

Written evidence submitted by Dr Amanda Thompsell (Chair, Faculty of Old Age Psychiatry, Royal College of Psychiatrists), Dr Hugh Series (Consultant old age psychiatrist), and Dr Sharmi Bhattacharyya (Consultant old age psychiatrist) (MCAB69)

INTRODUCTION

1. We are consultant old age psychiatrists and we are the mental capacity leads for the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists. We have previously contributed to the Royal College of Psychiatrists' responses made to Government and we are aware of the amendments tabled so far in the discussions in Parliament. We are submitting this in response to the Parliamentary invitation for submissions on the Mental Capacity (Amendment) Bill.
2. The comments we make in this submission specifically address issues that could arise for older people. They are the personal views of the authors, informed by our clinical practice, and have not been approved as the formal views of the Royal College of Psychiatrists.
3. Schedule AA1 uses the term 'cared-for person' rather than 'P'. In this paper 'P' is used as a shorthand to refer to the person under consideration and does not imply any legal status. 'D' has the same meaning as in the Bill (the person depriving P of liberty).
4. The Law Commission term 'Liberty Protection Safeguards' does not appear in the Bill (although they are often referred to in this way, following the Law Commission proposals). In this paper, the term 'new DOLS' is used to indicate the arrangements set out in the Bill.

SUMMARY

1. Should the Bill formally introduce the term 'Liberty Protection Safeguards'?
2. Clarification is needed on the meaning of 'emergency' (p.2).
3. There needs to be a full impact assessment. Hospital and care home managers have extensive new responsibilities which will require time, training and resources.
4. There is a new test of 'necessary and proportionate' (p.11). To whom is it necessary and to what is it proportionate?
5. There is a very disturbing lack of weight given to P's wishes and feelings. Although consultation is required to ascertain what they are (p.17), they do not appear to be given any specific weight in the decision to deprive P of liberty.
6. Authorisation in advance for up to 28 days (p.22) will often not be sufficient time to ensure that arrangements for discharge from hospital to a care home can be made.
7. As now, anyone who objects to treatment for mental disorder in hospital must be treated under MHA. This is creating a very large financial pressure because of the requirement under s. 117 MHA to fund aftercare without means testing for all those detained under s. 3. We recommend that the government consider reviewing the financial entitlement under s. 117.
8. We are strongly of the view that the introduction of a tribunal system for appeal against new DOLS offers advantages of speed, economy, inclusion, and well tested

approach (appeals against detention under MHA are currently heard by a tribunal).

9. We think the provision for an advance decision to consent to DOL could be helpful.
10. We very much hope that the Royal College of Psychiatrists will be involved in the development of the Code of Practice

MENTAL CAPACITY (AMENDMENT) BILL

S. 2 Authorisation of steps necessary for life-saving treatment or vital act: what has changed?

1. New section 4B authorises D ‘to take steps which deprive P of liberty’ for the purpose of giving P life-sustaining treatment or doing any vital act provided that either authorisation is being sought from the court or responsible body, or there is an emergency. An emergency means there is an urgent need to give this treatment or do the act and it is not reasonably practical to detain P under MHA or to apply for or secure an authorisation of the deprivation of liberty. It appears that the Bill, unlike the existing Act, allows D to deprive P of liberty without seeking an authorisation if there is an emergency. Objection is not relevant. No upper limit of time for the duration of the emergency is given.
2. The meaning of ‘emergency’ could be read inclusively to cover much of what goes on in hospital A&E departments and in medical and surgical urgent (i.e. non-elective) treatments, which might go a very long way to deal with the problem of authorising DOL in general hospitals. Or it might be read in a much more limited way to cover only extremely urgent or life-sustaining treatment. It would be helpful for the Code of Practice to give examples of what might be covered. We prefer the more inclusive reading, which would allow medical and surgical emergency (non-elective) treatment to be given in general hospitals without seeking DOLS authorisation. We think that it is impracticable to require general hospitals to seek DOLS authorisation for all assessment or treatment given to non-capacitous patients (which would appear to be required if the current definition of DOL were retained).

S. 3 (new section. 21ZA of MCA) Appeals

3. The current right of appeal to the Court of Protection (‘COP’) under section 21A is replaced by a new section 21ZA (section 3 of the Bill). Although the wording is different, the effect appears to be fairly similar. It needs to be clarified whether, if P has money and wishes to appeal, he may have to pay the costs of challenging his own detention. We very much regret the current situation whereby P is required to pay for the cost of challenging a DOL for appeals to COP other than those under s. 21A, for example if P is in supported living, and not in a hospital or care home.

SCHEDULE 1 (to be inserted as SCHEDULE AA1 of MCA)

Responsible body (para 6)

4. The Responsible Body for hospital patients will now be the hospital manager. This seems appropriate, but it transfers some workload from the local authority to hospital managers, who will require training and time to carry out these duties.

Assessments (para 11 and 16)

5. The six assessments required under DOLS have been replaced by three: that P lacks capacity; is of unsound mind; and the arrangements are necessary and proportionate. Necessary for what purpose? Proportionate to what? MCA s. 6 defines these terms further, but in a different context (that of harm to P). How can the determination be challenged without a clearer definition? On balance, we prefer the use of best interests as a criterion to the necessary and proportionate test, but we would like to see the wishes and feelings of P given greater weight in order to move towards compatibility with Convention on the Rights of Persons with Disabilities (CRPD) rather than further away from it.

Determinations of capacity, and unsound mind (para 15)

6. There is wide scope to make use of earlier assessments, even those made for other purposes provided 'that it is reasonable to rely on the assessment'. The Law Commission proposals had specified that there should be at least two assessors who must be independent of each other, although it was not clear what 'independent' meant. The requirement for independence appears to have been dropped, and there seems to be almost nothing in the Schedule to say who or how many people should make the assessments, or how they should be made, other than that the responsible body must consider 'that it is reasonable to rely on the assessment'.
7. It is welcome that the laborious and resource intensive assessment process for DOLS is being replaced. However, the new statutory description of the assessment is so open that there is a concern that almost anything could pass the required assessment stage. We are in favour of allowing the required assessments to be carried out by at least two people who are themselves part of the same clinical team (this is what the Law Commission proposal would appear to have allowed, although it used the word 'independent', not further defined), rather than having to get external assessors in every case. However, we think that the potential lack of independence of the assessors together with the very limited scrutiny or consideration of P's wishes and feelings could be a concern, unless the next stages of consultation and pre-authorisation review are robust enough to pick up any dissenting views.

Consultation (para 17)

8. Para 17 explains that the main purpose of the required consultation 'is to try to ascertain the cared for person's wishes and feelings in relation to the arrangements'.

Consultation is to be carried out by the care home manager or responsible body. That's fine, as far as it goes, but it fails to put any legal weight on P's wishes and feelings. The Law Commission's proposals to push P's wishes and feelings to the top of the list of factors to be considered in determining best interests appears to have been left out of the legislation, as indeed have almost all references to P's best interests (the phrase 'best interests' appears only three times in the Bill). Regrettably, there is no room here for supported decision-making. This seems to be a very weak part of the process which fails to give any real strength to P's wishes and feelings. The only effect of a finding that P does not wish to reside in the proposed place or receive the proposed care arrangements is that the case will be reviewed by an AMCP. If P's family are unhappy with the proposed arrangements, but P acquiesces, it appears that the family has little or no right to object. This is a situation which Steven Neary's father might well regret.¹

Preauthorisation review (paras 18 to 20)

9. As we understand it, in cases where there is agreement about the appropriate care arrangements for P, and there is no reason to think that P objects, all that is required is that two people who may be already involved in making arrangements for P's care should certify that P lacks capacity, is of unsound mind, and that the arrangements proposed are necessary and proportionate. This would then be signed off by the responsible body or hospital manager. It is only where it is considered that P objects that the case is referred to an AMCP, who must review P personally and consider the assessments. This appears to be a very substantial simplification and streamlining of the process compared with DOLS, and it should go a long way to address the resource problems associated with DOLS. However, we are concerned that there is so little in the Bill to explain the nature of the assessment process, and in particular how P's wishes and feelings are to be given the weight that they ought to have.

Time for which authorisation has effect (para 22)

10. Authorisations relate to care arrangements, including the means of transfer to a place of care. Authorisations can be assessed and granted in advance, when there is still a possibility of considering alternatives, and before irreversible steps such as selling a house have been taken. All of this is very welcome. However under para 22, an authorisation cannot be given more than 28 days before it is due to take effect, which means that in many cases the authorisation will expire before a suitable available placement has been found, given the very large amount of time that it can take to find a suitable care home or care package once those involved have agreed that that type of care is required, particularly for those with complex needs (which is usually the case

¹ Mark Neary's blog is well worth reading for a very person-centred and powerful view on capacity assessments. <https://markneary1dotcom1.wordpress.com/2018/06/09/silly-dols-talking/>

for hospital patients). It would be helpful to have a mechanism to extend the 28 days for further periods of 28 days if necessary, provided that P's condition and needs have not changed.

Part 7 Excluded arrangements: mental health

The financial significance of objection

11. Para 45(5) states that condition 4 is that P objects to being accommodated in hospital for the purpose of being given medical treatment for mental disorder or to being given some or all of the treatment. Para 46 sets out the factors to be considered in determining whether P objects. The effect of this is that, in a hospital, if P shows any sign of objection, MHA must be used, however the outcome of the MHA review recommendations need to be considered. Objection therefore becomes the dividing line between the two acts for hospital patients who lack capacity.

12. Consider the following very common scenario:

An elderly person with dementia living at home develops behaviours which carers find challenging, and which lead to a breakdown of the care arrangements at home. He or she is admitted to a psychiatric hospital, probably under s. 2 MHA for assessment. The hospital assesses if there is a physical illness present which could be causing the change in behaviour (such as a urinary tract infection), and tests will be done and medication may be prescribed. Quite soon, all that can be done has been done. If that is enough for the person to return home, that's fine. But very often, either the person remains somewhat disturbed, and/or the carer decides that they cannot cope any longer with caring for the person, even if the immediate behaviour has settled down, and will not accept them home. Then the long process of looking for a suitable care home begins. This is always difficult for a person with behaviours that carers find challenging, especially if the patient has been on a MHA section. Funding must be applied for and obtained. This can take months, and often does. Meanwhile, the section 2 lapses after 28 days, and new authority to keep the person in hospital while a suitable care home is being found is required. Should this be DOLS or s. 3 MHA?

13. MCAB (and current MCA/DOLS) means that if the patient is showing any sign which could be interpreted as objection he is ineligible for DOLS and must therefore be detained under MHA s. 2 or 3. This will usually be the case for a person with behaviours which are viewed as challenging, even a person showing 'normal' dementia behaviour such as walking around the ward and trying any doors they come across could be considered as objecting. However, this could also be seen as normal human behaviour—it is what many people do the first time they go into a new holiday house: to explore it, not to escape from it. It is a matter of the perspective of the person assessing it whether the behaviour is seen as normal or objecting.

14. Using MHA rather than DOLS in these circumstances can have very unfair (meaning unequal) and very expensive consequences under s. 117 MHA. In the scenario above, if the patient with dementia is detained under s. 3 MHA, he gets free aftercare for life, while someone else with dementia who needs a care home, but who did not show that behaviour, or for whom a care home was found within 28 days does not. This is hugely unfair, and distorts the already very tight budgets of local authorities by forcing them to prioritise s. 117 aftercare, irrespective of current need, over other care which, on grounds of need, might be more deserving of funding. This undermines the ability of local authorities to charge fairly. Our own very crude estimate suggests that s. 117 could cost up to £450M per year (see appendix).
15. One way of dealing with this would be to revise s. 117 of MHA so that it no longer entitles the patient to free non-means tested after-care, which is the position under current case law.

Other matters and omissions

16. The term 'Liberty Protection Safeguards' does not appear in the Bill. Is the term 'Deprivation of Liberty Safeguards' to be retained?
17. We regret that there is no proposal for a tribunal system for appeal, which we believe offers advantages of speed, economy, inclusion of P, and a well-tested approach with much relevant regulation and case law in MHA which could inform MCA/DOLS tribunals. We accept that appeal cases which reach COP are often difficult and nuanced, but we do not accept that such cases could not be dealt with in the first instance by a tribunal system. One of us has experience as a Responsible Clinician who gives evidence to MHA tribunals, a medical member sitting on tribunal panels, and as an expert witness who regularly gives evidence in DOLS appeal cases before the Court of Protection. In his experience, the MHA Tribunal already deals successfully with similarly nuanced and difficult cases, and already has a body of practitioners with relevant skills and experience. Appeals from a first tier tribunal could still be made to COP, acting as the Upper Tribunal. We hope that that this will be considered in the wider review of the court system.
18. There does not appear to be specific provision for an advance decision to consent to deprivation of liberty, which we think could offer many advantages. The problem of how to authorise deprivation of liberty for elective surgery during anaesthesia or anticipated ICU treatment remains. This might largely be addressed by making provision for a patient to give advance consent to DOL at the time of consenting to the elective procedure (in our own practice, this might be relevant for electroconvulsive therapy for depression, but the implications are much wider for patients in general hospitals). Alternatively, the proposed new definition of deprivation of liberty may address this problem.
19. There is no consideration in the draft bill of ECHR article 8 issues, or the problem of lack of compatibility with CRPD.

20. There appears to be nothing in the draft bill to indicate how 'objective medical expertise' is to be provided. We understand that this is necessary following the ECtHR case of *Winterwerp*. A natural point for this to be provided would be in the assessment of 'unsound mind'.
21. With the repeal of the old schedule A1, RPRs will go. IMCAs are retained, but with some changes which are quite difficult to follow. The IMCA's duty is 'to represent and support the cared for person'. There is provision for 'an appropriate person' (para 36(5)) to 'represent and support the cared for person'. It is not clear to us where the boundaries and/or overlaps are in relation to these roles.
22. We hope that the Royal College of Psychiatrists (and of course other stakeholders) will be closely involved in the development of the Code. Much of the Bill is so open-ended and limited in detail that the Code will be critical in determining how it is implemented.

Appendix: Estimate of costs accruing as a result of entitlement to MHA s. 117 aftercare.

We do not have data to estimate this reliably, but to give an idea of the order of magnitude potentially involved, there were 3,549 occupied old age psychiatry beds (mainly adults aged over 65) in 2018 Q1. If the average length of stay in hospital for an older adult in a psychiatric bed is 3 months (our perception, not based on data) then about 14,000 older people per year would be admitted to a mental health hospital bed. The large majority of these patients probably lack capacity, and the majority of those would be in hospital for longer than 28 days, requiring a decision between DOLS and MHA. A large proportion of those would be likely to show some behaviour which could be seen as 'objection' at some point, and under the Bill would therefore have to be detained under s.3, making them eligible for s.117 aftercare. The proportions of people in each of the groups is uncertain, but if even half of the 14,000 lacked capacity, stayed for longer than 28 days and showed some sign of objection, then that would mean that 7,000 older people per year were detained under s.3, and would be entitled to free care under s. 117. The majority of those would eventually be placed in care homes. Some of those people would have been entitled to free means-tested care under existing law in any case (because all of the relevant decision-makers involved in their care agreed that MHA was necessary, objection notwithstanding, and some would have been entitled to fully-funded care anyway because they were below the financial threshold for being required to contribute to their own care costs), so perhaps the Bill would account for an increase in entitlement to state funding of long term care of around £150,000,000 pa (5,000 people x £30,000 pa average care costs). The average survival in a care home is about 3 years, so this would build up over 3 years to a rolling additional cost to statutory funding agencies of about £450,000,000 pa. Even if these estimates are far off the mark, the sums involved are very large indeed.