

Written evidence submitted by the Royal College of Psychiatrists (RCPsych) (MCAB44)

Mental Capacity (Amendment) Bill – Committee Stage

The Royal College of Psychiatrists welcomes action to reform the broken system for making sure that people who lack capacity get the right care and are safeguarded against abuse.

We are very pleased that the Government has listened to some of the key concerns expressed by psychiatrists removing the stigmatising phrase 'unsound mind' and extending protections to 16- and 17-year olds.

Our members are however concerned about how quickly the Bill is progressing and the number of major decisions being made without proper consultation. For example, the Government's proposed amendment to create a statutory definition of a deprivation of liberty will have a far-reaching impact who the Bill will apply to so needs careful consideration.

The Bill as it is currently written, leaves many of the important details to statutory guidance and the code of practice. It is therefore important that the Government makes a firm commitment that they will consult fully on a draft code of practice for clinicians and others who need to work with the Act.

We believe the Bill can still be improved in the Commons. In particular, we would like to get a guaranteed safeguard that no one has their liberty denied, because of a mental disorder, without first being seen by a qualified doctor.

Ensuring medical assessments can only be undertaken by qualified people (Amendment 31)

Amendment ensure no one has their liberty deprived because of a mental disorder without being seen by a doctor

Page 13, leave out lines 47 and 48 and insert—

"(b) a determination made on an assessment by a registered medical practitioner in respect of the cared-for person that the person has a mental disorder."

Under the new rules set out in the Bill, the "authorisation conditions" include that someone should be assessed for whether they have a mental disorder.

The Royal College of Psychiatrists believes that the assessment of a 'mental disorder' should be made by a 'Registered Medical Practitioner' as no one should have their liberty denied, because of a mental disorder, without first being seen by a qualified doctor.

It is essential for the clinician making the assessment to be able to make the judgement whether the individual has a mental disorder and not another condition which is presenting as a mental disorder. It is also important to consider whether or not the disorder can be treated or managed without depriving the person of their liberty. This can require assessment not only of their medical history and mental state but also of their past and current physical health and medication.

Under the current DoLs system the equivalent assessment must be carried out by medical doctors either approved under section 12 of the Mental Health Act 1983, or be registered medical practitioners with at least three years' post-registration experience in the diagnosis or treatment of mental disorder, such as GPs with a special interest.

The new Bill says that the person commissioning the assessment has to decide whether the person carrying out the assessment has the relevant skills and experience. This could lead to a significant watering down of the levels of protection if we don't clearly state who can carry out these assessments.

The JCHR report[i] was clear that in order to comply with human rights law, any deprivation of liberty under Article 5(1)(e) requires 'Objective medical evidence of a true mental disorder of a kind or degree warranting compulsory confinement, which persists throughout the period of detention;'[ii].

Given this requirement for 'objective medical evidence', there needs to be a guarantee on the face of the Bill that only a Registered Medical Practitioner with appropriate training has the power to determine whether someone has an 'unsound mind' or 'mental disorder'.

So far, the Government have not committed to guarantee that only Registered Medical Practitioner should make the assessment but have said they will set out in the code of practice what competencies the person carrying out the assessment would need. In the Lords the Minister suggested this would be a physician but did not give any guarantees.

This assessment is a core part of a process which is of huge significance given that it relates to the deprivation of an individual's liberty. The Royal College of Psychiatrists therefore believe it is critical that stipulations of who this can be carried out by are on the face of the Bill or in Regulations, rather than being relegated to a Code of Practice.

Ensuring an appropriate definition of deprivation of liberty - New clause 1 - 4ZA

We recognise, as stressed by the JCHR, that providing a statutory definition of deprivation on liberty which is compliant with the ECHR Article 5 is difficult due to the lack of clarity in Strasbourg case law.

The well recognised impact of the definition set out within the Supreme Court's *Cheshire West* ruling highlights the importance of any statutory definition being appropriate and workable and how much such a definition can impact on the scope of such a scheme.

A definition of deprivation of liberty that has not been thoroughly consulted on and thought through could have the very opposite effect to that called for by the Joint Committee on Human Rights- clarity for families and frontline professionals.¹

The process around the Mental Capacity (Amendment) Bill has been extremely rushed, nowhere more so than around the formation of this definition. We are calling on government to consult more thoroughly on this with patients, families, carers and professionals.

A statutory definition of a deprivation of liberty is likely to impact on the scope of the safeguarding system within this Bill. We would strongly advise that the Government reissues an impact assessment which takes the definition into account.

Comments on subsections of the proposed definition

Sub-section 2 - "*A person is not deprived of liberty in a particular place if the person is free to leave that place permanently.*"

The meaning of this subsection is unclear, and so it would be difficult to apply in its current form.

The phrase "free to leave that place permanently" requires clarification. Is there a time limit before which someone must be allowed to leave? And how would short term-placements be approached?

Scenarios, which could all fall under this subsection and be excluded from the safeguarding scheme in this Bill, differ widely. Constraints could arise primarily from what a care team may allow, or from external factors such as cooperation of family members or personal finances.

¹ <https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/1662/1662.pdf>

To illustrate this, patient A could find herself in a range of scenarios.

Patient A has dementia and needs for personal care, which she some-times resists. She has been placed in a care home with nursing to meet her needs. She is not happy there and wishes to leave.

- **Scenario 1A:** The care team would be happy for her to be transferred to an alternative facility offering similar care, and have offered a range of alternatives, but Patient A isn't happy with any of the alternatives and wishes to return home. The care team is not prepared to agree to this as it has already failed in the past.
- **Scenario 1B:** The care team offers only one alternative: a similar long-stay residential care home 300 miles away from Patient A's family.
- **Scenario 1C:** The care team offers only one alternative; Patient A is happy with the alternative offered and agrees to go there.
- **Scenario 1D:** As per Scenario 1A except that the care team is prepared to allow her to return home if social services can put in place a care plan that sees the Patient A visited at least four times a day. Social services are unable to fund this alternative and the patient cannot afford to arrange this privately.
- **Scenario 1E:** As per Scenario 1A except that a patient does not wish to return to her own home. The only acceptable living arrangements, which the care team would be willing to accept, would be for her would be to live with her daughter and the care team would be willing to allow this.
- **Scenario 1F:** As per Scenario 1A except that the patient wishes to live in a suite at the Ritz with a personal nurse to look after her. The care team would agree to this but she does not have the means to pay for this.

Subsection 3

3) *A person is not deprived of liberty in a particular place if—*

(a) the person is not subject to continuous supervision, and

(b) the person is free to leave the place temporarily (even if subject to supervision while outside that place).

This section requires clarification. What is meant by "continuous supervision"? Would use of monitoring devices would be covered? What frequency of checking would amount to continuous supervision? Without clarity there would be room for this subsection to be interpreted very broadly. Should an elderly person in a care home, who spends a lot of each day on their own in their own room, be regarded as being under continuous supervision, as is currently the case?

What is meant by "free to leave the place temporarily"? At any time or would it still apply if the person could only leave at times determined by others?

Does who decides the length of time away 'temporarily', the person or someone else, determine whether or not there is a deprivation of liberty?

Should it mean having an untrammelled ability to go out, or is reasonable provision enough, and how is reasonable defined? Would a scenario where someone is able to have only one accompanied trip out per week amount to being "free to leave"?

Subsection 4

4) *A person is not deprived of liberty if—*

(a) the arrangements alleged to give rise to the deprivation of liberty are put in place in order to give medical treatment for a physical illness or injury, and

(b) the same (or materially the same) arrangements would be put in place for any person receiving that treatment.

We acknowledge the intention behind this subsection - to put into statute the principle set out in the case of *Ferreira*², that a patient detained due to the physical health treatment would not give rise to a deprivation of liberty, however we believe that the current wording is inappropriate and would question how widely the principle in a case with very specific circumstances should be applied.

The exemption under subsection (4)(b) is likely to lead to confusion. Would this apply if patients in different hospitals or care settings receive different treatment?

Forcing a distinction to be drawn between people being treated for physical illness and people being treated for mental illness could worsen stigma and discrimination in relation to mental illness and would represent a retrograde step.

Furthermore, it can be difficult to distinguish how, and to what extent, someone's presentation is due to their physical rather than mental illness and it is not uncommon that the two are interlinked.

As the Joint Committee on Human Rights points out, such a "causative" approach could be discriminatory as it could result in a different approach depending on the nature of a person's disability or lack of capacity.

It would be unclear in many situations, where people lack the capacity to make decisions about their care and treatment, whether or not this definition would apply, including the following:

- Someone with delirium being treated in a hospital – whether a physical or a psychiatric hospital:
 - A 78-year-old admitted to hospital for the investigation of sudden onset of confusion. They are found to have a chest infection, causing delirium. Due to confusion and associated behaviour they require continuous supervisions and it is judged to be in his best interests for him not to leave the ward. Antibiotic treatment is likely to treat his chest infection and the associated delirium.
 - A 34-year-old admitted to hospital for the investigation of sudden onset confusion. She is found to be experiencing acute alcohol withdrawal, causing delirium tremens. It has been judged that admission and treatment is in her best interests and it would not be safe for her to leave the ward. It is anticipated that, with an alcohol detoxification regimen, the associated delirium will quickly resolve.
- Someone with a head injury who, as a result of the injury, has ongoing need for care and supervision either in hospital or in a supervised community setting.
- Someone with severe anorexia nervosa who requires nutritional supplements by nasogastric tube
- Someone in need of immediate hospital treatment for self-harm where it is not yet known whether or not there is an underlying mental disorder
- Someone who, due to severe known personality disorders or depression, repeatedly self-harms and requires physical treatment of the resulting injuries.
- Someone who whose hospital admissions are no longer required for treatment of physical illness but are awaiting a care placement:
 - An 83 year old lady with a diagnosis of dementia admitted to hospital having fallen at home and sustaining a fractured neck of femur. During the admission, concerns were raised about her cognitive impairment and whether she could be safely supported at home, even with a package of care. Mrs A has made a good physical recovery from her fracture, and is now mobile. It has been judged that

² *Ferreira v HM Senior Coroner for Inner South London and Others* [2017] EWCA Civ 31

her care needs would best be managed in a care home. However, she lacks the capacity to consent to hospital admission and to make decisions about her long-term care. She no longer requires hospital admission for her physical health problems, but remains an inpatient whilst an appropriate care home is identified. Whilst on the ward, Mrs A is subject to continuous nursing observation to prevent her from inadvertently walking off the ward or interfering with the care of other patients.

16 and 17 year olds (amendments 30, 34, 38)

Steps taken earlier in the passage of this Bill to extend the safeguarding scheme contained in its provisions to 16 -17 year olds are welcome. It would mean that when a vulnerable 16-17 year old, who lacks capacity to make their own decisions, needs to have their liberty deprived this can be authorised by an appropriate safeguarding system.

Front-line clinicians are often left unsure which piece of legislation should be applied when young people 16-17 year are in situations where the risks they present can only be safely managed by depriving them of their liberty. This can cause significant delays whilst professionals seek further legal advice and professional opinions to determine the most appropriate option.

In the meantime, the 16-17 year-old is in a “legal limbo” often stuck in a paediatric ward or A&E while these debates take place.

It is the College’s view that that:

A parent or legal guardian, with capacity to make the decision, should be able to authorise the required deprivation of liberty. This is in line with the Court of Appeal decision in *Re D*³, which is currently before the Supreme Court. We think **amendment 30** should be supported so that this position is maintained should the Supreme Court give a different view based on current legal provision.

If there is no parent or guardian with capacity to make the decision, then the safeguarding scheme provided for by this Bill should be available.

If a parent or guardian objects to a deprivation of liberty then a Court Order under the Children Act 1989 would be required to authorise safeguarding scheme under this Bill. This is in line with amendment 30.

We see this approach as proportionate and do not believe it would be a common occurrence as the objecting parent would in effect be asking to look after a child with very high needs. We welcome the call for enhanced safeguards for this age group, through requiring AMCP review in all instances (**amendment 38**) and ensuring that parents are consulted (**amendment 34**).

Safeguarding people with fluctuating capacity – Amendment 32

Schedule 1, page 13, line 46, at end insert—

“(aa) 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”

To ensure that people with fluctuating mental illnesses are protected from detention when they regain capacity (because the length of time for which that is likely can be very difficult to predict), we are supporting amendment 32 to ensure that whether a person’s capacity is likely to fluctuate is included within initial assessments. We note the Government’s commitment during Lords debates to make

³ D (A Child) [2017] EWCA Civ 1695

reference to fluctuating capacity within the Code of Practice⁴ but feel that such an important issue should be included in the face of the Bill.

This is particularly important for people who are likely to be subject to the provisions of the Bill with either neurodegenerative conditions or mental illnesses. Without this, it is likely that, where people regain capacity for a short period of time, they will have to go through the extensive safeguarding authorisation process again. This will create inefficiencies, patient distress and an undue burden on the responsible authorities.

Probing amendment to preventing psychiatrists being called away from frontline services – section 49

After Clause 3

Insert the following new Clause—

"Power to call for reports"

The Mental Capacity Act 2005 is amended as follows.

In Section 49, leave out subsection (3)

This proposed probing amendment would remove the power of the court of protection to compel NHS bodies to provide reports on a person's mental capacity.

This power while seemingly sensible when introduced has had serious unintended consequences which are impacting on patient care.

The Royal College of Psychiatrists would not necessarily want for this amendment to be pushed to a vote but we hope it would be a chance to encourage the Government to commit to give guidance to courts and NHS bodies that patient care should take precedent over the production of reports.

Section 49 of the current Mental Capacity Act allows courts to require a local authority or an NHS body to prepare a report on 'such matters as the court may direct'.

In practice this often means that consultant psychiatrists are called away from their patients to write a court report on someone's mental health or mental capacity. These reports take approximately 10 hours on average to compile and often written at short notice about someone the clinician has often never met before.

This means that patients who have may have been waiting for months to see a consultant have their appointments postponed with little notice.

As there is no means for NHS Trusts to be reimbursed for clinicians' time, their patients suffer as clinicians have less time to spend on patient care. RCPsych has gathered evidence that shows that the use of Section 49 has increased over the last few years and that it varies significantly by area.

The Royal College of Psychiatrists has written to medical directors asking them their experience of Section 49 and the effect it has on their trust, clinical work and the care of patients. In response, we heard that the situation is: "worrying" and that they "have a considerable impact on consultant workload". We also heard that "The consultants are finding the time frames very tight and this does impinge on their clinical time, and so does court attendance."

This section is a legal anomaly. If a court requires a medical professional to give them any other kind of report, they have to commission it themselves from medical practitioners who specialise in providing such reports. The reports provided by these experts are therefore often better suited to the specific needs of the courts as the clinicians are more experienced in providing them.

If this power was removed than the Court of Protection can still commission reports but they would have to either reach an agreement with a professional who already knows the person or from a clinician who has experience in writing reports.

⁴ Mental Capacity (Amendment) Bill [HL] [Lord O'Shaughnessy](#) 22nd October 2018 Column 711

When this issue was raised in the Lords the Minister agreed to talk to the Ministry of Justice about it. The response was that the MoJ would ensure that Section 49 would only be used 'proportionately'.

We hope the Government can go further and agrees to update the guidance on Section 49 to guarantee that clinical care should always take precedent over the production of court reports. This would mean that patient care is not jeopardised by calling away clinicians and that court reports are written by clinicians who are experienced in providing them.

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^[1] [Joint Committee on Human Rights](#), *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards*, 2018

^[2] *Winterwerp v Netherlands* (1979) 2 EHRR 387.