveness and in its present role the PPC may have a limited future. I forecast that it will either be fragmented and absorbed into other College bodies or that it will thrive with more sharply defined, if more restricted, terms of reference.

Medical Visitors and the Court of Protection

The following guidelines (approved by Council in June 1982) are published to assist doctors who may be involved in preparing medical certificates for the Court of Protection in connection with the appointment of a receiver for a patient who is incapable of managing his affairs.

Certificates of Incapacity—Guidelines for Medical Officers

1. Doctors should be aware that if a person owning real or personal property becomes incapable, by reason of mental disorder, of safeguarding and managing his affairs, an application should be made to the Court of Protection for the appointment of a Receiver. This procedure applies equally to those cases in which a patient has given a Power of Attorney but which ceases to be valid when the patient, by virtue of such disorder, is no longer capable of withdrawing it.
2. The Court of Protection is an office of the Supreme Court of Judicature, under the direction of a Master, assisted by a Deputy Master and other nominated officers known as Assistant Masters. The Court's existence in some form is considered to have arisen in the reign of Edward I; its jurisdiction and procedures are now governed by the Mental Health Act 1959 and the Court of Protection Rules 1982. The Court's primary function is to safeguard the interests of a patient by providing for his maintenance and that of his family and dependants and for the general management of his property and affairs. The latter will include, for example, authorizing the Receiver to receive rents, dividends, pensions or other income arising, sign documents and care for or possibly sell the patient's house (if he is no longer able to reside there) and, of course, general oversight by the Court in all these and many other matters.
3. An application to the Court of Protection for the appointment of a Receiver must be supported by a medical certificate stating that, in the doctor's opinion, the patient is incapable of managing and administering his property and affairs by virtue of mental disorder (as defined in Section 4 of the Mental Health Act 1959).
4. Criteria for assessing incapacity are not identical with those for assessing the need for compulsory admission to hospital. The fact that a person is suffering from mental disorder within the meaning of the Mental Health Act 1959, whether living in the community or resident in hospital, detained or informal, is not of itself evidence of incapacity to manage his affairs. On the other hand, a person may be so incapable and yet not be liable to compulsory admission to hospital.
5. The certifying doctor is usually the person's general practitioner or a consultant, but any doctor who has examined the patient may give a certificate. He does not have to be approved under Section 28 of the Mental Health Act 1959 as having special experience in the diagnosis or treatment of mental disorder.
6. The certificate is given on form C.P.3 which requires the doctor to state in paragraph 3 the grounds on which he bases his opinion of incapacity. It is this part of the certificate which appears to give the doctor the most difficulty. What is required is not merely a diagnosis (although this may be included) but a simple statement giving clear evidence of incapacity which an intelligent lay person could understand, e.g. reference to defect of short-term memory, of spatial and temporal orientation or of reasoning ability, or to reckless spending (sometimes periodic as in mania) without regard for the future, or evidence of vulnerability to exploitation.
7. In many cases of senile dementia, severe brain damage, acute or chronic psychiatric disorder and severe mental