

## Written evidence submitted by Rethink Mental Illness (MCAB18)

### Rethink Mental Illness' Consultation Response to Public Bill Committee on the Mental Capacity (Amendment) Bill | House of Commons

#### Rethink Mental Illness and the Mental Capacity (Amendment) Bill

Rethink Mental Illness has a significant interest in the Mental Capacity Act 2005 (MCA), because people severely affected by mental illness will often rely on the protections of the MCA if they lack capacity. Over the past year, we have undertaken significant work on the Liberty Protection Safeguards (LPS), including a response to the consultation by the Joint Committee on Human Rights<sup>1</sup> and briefings and coalition work during the Lords stages of the Mental Capacity (Amendment) Bill (the Bill). Much of our work has focussed on the possible interactions between this Bill and the Independent Review of the Mental Health Act, which published a final report on the 6<sup>th</sup> of December 2018.

Since the Review has been published, the Government has committed to bringing forward a Mental Health Bill and confirmed that they will not seek to amend the interface between the Mental Health Act (MHA) and the Mental Capacity Act within the current Mental Capacity (Amendment) Bill. We welcome both of these commitments and our focus during the Commons stages of the Bill is ensuring that the LPS are as suitable as they can be for people severely affected by mental illness.

While the question of the complex interface between the MHA and the MCA is likely therefore to be dealt with at a later date, and in a deliberative and consultative manner, people severely affected by mental illness can already be treated under the Mental Capacity Act, so will be affected by this Bill regardless of later changes. Our suggested considerations and amendments will also affect other groups of people, making a positive impact on those affected by the provisions of this Bill regardless of their diagnosis or condition.

Finally, Rethink Mental Illness is concerned that this Bill is being rushed through Parliament without due consideration for the significant issues that have emerged before and during Parliamentary scrutiny of the legislation.

#### Overview

The Public Bill Committee should consider the following key changes to the Bill:

1. Safeguard people with fluctuating capacity.
2. Broaden the criteria of objection beyond the current limitations (of objecting to treatment in a particular place, or to living in a particular place) so that objections to receiving particular kinds of treatment and care, or detention overall, are captured.
3. Enhance the conditions that can be set on LPS authorisations to ensure that people who may recover from their condition mid-way through their detention do not continue to be detained.
4. The 'best interests' test for the provision of independent advocacy to be amended.

We suggest amendments to address these issues in each section. Improvements in these areas are also likely to benefit people detained under the LPS with conditions other than mental illnesses.

In addition, we support broader amendments to the Bill through our membership of the Mental Capacity 3<sup>rd</sup> Sector Forum. We are therefore also calling for:

---

<sup>1</sup> Rethink Mental Illness (2018) [Consultation Response: The Right to Freedom and Safety](#) Written evidence: DOL0055

1. The Government to alter their proposed replacement for the 'rights to information' clause. We would like to keep aspects of the clause which require the cared-for person to be informed about their right to an independent advocate, and for people to be given information about their rights before they are detained under the LPS.
2. A shortening of the maximum 3-year renewal period for authorisations. While we are aware that this is intended only for the most severe and degenerative conditions, and that there are two one-year renewals which are required first, the Mental Health Act Review recommended that the maximum period of detention be reduced under that Act. We would like to ensure there is consistency and clarity across the two Acts, including with regard to the length of renewals.

## Detailed discussion

### Fluctuating capacity

People with conditions which mean that their capacity fluctuates are likely to be particularly affected by the proposed LPS. There are numerous conditions which can cause the capacity of the person affected to fluctuate, in very different ways. An obvious example is bipolar disorder, where people affected by the condition can lose capacity during the manic and depressive phases of the illness, either of which can also be accompanied by psychotic symptoms. The duration and severity of manic or depressive phases cannot necessarily be predicted in advance.

Other conditions, such as Alzheimer's, can also result in the capacity of the person fluctuating dramatically, in some cases multiple times over the course of a single day. While fluctuating capacity links to safeguards around recovery (if someone gets better during the course of their detention – a particular possibility with mental illnesses), the two are distinct as fluctuating capacity can include lucidity that is very short term. Recovery would mean that a person no longer qualifies as lacking capacity – someone with an acquired brain injury who has been given significant support and can now live independently as a result is one example.

At its heart, provisions around fluctuating capacity represent a fundamental issue for the deprivation of liberty for the purposes of care and treatment. Where people regain their capacity and are lucid, it is clearly not morally right that the legal regime which deprives them of their liberty does not take that fact into account.

The Bill does not currently include considerations or safeguards for people with fluctuating capacity and does not call for the vital consideration to be explicitly included in initial assessments or care planning. Speaking at Committee Stage in the House of Lords, Lord O'Shaughnessy argued that:

'...we believe this would be better dealt with through a code of practice, which would allow for more detail and more regular updating but would also allow the use of case studies to bring examples to life. We plan to give much more detailed guidance in the new code of practice, and I reassure noble Lords that we will be working with the sector in order to produce it.'<sup>2</sup>

We disagree with his assessment, as we do not believe that such a fundamental issue should be left entirely to the Code of Practice, a draft of which has not yet been produced, but should be spelled out on the face of the Bill.

As such, we urge the Committee to consider to our proposed amendment below.

---

<sup>2</sup> Mental Capacity (Amendment) Bill [HL] [Lord O'Shaughnessy](#) 22<sup>nd</sup> October 2018 Column 711.

### Suggested amendment: Fluctuating capacity

Page 13, line 47, replace sub-paragraph (b) with:

- (b) a determination made on an assessment in respect of the cared-for person as to whether the person's capacity is likely to fluctuate, and
- (c) a determination made on an assessment in respect of the cared-for person, that the person has a mental disorder.

**Explanatory note:** This amendment requires that an assessment of whether a person's capacity is likely to fluctuate is included within the initial capacity and medical assessments, and therefore seeks to ensure that fluctuating capacity is reflected in the care plan of the cared-for person.

### Advocacy

Independent advocacy is vital to help vulnerable people to understand and exercise their rights under the law. Rethink Mental Illness is a provider of advocacy services, including statutory Mental Health Act and Mental Capacity Act services, and provided two representatives to the Topic Group of the MHA Review which considered advocacy. As a result, we have significant experience in this field.

We are concerned, as are many other stakeholders, that the provision of independent advocacy within the current Bill is subject to a 'best interests' test. The clause states that an IMCA should be appointed unless the responsible body is satisfied that 'being represented and supported by an IMCA would not be in the cared-for person's best interests.'<sup>3</sup> While we agree with the government that no one should be forced to have an advocate if they have stated with capacity that they don't want one, we believe an opt-out approach to advocacy would greatly improve the Bill and give clarity to service users and providers.

In an analogous situation, amendments made to the Mental Health Act in 2007 introduced statutory advocacy to that Act. Yet safeguards which were intended to be used only in the very rare circumstances that an advocate would be inappropriate were greatly overused, to the point where the MHA Review states that:

'Despite a right to an advocate for those subject to the MHA, we heard evidence that in some areas IMHA services are insufficiently promoted and difficult for patients to access'

The MHA Review suggests as a solution that:

'[...] 'Opt out' service models have been successful where they have been developed and delivered, such as those provided by Advocacy Focus and seAp (Plymouth and Cornwall), but the use of this model is patchy. Under the opt out model, patients are automatically referred and advocates regularly visit wards to speak to patients.'<sup>4</sup>

Many of the difficulties around access appear to stem from the fact that the right to advocacy under the MHA does not require advocates to be assertive or even present on ward, resulting in under-commissioning by local authorities. The clear lesson from the experience of Rethink Mental Illness and numerous other service providers, campaigning organisations, and service users, over the past 11 years of statutory advocacy provision under the MHA, is that great care is needed not to limit how any right to advocacy translates in practice.

<sup>3</sup> Mental Capacity (Amendment) Bill, Schedule 1, clause 39 (3)(b), page 22.

<sup>4</sup> Independent Review of the Mental Health Act (2018) [Advocacy](#), pages 88-89.

As a result, we are calling for the ‘best interests’ test for IMCA provision to be removed from the current Bill and would strongly recommend that the Committee consider our two amendments below.

### **Suggested amendment: Advocacy**

On page 22, after (3) insert (3A)

“(3A) In exercising (2) and (3) above the responsible body must

- a) take all reasonable steps to encourage close working relationships between clinical and care staff and the IMCAs who may be appointed to support the cared for people in their services
- b) require IMCA services to wherever possible meet the cared for people in the places where they are receiving care and treatment
- c) monitor the rate of appointments of IMCAs and take all reasonable steps to ensure that all cared for people who would benefit from an IMCA are supported by one
- d) ensure that where a cared for person with capacity has chosen not to accept the offer of an IMCA, they are given further opportunities to be supported by one at appropriate intervals and when their circumstances change
- e) ensure that where it has determined that it is not in a cared for person’s best interests to be supported by an IMCA, this decision is reviewed at appropriate intervals or when their circumstances change”

**Explanatory note:** This is a probing amendment showing some of the practices that could help ensure that all those who would benefit from advocacy receive it. We believe it would be very helpful to have ministerial commitments that the Code of Practice will address these points.

### **Suggested amendment: Allowing cared for people to meet IMCAs**

On page 25, after line 6 insert (5)

“(5) Nothing in section 39 (3)(b) above should be interpreted as preventing the responsible body from arranging for the cared for person to meet an IMCA, where this could enable a more considered or informed judgement to be made by the responsible body about the cared for person’s best interests.

**Explanatory note:** This amendment recognises that giving a cared for person a chance to meet with an IMCA and to hear about advocacy first hand may enable the responsible body to make a better informed view of that person’s best interests with regard to the appointment of an advocate. The aim would be to reduce the risk of wrong assumptions being made that cared for people would not benefit from an advocate.

## **Objection**

Under the Mental Capacity (Amendment) Bill, a pre-authorisation review of the proposed LPS application must be conducted by an Approved Mental Capacity Professional (AMCP; with enhanced powers of scrutiny and investigation) if it is reasonable to believe that the cared-for person:

- Does not wish to live in the place the arrangements require them to live in, or
- Does not wish to receive care or treatment in the place the arrangements specify.<sup>5</sup>

In other words, if there is reason to believe there is an objection to the place provided for in the arrangements, then the initial review of those arrangements is more intensive.

---

<sup>5</sup> Mental Capacity (Amendment) Bill, Schedule 1, clause 21 (2), page 16.

Rethink Mental Illness are concerned that the limitation of objection to be purely place-based on the face of the legislation will have significant consequences for people who may object to other aspects of their detention under the LPS. This is likely to affect people severely affected by mental illnesses, who may be more likely to experience other forms of restrictions which are not linked to a place but will have an impact on other groups of people as well. If someone wishes to object to being injected, for example, those objections would not trigger any additional oversight.

We are therefore calling for the government to broaden the kinds of objection which trigger AMCP involvement to include objections to specific kinds of care and/or treatment, and objection to care and/or treatment overall, and have drafted an amendment to that effect.

### **Suggested amendment: Broadening the criteria for objection**

Page 16, line 13, insert sub-paragraph:

(c) the arrangements provide for the cared-for person to receive care or treatment, and it is reasonable to believe that the cared-for person does not wish to receive the specific kinds of care or treatment which the arrangements provide for, or

(d) it is reasonable to believe that the cared-for person does not wish to receive care or treatment overall.

**Explanatory note:** This amendment broadens the criteria of objection in the Bill, so that it applies to objections to the kinds of proposed care or treatment to be given, or to an overall objection to care or treatment. The amendment is particularly important for people with mental illnesses who may be treated under the LPS but applies beyond this group as well. Broadening the criteria of objection requires additional scrutiny by AMCPs in these cases.

### **Safeguards for people who may recover**

There is a dramatic difference in rights, entitlements, and safeguards between the legislative frameworks for detention under the Mental Capacity Act compared with the Mental Health Act. This disparity will become particularly pronounced if the MHA Review's proposals are enacted alongside the LPS but will remain true even if the Review's proposals are not enacted.

Part of our concern is that, because the LPS appears to have been designed around the needs of people with neurodegenerative conditions or learning disabilities (though our colleagues in organisations focussed on such conditions do not believe it protects people with those conditions sufficiently), there are currently few protective mechanisms to ensure that people can be discharged quickly should they recover.

This will be particularly pronounced if the Review's proposals are enacted and some people with mental illnesses become eligible only for LPS detention, which is why we have drafted an amendment, below, for consideration by the Committee which seeks to ensure the needs of such people are considered. The amendment will ensure that the variation of authorisations, which the responsible body can undertake, may take fluctuating capacity and the likelihood of change in a person's condition into account.

### **Suggested amendment: Safeguards for people who may recover**

Page 19, line 34, add sub-paragraph:

(2) In varying an authorisation, the responsible body may also consider:

(a) Whether the cared-for person's capacity is likely to fluctuate, and

- (b) Whether any restrictions imposed are necessary to prevent harm to the cared-for person and proportionate to the likelihood of that harm, and are likely to continue to be necessary for the duration of the authorisation.

**Explanatory note:** This amendment enhances safeguards around the variation of conditions by the responsible body. It indicates that the responsible body should consider whether the person's capacity may fluctuate, and whether the restrictions which are proposed should be in place for the duration of the authorisation. The intended effect is to enhance protection for people with mental illnesses who could be detained under the LPS, as their conditions are likely to fluctuate.

*January 2019*