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<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Evidence</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Judge Denzil Lush (Court of Protection)</td>
<td>Written evidence</td>
<td>1014</td>
</tr>
<tr>
<td>Luton Borough Council</td>
<td>Written evidence</td>
<td>1031</td>
</tr>
<tr>
<td>Nicola Mackintosh and Sophy Miles</td>
<td>Written evidence</td>
<td>1041</td>
</tr>
<tr>
<td>Mira Makar MA FCA</td>
<td>Written evidence</td>
<td>1051</td>
</tr>
<tr>
<td>MCA and MCA DoLs’ Team of Cambridgeshire County Council</td>
<td>Written evidence</td>
<td>1065</td>
</tr>
<tr>
<td>Dr Julie McVey (University of Liverpool)</td>
<td>Written evidence</td>
<td>1072</td>
</tr>
<tr>
<td>Susie Meehan and Andy Armstrong (Safeguarding Adults Mental Capacity Act and DoLS service at Stockport Council)</td>
<td>Written evidence</td>
<td>1077</td>
</tr>
<tr>
<td>Mencap, The Down’s Syndrome Association and the National Autistic Society</td>
<td>Oral evidence (QQ 74 – 89)</td>
<td>1078</td>
</tr>
<tr>
<td>Mencap</td>
<td>Written evidence</td>
<td>1079</td>
</tr>
<tr>
<td>Mental Disability Advocacy Center (MDAC)</td>
<td>Written evidence</td>
<td>1100</td>
</tr>
<tr>
<td>Mental Health Alliance</td>
<td>Written evidence</td>
<td>1106</td>
</tr>
<tr>
<td>Mental Health Foundation and Sense</td>
<td>Oral evidence (QQ 45 – 55)</td>
<td>1125</td>
</tr>
<tr>
<td>Mental Health Foundation</td>
<td>Written evidence</td>
<td>1137</td>
</tr>
<tr>
<td>Sophy Miles and Nicola Mackintosh</td>
<td>Written evidence</td>
<td>1149</td>
</tr>
<tr>
<td>Mind, Alzheimer’s Society and Headway</td>
<td>Oral evidence (QQ 90 – 105)</td>
<td>1150</td>
</tr>
<tr>
<td>Mind</td>
<td>Written evidence</td>
<td>1151</td>
</tr>
<tr>
<td>Ministry of Justice and the Department of Health</td>
<td>Oral evidence (QQ 1- 24)</td>
<td>1168</td>
</tr>
<tr>
<td>Ministry of Justice and Department of Health</td>
<td>Written evidence</td>
<td>1194</td>
</tr>
<tr>
<td>Ministry of Justice and the Department of Health</td>
<td>Supplementary written evidence</td>
<td>1205</td>
</tr>
<tr>
<td>Ministry of Justice and the Department of Health</td>
<td>Further supplementary written evidence</td>
<td>1219</td>
</tr>
<tr>
<td>MM</td>
<td>Written evidence</td>
<td>1221</td>
</tr>
<tr>
<td>Tussie Myerson</td>
<td>Written evidence</td>
<td>1226</td>
</tr>
</tbody>
</table>
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Social Care Institute for Excellence (SCIE), British Institute of Human Rights and Paul Gantley – Oral evidence (QQ 185 – 196) ................................................................. 1580

Society of Trust and Estate Practitioners (STEP) – Written evidence ........................................ 1581

Solicitors for the Elderly – Written evidence ............................................................................ 1594

Dr Oluwatoyin Sorinmade MSc (Psychiatry), MRSCPsych, LLM (Oxleas NHS Foundation Trust) – Written evidence ........................................................................... 1603

South Essex Partnership University NHS Foundation Trust (SEPT) – Written evidence ... 1605

South West IMCA Group – Written evidence ........................................................................... 1613

St Helen’s Council – Written evidence ..................................................................................... 1615

St Mary’s House – Written evidence ........................................................................................ 1622

Standing Commission of Carers – Written evidence ............................................................... 1625

Michael Stanley (Barnsley MBC/ PCT) – Written evidence ..................................................... 1631

John Stockley – Written evidence ............................................................................................ 1636

Sussex Partnership NHS Foundation Trust – Written evidence .............................................. 1644


Dr Paul Swift, Toby Williamson, Dr Val Williams, Dr Geraldine Boyle, Dr Marcus Jepson and Dr Pauline Heslop (School for Policy Studies, University of Bristol) – Written evidence. 1649

The Advanced Decision Evaluation (ADE) in Bipolar Disorder Study Team, Institute of Mental Health, University of Nottingham – Written evidence ................................... 1650

The Aire Centre – Written evidence ........................................................................................... 1656

The Brain Injury Rehabilitation Trust – Written evidence ....................................................... 1681

The Challenging Behaviour Foundation – Written evidence .................................................. 1685

The College of Emergency Medicine – Written evidence ........................................................ 1692

The College of Emergency Medicine, British Medical Association, Academy of Medical Royal Colleges, Royal College of General Practitioners, Royal College of Psychiatrists – Oral evidence (QQ 153 – 171) ............................................................... 1697

The College of Social Work – Written evidence ..................................................................... 1698

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Lancashire County Council DoLS Team – Written evidence

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The aims of the Mental Capacity Act were to identify and protect the rights of people who lacked the capacity to make specific decisions in a timely manner for themselves. The aims are commendable, but there are still worryingly large pockets of ignorance of the existence of the MCA in both public sector services and in the general population. Despite the MCA being in its 6th year of enactment, we still encounter public sector workers believing it's something that is discretionary in its use: this appears to be a particular feature of health care, where workers are often of the opinion that if they are 'doing good' to someone it must therefore be in their best interests and due process is often not followed (establishing capacity etc…). However, there are also examples of excellent practice, and the increased use of the Court of Protection is an indicator of this: health and social care agencies are becoming more aware of the need to practice within a legal framework, and that decisions that may have been made in the past in an almost 'ad hoc' manner must now be justified and transparent. Defensible decision making is becoming part of best practice rather than a means to avoid being sued. This can only be to the benefit of service users.

2. Which areas of the Act, if any, require amendment; and how?

The Act's focus is that of the incapacitated person and the risk of harm to themselves. It pays no attention to the risk the person may pose to others: this is left to the Mental Health Act. This is an area that needs to be looked at: most people do not meet the criteria of the MHA, but their behaviour does pose a risk to others. It would be useful to have an amendment stating if the risk is to others, and the possible consequence of this would be that the person is either subject to the criminal justice system or the MHA, then lack of capacity to understand this risk to others falls within the remit of the MCA.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

The principles of the MCA are laudable, but in our experience can be used as an excuse to do nothing (I have presumed capacity so need take no action); can paralyse workers (is it an unwise decision and if so, what do we do to 'protect' someone); create confusion as to whose best interests are we really meeting, the person or their family? The principles are appropriate, but need to be better understood by everyone.

The definitions of capacity are problematic especially for someone with fluctuating capacity. Decisions should be time and situation specific but there is often not the time to continually be assessing someone's capacity and recording outcomes. How far should you go in helping someone to make a decision is also hard to determine: in everyday day decision making it is often untrained staff or family members supporting the person.

Another issue we have encountered is that of workers not wanting to 'label' someone as lacking capacity as they feel this is a negative reflection on their practice, and it discriminatory. A recent case where we were mentoring a social work colleague almost resulted in someone being deemed to have capacity and they were on the point of giving up

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In their efforts to be non discriminatory, the social worker did not want to say the person met the first part of the 2 stage test and had an impairment of the mind or brain: this led to them not having a capacity assessment, although this was later rectified following reflective discussion. However, this is not a 'one off' happening and many more people may not be having their capacity assessed due to the good intentions of workers.

**Implementation**

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

Implementation is improving, but we still have a very long way to go. Many workers can recite the principles, but try to ask them how these translate into everyday practice, and they struggle to answer. Some take the principles at face value, and don't move beyond presuming capacity. There is still a concern that we can't assess capacity unless we have hard evidence the person actually lacks capacity – there seems to be a lack of understanding around acting on a 'reasonable belief' that someone's capacity may be impaired in relation to the significance of the decision to be made.

Safeguarding adults at risk is a particular area of concern: there appears to be a polarisation of actions – safeguarding plans are either engaging articles 5 and 8 of the Human Rights Act without legal sanction or workers feel they can do very little to protect an adult at risk of harm. We do feel in Lancashire this is an area where we have made great improvements, but workers still feel vulnerable when making decisions, and uncertain about the legal framework they are working in. There is often added pressure from other agencies (such as the police) who often think we have powers which can effectively remove someone from a risky situation. Enabling someone to take risks is scary, and workers can be under tremendous pressure from families and within their own agencies – what if something goes wrong? Whose name will be headlined? The MCA has not made us any less risk averse.

When the legal frameworks we do have are well implemented the results can be astoundingly successful: there are many examples we have witnessed that have led to people being well protected, and they have been central to the process and decisions made were fully inclusive. Adults with a significant degree of vulnerability have found their voice, and their lives have been transformed: but this takes courage, time and evidence and these can be in short supply in over stretched social work and healthcare teams.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

Monies were made available to implement the MCA, but we are not convinced they were made best use of. Many authorities appointed MCA leads, and invested in training, but neither of these appear to have really made a difference. We think the problem lies in the lack of appreciation of how significant the MCA is: it should underpin and influence everything we do, but it is often seen as a bit of an 'add on'. If you look at the amount of time given to train managers in finance systems, or any other systems that affect the working of their organisation, it is often far greater than that given to MCA. What message does this give – money is more important than people?

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Unpaid carers were part of this targeting of information, but it is likely that it is the people who are already clued up on legislation that were part of this. We have still to make an impact on those families and unpaid carers who are trying to get on with their lives and continue care for their loved ones. It is only when services get involved that families realise the implications of the MCA: we are often asked why we have to go through this process and waste time when it is obvious what the person needs. Families still cannot understand why we assess capacity, especially if their relative is elderly or has a learning disability.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

The Act is much better known across professions, but understanding and implementation is still problematic. Banks do appear to have increased their skills and knowledge, but this is not an area we are overly familiar with. GPs have also enhanced their understanding of MCA but still appear to be reluctant to assess capacity. Registrars need to be able to assess someone’s capacity to marry or enter civil partnership, and I’m not sure how competent they are – there seems to be some evidence that people have the capacity to marry but not to divorce, and the courts need to get involved in this.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

MCA is weighted in favour of the incapacitated person: the best interests of the person are central, and if these conflict with the family or unpaid carers then their article 8 rights are dealt with by the Court of Protection. Balancing the rights of all parties is difficult, and the MCA code of practice does not give much guidance on how this should be done. If the risk of harm is to the carer and not to the incapacitated person then MCA cannot be used as it’s central aim is to protect the incapacitated person.

8. Has the Act ushered in the expected, or any, change in the culture of care?

More attention is paid to capacity issues, but we are not convinced this is a true change of culture or a desire not to run foul of the law.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

No response to this as we have no evidence.

**Decision making**

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

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Decision making is a huge problem area: we are not sure that the MCA has empowered people, we just have a framework now to justify decisions that we are still making on behalf of people. There is a lack of understanding of who can be a decision maker, what authority LPA gives, what the difference is between LPA, CAD and CoP decision makers. A recent example is that a person has donated LPA health and welfare to family member: they are self funding residential care home; person appears to be objecting to residence; what role does social worker have? We report to OPG if we have concerns, but it can take a long time for anything to be done that the person is left relatively unprotected. LPA holder (if family) does not feel they need to justify to others decisions made even when it is pointed out that they need to follow code of practice best interests checklist. Quality of decisions generally hard to determine as lack of proper recording still an issue. Defensible decision making is still not central to what we do.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

Issues around lack of understanding of what an advance decision is, and if it binding. This links to DNAR issue, which has caused great concern in Lancashire. Some people in care homes and hospitals have DNAR's which state the reason not to resuscitate is 'Dementia' with no other explanation; no review date; no evidence of capacity assessment or best interest process. LCC has been proactive in trying to address this issue, but it does show a lack of understanding in both healthcare, families and care homes.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

Again, some examples of really good practice but also areas where families are almost incidental to the process, especially if they have a different view to the care team or decision maker. Some of this may be due to focussing on best interests of the person only and not looking at the wider best interests of the person's life.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

Use of IMCA has been problematic in Lancashire, but we now have various protocols in place to ensure there is no delay in commissioning IMCA. Better understanding of IMCA role as opposed to advocacy in general.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

Referrals for IMCA d in dols was low in Lancashire, but it is now our policy to automatically commission IMCA D unless there are exceptional reasons not to. Dols schedule says to appoint if appropriate, but this is subjective, and we now have a more consistent approach. There was also a problem with low referrals for safeguarding IMCA involvement: again, we have addressed this and now have an automatic referral to IMCA is investigation is needed. This provides an independent voice for the person: if they subsequently are deemed to have capacity, then IMCA withdraws, but at least the person will have been represented during
the time capacity was being determined. In Lancashire we have found that we need to be proactive in making sure safeguards are in place.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

IMCA service for Dols in Lancashire is excellent, with well trained and experienced IMCAs. We cannot comment on how well they are resourced – we would say that if asked though that we would like more IMCA resource.

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate? In Lancashire we have a dedicated Dols team that has recently expanded in response to additional Supervisory Body responsibilities from April 1st and increasing number of applications from care home. The safeguards Dols provides are much needed and adequate, but the implementation of Dols by Managing Authorities is problematic. If used properly, Dols does protect people from arbitrary detention (central intention of Dols). The problem lies with situations where the person presents risks to others but not necessarily themselves: this excludes them from dols and relies on the MHA to detain if appropriate: my view is that this is a heavy handed approach that seeks to fit someone into an inappropriate box. Use of the MHA is not usually appropriate for people engaging in behaviour that could be a danger to others: consider the person with dementia who is hitting other people – they are not a danger to themselves, but need to be prevented from going out alone so they don't assault members of the public. Currently, to justify depriving them of this liberty, we have to 'create' a risk to the person by saying if they hit someone they are in danger of retaliation. This is likely to be true, but is a speculative rationale. The person would not be suitable to be detained under the MHA but still needs to be 'confined'. If dols had an element of protection of the public then it would prevent some inappropriate usage of MHA and give a more relevant legal framework within which to restrict someone.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

No. The process is bureaucratic, inflexible, off putting to Managing Authorities, incomprehensible to most people outside of the Dols world, repetitious, clumsy and generally the process is not fit for purpose.

Application process: the forms are difficult for many Managing Authorities to understand. There is a lot of duplication and many of the questions are not necessary. Separating Urgent and Standard forms is problematic as MAs do not fully understand the purpose of the Urgent authorisation so don't see the need to make standard application. This leads to time delays in processing applications. The forms are not easily accessible online. The timescales are on the edge of being unmanageable, particularly in complex cases: a good best interests assessment takes many hours to write up, and the consultation process is lengthy. Mental Health Assessors often cannot meet the even tighter deadlines we set them, and this can compromise their assessments, particularly the capacity assessment. Use of continuation sheets in the form 10 is clumsy, and makes the report hard to read (cannot use expandable boxes as this negates the use of digital signature). Extension of urgent period is usually due to BIA or mental health assessor not completing their work in time but MA has to make the
application: this adds to their workload and delays in receiving the application from the MA can lead to possible unlawful dol.

Review: need to have a further step in the reviewing process between SB reviewing and applying to CoP. Very clumsy; extremely costly to all in finance, time and anxiety. Court system not able to cope: unacceptable delays in having a final declaration; running both dols and CoP in parallel is wasteful of time and resources – CoP should take responsibility for dol authorisation whilst the case is with the court; paperwork associated with review is completely unnecessary; review process almost just a paper exercise as a stepping stone to CoP rather than a real effort to re-look at the situation.

Solutions: re-write and simplify the whole dols process and associated paperwork and make it more accessible to both managing authorities and the relevant person. Introduce an arms length reviewing process (such as a review panel) if the person is not satisfied with the SB review. Allow SBs to assess in their own care homes – if the process is transparent then this should not be a cause for concern of collusion. Increase the initial urgent period from 7 to 10 calendar days – it is acknowledged that we should not deprive someone of their liberty for longer than necessary, but a realisation of the true length of time it takes to offer the person a high quality assessment must be part of the review of dols process.

Dols works well when it is properly used and applied applied.

The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully? A qualified 'no' to the first question. Some professionals are extremely familiar with both CoP and OPG – others are not. Applications to CoP have increased in Lancashire and we do know that many social work teams make enquiries to OPG re: LPA registrations. Courts and OPG still very much a mystery to most people though – including health and social care colleagues.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

Still a lot of confusion around who can make what decisions relating to personal care and welfare. Issue of what role (if any) do social services have in cases where the person is self funding and has donated decision making to family? In case of dispute within the family what should happen? Also issues around concerns raised about the LPA holder – often OPG reluctant to get involved, and when it does, it is a slow process.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

Anecdotal evidence from families that the cost does put people off: some think that they have completed the paperwork so the LPA is 'live'. Even more problems with cost of CAD. Misunderstanding in relation to when LPA 'powers' can be used – difference with finance and personal welfare in terms of capacity. Also lack of clear understanding that if the person regains capacity for a specific decision the LPA ceases to be decision maker.

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21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

Legal aid still available in Dols 21a challenges, but only if the SB continues to hold the authorisation responsibility. Direct applications to CoP subject to legal aid restrictions, and it falls to the local authority very often to bear the burden of the initial application. In times of reduced budgets the concern must be that local authorities will not take the lead, and the independent scrutiny offered by the courts will reduce considerably.

**Regulation**

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

The powers are probably adequate, but the culture in CQC in relation to MCA and Dols is not. We have undertaken Dols assessments in care homes that clearly are not MCA compliant but CQC have given them good reports. The team have reported concerns to CQC on several occasions, and each time have had a less than satisfactory response. The impression is that CQC are concerned with systems and record keeping rather than with the ethos of an establishment. We would argue that the principles and ethical approaches an establishment can demonstrate should be given equal (if not more) importance to any amount of systems and processes they have in place. CQC needs to change its culture from one of system centred to being more person centred. This will give a clear message to anyone providing a service to the most vulnerable in our society that their actions are being scrutinised and that care and respect for the individual is paramount.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

The Quality Control Boards that are part of the newly established Clinical Commissioning Groups (CCGs) need to take more of a lead in monitoring both their provider units and also the care packages that they fund via Continuing Health Care (CHC) funding. Nursing and social care regulatory bodies should ensure anyone registered is able to demonstrate up to date knowledge of MCA and caselaw developments that may affect their practice. Training for nurses and social workers must give more time and attention to MCA and ensure that students are able to translate the theory of MCA into their everyday practice.

**Other legislation**

24. How well is the relationship with the mental health system and legislation understood in practice?

This is an area that again demonstrates really good practice and poor understanding of how the MCA interacts with MHA. Particular concern is with voluntary patients and how their rights are protected. The relationship between Dols and MHA is still problematic – we have dealt with people who are in patients on mental health units, deemed to be ineligible for Dols as they are objecting to mental health treatment, but clinician or AMHP will not recommend use of MHA. In the Lancashire Dols team, we are very clear about the hierarchy of the triad of legislation, but this is not the case everywhere.
Devolved administrations and international context

25. Does the implementation of the Mental Capacity Act differ significantly in Wales? No response to this question.

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions? No response to this question.

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

The MCA states very clearly that decisions on capacity must not be made on appearance, condition, gender, culture, behaviour or any other 'value' or subjective judgements. It is probably one of the most person centred pieces of legislation we have in this country. We believe it is compliant with the CRPD if implemented properly and in the spirit it was written.

29 August 2013
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limited in that respect. I thought it might be helpful to look at the Act itself and then at
DOLS, because although the DOLS legislation is part of the Mental Capacity Act, in practice
they are two separate pieces of legislation. That is how they are regarded. I have three brief
comments on the Act itself.

First, it is generally well drafted and easy to understand. In my experience a major problem
is that many people who should be aware of the Act are not, and those who are aware of
the Act often have a flawed understanding of its provisions. In that respect I take issue with
the evidence that this Committee received last week from officials who indicated that the
Act was well embedded in our culture. My experience, and, in my opinion, most of the
evidence, points in the opposite direction. The Act is not well embedded in our culture.
There is a lot of work that needs to be done. My second point relates to what in my opinion
are unrealistic expectations that the Act places on both lay and professional carers, in terms
of capacity assessments and best-interest judgments. I think that those expectations lead to
the major provisions of the Act basically being ignored in terms of the day-to-day care of the
mentally incapacitated. That is obviously something to be regretted. My last point relates to
the Court of Protection. In my opinion, it is not an appropriate forum for bread-and-butter
welfare cases, if I may use that term. Serious consideration should be given to an alternative
tribunal structure.

Moving on to DOLS, I have five brief points to make. Perhaps I may quote from myself when
I wrote about DOLS in 2008, when I said that, “DOLS is a procedure that has been created
that is hugely complex, voluminous, overly bureaucratic, difficult to understand and yet
provides mentally incapacitated people with minimum safeguards”. Since then I have had no
cause to resile from that statement.

Secondly, the Department of Health, in a circular published in 2010, reported that DOLS
had been “successfully implemented”. I think that that was a wildly optimistic judgment to
make in 2010. There is a lot of evidence to suggest that the opposite is the case. Most of this
evidence will be familiar to the Committee. There are huge regional variations in the
application of DOLS. Fewer than 1% of patients who are subject to DOLS make an
application to the Court of Protection for their release. Some cases indicate that DOLS has
been used as an instrument of oppression, where local authorities acting as supervisory
bodies have used DOLS to get their way, in a sense. I am thinking in particular of the Neary
case, and also of a lady called Peggy Ross, who comes from Cardiff.

Thirdly, the relationship between the DOLS legislation and the Mental Health Act is not
clear. People do not understand it. That is totally understandable, given that there are two
parallel pieces of legislation, both allowing for the detention of mentally incapacitated people.
There is bound to be confusion, and although, again in evidence last week, you were told
that the relationship is now well understood, you were given an example by an official which
suggested that she did not understand the relationship between the two Acts. It was an
example relating to Winterbourne View.

Next, I think that the protections given to patients who are subject to DOLS are far, far less
than the equivalent protections given to patients who are detained under the Mental Health
Act. There is a long list. I will not go through it, but it relates to patients who are sectioned
having free after-care and automatic access to a tribunal if they do not apply. There are also
major provisions in the Mental Health Act that protect the Article 8 rights of patients, in

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particular the consent to treatment provisions. There is no equivalent in DOLS. In fact, in a very recent case a judge complained that the DOLS legislation was silent when it came to the Article 8 rights of patients.

It will be clear from what I have said so far that I am not desperately in favour of the DOLS regime. Parliament did not undertake its proper duty when DOLS went through both Houses—with the notable exception of Lady Browning who, when she was an MP, was one of the few parliamentarians who spoke on the DOLS proposals. When the two schedules—A1 and 1A—that make up the DOLS procedure went through Parliament, there was not one word of parliamentary debate*. Not one word. Those schedules comprise more or less 200 paragraphs. In statutory terms, a paragraph is the equivalent of a section of an Act. So a major Act of Parliament dealing with the liberty of the citizen went through Parliament without one word of parliamentary debate. With all due respect, I think that is scandalous, and Parliament has a lot to answer for. But we are where we are. What shall we do? In my opinion, the DOLS regime is so complex and interlinked that it is impossible to amend.

* Since giving my evidence, I have discovered that there was a debate on two paragraphs of what is now Schedule A1 at the Public Bill Committee hearing on May 15, 2007. I should therefore have said that there was virtually no debate on the two Schedules.
Kirsty Keywood: Perhaps I could add to that. One of the unanticipated consequences from my perspective, interested as I am in adult protection issues, is that it is absolutely true to say that the Mental Capacity Act had a very empowering ethos behind it. However, what we have discovered since the enactment of the legislation are the very serious harms that many vulnerable people have come to. In reviewing their experiences, many of which were profiled in serious case reviews, and perhaps most prominently in the Winterbourne View case, it is quite clear that we have had a series of developments in policy and also in law that should force us to think carefully about how we balance empowerment and provide vulnerable people who have challenges around decision-making because of their circumstances with protection. I will offer you a few examples of that.

One of the difficulties that I have seen in practice—I suppose this echoes Richard’s point about training and understanding at the coal face—is that I am aware of a number of people who have either failed to receive care or have “chosen” to disengage from beneficial services when relevant agencies have not asked questions about whether the decision to refuse care was a capacitous one. When pushed by people like myself to explain why, with a person whose decision-making at least raises concerns or questions that need to be answered, an assessment of capacity did not take place, the answer came back, “Well, there is a statutory presumption of capacity. We did not know that we had a basis to ask questions and at least interrogate the basis of the decision”. Clearly, that is not legally correct, but there is something about the presumption of capacity as it is currently worded in the Mental Capacity Act that has obscured the thinking of a number of people working at the grass roots.

I will offer one example. I was involved in a serious case review of a man called Steven Hoskin, who was tortured and murdered by a gang, many of whom were convicted following prosecution. He was entitled to a community care service and was receiving support to manage his finances. Steven lived in a bedsit that accommodated one person but at the time when he disengaged from services, a number of people were living with him. He was not capable of expressing free choices at all, yet his decision to decline the service was not interrogated. It would be quite beneficial, if any reforms to the Mental Capacity Act are to be made, to clarify that it is simply not reasonable, where a person is exercising a choice that results in significant harm, not to undertake an assessment of capacity. That is not to say that their decision should be overridden, but we should ask searching questions about whether the decision is legally valid. That is one issue that has arisen with regard to adult protection.

The other issue is that the courts have now taken it upon themselves—quite rightly, in my view, given that we have no legislation—to provide some kind of legal remedy and course of action to protect vulnerable people whose decisions are the product of considerable constraint and abuse by family members in some cases, or by friends. What the Mental Capacity Act, at least in the code of practice, needs to do is make it very clear to people working on the ground exactly how adult protection law and the Act work together. I have seen enough horror stories involving self-neglect and abuse to indicate that those lines of connection need to be made much clearer, not just to people working on the ground but to the lawyers who are advising them.

Q27 The Chairman: Ms Mackintosh?
Nicola Mackintosh: I will echo some of what has been said. Richard and I probably disagree on a few issues, which we will come to later. I think that the Act is a good start. My practice is in community care, and was in mental health and homelessness pre-MCA. Before the Act came in, obviously there was no legal structure for decision-making and the assessment of potentially mentally incapacitated people. My concern is at the way it has been implemented. Often in my practice, I see decisions being made by statutory agencies on behalf of vulnerable people who may or may not lack capacity, under the guise of best interests. I echo what was said about the answer being, “Does the person have capacity?”, and the outcome being led by resources. I see lots of cases where a person has been neglecting themselves, and the local authority or the relevant health agency has used the presumption of capacity to allow that to continue. Equally, I have many, many cases where my clients have been deemed to lack capacity because the outcome is going to be that the state spends less on them. That is one of my concerns.

Most people who are affected by the Act have no independent advocacy. They do not have access to an IMCA or to relatives. A lot of people with particularly severe disabilities—challenging behaviour and so forth—are less likely to have family and friends involved in their welfare. One of the things that could be done is to bolster the advocacy services and the right to independent advocacy over a larger range of decision-making than is the case under the current IMCA scheme.

Winterbourne View, in my view, is just the tip of the iceberg. Every single case I deal with—and I deal with these cases day in and day out—is an example of the abuse of a vulnerable person. I have not had one case where there has not been financial, physical or psychological abuse, and in many cases there has been all three. Safeguarding is a big issue. You ask, “What could we do? Could the legislation be changed?”. Yes. There needs to be a safeguarding Act. There needs to be protection against cruelty and the abuse of vulnerable people.

Professor Richard Jones: Can I come in briefly? One of the themes that has come out from my colleagues is something that I very much agree with. Most decisions made on behalf of mentally incapacitated people are not preceded by a capacity assessment or a best-interests evaluation. Carers just get on with it. One of the needs that there is in terms of the legislation and perhaps the code of practice is to identify when a formal capacity assessment and a formal best-interests judgment need to be made. The code of practice at the moment refers to complex decisions needing a formal capacity assessment. That is not sufficient. Many simple, straightforward decisions relating to a mentally incapacitated person can be extremely important for them. They can be crucial. “Who do I live with?”. That is not necessarily a complex issue, but clearly it should be preceded by a formal capacity assessment and a formal best-interests judgment. That is where the Act is in danger of coming into disrepute. The vast majority of decisions are not made in compliance with the Act. As I said, people just get on with it. So when is it that there should be a trigger for the formalities of the Act to be complied with?

Q28 Baroness McIntosh of Hudnall: Professor Jones, could I ask you something in relation to what you just said, and indeed to what everybody else said? I was wondering about the differences in practice between formal and informal care. I am no expert, and nor am I somebody who has great experience in this area, but it strikes me immediately that the implementation issue is very much harder to follow through where people are in the care of their families, for example. Indeed, it may be—this is a question—that there should be

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different ways of looking at how those things are followed through in informal settings. Have you any observations to make about whether this is an issue?

Professor Richard Jones: First, we do not know what goes on behind the vast majority of doors where mentally incapacitated people are being cared for. My own view, which is not really based on hard evidence, is that there will be little difference between what a family carer and a care assistant in a care home do in relation to formal assessments and formal best-interests judgments. A care assistant looking after a resident of a care home is not going to go through that process when a decision is made—for example, when should that person watch television? When should that person go out into the garden? What should that person wear?—all the trivial decisions that have to be made. It just does not happen.

Baroness McIntosh of Hudnall: I am sorry to interrupt you, but within formal care settings there is presumably some sort of hierarchy within which, in theory, somebody who has a daily responsibility for those sorts of decisions ought to be able to refer up any issues that they might have or indeed be instructed, which would not be the case in an informal setting. This may not bear further examination; I am just interested.

Professor Richard Jones: That may happen, it may not happen; we do not know. There is nothing in the code of practice or the Act to focus on that issue.

Kirsty Keywood: I have certainly spoken to many family members and carers who have felt desperately unsupported in the very onerous task of facilitating someone’s decision-making when they lack capacity. Something that has struck me over the years—and it comes back to something that Professor Jones said earlier—is that the Court of Protection, as a vessel of advice and legal guidance, is so removed from the experiences of most family carers that there is nowhere for many of them to turn to in order to get some support and advice.

I am particularly concerned about individuals who are self-funding in care homes. We know that they are not subject to the same kind of scrutiny and practice. Families have very limited opportunities to access support unless they are prepared to take the tortuous and financially difficult road of approaching the Court of Protection. Access to justice for informal caregivers is a real problem. Partly for that reason, I support the view that a tribunal system that operates much closer and is much more accessible to family members and informal caregivers might be able to resolve some of these quite complicated issues. We see this happening in other countries. It is not beyond our capability to do it here, but it comes with a price tag, of course.

Q29 The Chairman: You mentioned people who are self-funding in care homes not having anyone to assist them. My mother was in a care home for three years. She was self-funding but she also had a local authority social worker who worked out her care plan for her. This was in Scotland—I do not know if that is unusual.

Kirsty Keywood: She is lucky. I have been given permission to tell you this story. Dr Margaret Flynn told me of a case concerning a lady who was a self-funder who was placed in a home that the local authority had refused to engage with because of the poor standards of care; yet this home was continuing to take self-funders. This lady’s only living relative was not able to advocate and inspect the circumstances at that home. The lady died, and nobody was able to offer any kind of intervention or scrutiny. We can say that there are bad care
homes and there are good care homes, but there an awful lot of care homes where people are self-funding and do not have ready access to any kind of advocacy service and family members may simply not be close enough to offer that kind of insight and scrutiny of what is happening.

**Baroness Browning:** Perhaps I might add that one of the critical points for self-funders is when their needs change, very often from when they change from needing care to needing professional nursing care. The classic fractured neck of femur is the critical point in decision-making at which some homes can no longer cope with somebody who is not weight-bearing. But it sounds from what you have just said that if there are no family members around to help through that process of change, that is when those areas of weakness show a lack of proper care. Is that right?

**Katie Johnston:** I will say that the problem of self-funders is exacerbated by what has become known as the YL loophole, which is that, as the law currently stands, persons who are in a self-funded care home or residential home are not subject to the same protections of the Human Rights Act as they would be if they were in a local authority-funded care home and they were placed by the local authority.

On an unrelated note, there is often delay in appointing an IMCA—the independent mental capacity advocate—and one of the reforms that we would consider would be that if the representative appointed for the person lacking capacity were a family member or a friend, instead of leaving the care home with more flexibility in appointing in the IMCA, that should be automatic to ensure a ready means to access justice.

**Nicola Mackintosh:** Just to add to that, my practice goes back more than 20 years in community care law and I have seen practice changing. We no longer have the old-fashioned social work, the therapeutic work between social workers and families or individuals, which we used to. We have a very different system of a single one-off assessment of needs followed by a brokering of a care package, and then effectively the case is closed until the next review, which might be a year hence. For those cases, whether they be self-funders or other people who are funded by the local authority, perhaps in a care home, the case is effectively closed to the statutory services for quite a long period of time. In my experience, where a social worker is allocated to the case and has ongoing involvement with that person, that involves a much greater degree of protection—not always and not always brilliantly—for that person. So it is about old-fashioned social work going out of the window and being replaced by a simple one-off assessment and then brokerage, which is a real problem.

**Q30 Baroness Browning:** Perhaps I might come back to the question that I was going to ask you: when this Committee concludes, our report will show, I hope, from the evidence we have received, what needs to happen to make the Mental Capacity Act more effective and fit for purpose. I am basically saying that I not think it is fit for purpose. In fact, we were told last week by officials that, “Overall, our view is that the Act has been a success”. I would say that, like the curate’s egg, parts of it may have been a success but other parts of it are seriously lacking. You have all started to outline to us where tangibly you see change and where change might make it better.

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We have received from Liberty the letter that Shami Chakrabarti sent to Dr Hywel Francis at the end of last year asking his Committee to look at reviewing this Act. At the same time, I wrote to Dr Francis to ask if his Committee could do it, having had a conversation with Dr Margaret Flynn, who did the report on Winterbourne View, in which I discovered that the Act had not been used—had not even been mentioned—at Winterbourne View. You have all clearly had a lot of experience in coming to the conclusions that you have shared with us this morning. Clearly, by November of last year, Liberty had come to the conclusion that something needed to happen. Before that letter was sent to Dr Francis, had Liberty—had any of you—made representations to the two departments that we took evidence from last week?

Katie Johnston: I do not believe that we have, but I can check and respond in writing.

Baroness Browning: I just wondered if the letter to Dr Francis was as a result of having had discussions with government departments. I was interested to know what their response was to any representations you may have made.

The Chairman: It might be useful if you could check that and give us a handwritten note.

Katie Johnston: I will.

Baroness Browning: If the panel is able to share any of that information with us, it would be very helpful because if we do recommend any changes, is the Government whom we have to persuade of our views.

Professor Richard Jones: Whatever changes may or may not be recommended and perhaps translated into a new code of practice or an amendment to the Act, the current situation will still obtain, in that many people will not be aware of the new, better legislation. Perhaps the Government should use, if not their power then their influence to ensure that all relevant professional bodies—not just health and social care professionals but housing managers, bank managers and the police—have the Mental Capacity Act as part of their basic core curriculum. It should be bedded into basic training. It is not at the moment. That could have a significant impact in the longer term, perhaps. Apart from that, I do not think that a new, very expensive training initiative will be particularly helpful. I wonder whether some consideration should be given to funding a public information campaign about the Act.

Q31 Lord Swinfen: I think that you have probably just answered my question. I was going to ask whether we have enough people with the right qualifications and knowledge to help people who are mentally incapacitated. Do we have a great shortage of such people?

Professor Richard Jones: There are a lot of people there who are providing help, but a lot of them are not aware of the Act and of their responsibilities under it. That is my experience. I am referring to people you would expect to know the Act—surgeons, for example. I was involved in a case not long ago where the surgeon who was refusing to operate on somebody because he was not able to give consent did not know about the Mental Capacity Act. He was totally ignorant of it. That is an awful state of affairs.

Lord Swinfen: Do people who are actually working with people with a mental incapacity have the appropriate knowledge of that incapacity, let alone of the law?

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**Professor Richard Jones:** I do not know, frankly. One of the problems is that the Act makes certain assumptions about the ability of individuals to assess capacity. I know a fair amount about the law. I was trained as a social worker many years ago. I do not feel competent to assess capacity, apart from very straightforward cases. It is a very skilled activity, but we assume that people have this skill. I question that.

**Nicola Mackintosh:** I support the need for training. Training on the Mental Capacity Act and its principles should be embedded in—I agree—housing officers, but also in all nurses, doctors, social workers, teachers and everyone in society. If the citizenship programme still exists, it should be part of that. Young people growing up in schools should be able to tell their parents, so the message can be imparted more widely. I would like to see—this may sound rather dull—standard forms for assessing capacity. They need not be very complicated, but, in my experience, having a standard form encourages a) a great paper trail of decision-making, and b) the correct procedures being gone through in terms of different levels of decision-making.

I echo what was said also about the lack of awareness, particularly within the NHS. I have had cases of vulnerable people who, were it not for the intervention of the Court of Protection, alerted by relatives, would have undergone very invasive, permanent, irreversible surgery because of the tendency to use the Mental Capacity Act in a best-interests, paternalistic way, particularly within the medical profession and the NHS. That is a real issue. There is a different ethos in terms of the social model of care, particularly with regard to people with learning disabilities. It is different for different client groups. For people with mental health needs and people with dementia, a different approach is taken from that taken with people who have learning disabilities.

**Q32 Baroness Shephard of Northwold:** It would be interesting to hear the views of the panel on the different requirements of this Act, and the clients with whom it deals, and the provisions of the Mental Health Act. I come new to this, but I have some knowledge of the Mental Health Act. It seems that it is infinitely more complex because you are involving families, carers and a lot of informal settings. You have already said that there should be training for X, Y, Z and the rest of it, but what about families and carers? You are then going into the realms of unreality. It may be desirable, but there is no way that you can get into all of that. You pointed out a lacuna in the area where people are self-funding in residential settings. Again, we are dealing with families—perhaps distant families. I do not see how you could achieve all of this. You could certainly put a lot of it into training the most obvious groups of people who might have to deal with the situation, but you are still leaving a huge area of vulnerability where people are being informally cared for, or looked after by care assistants and so on. How would you tackle that? That would be what Ministers would ask. They would say, “Okay, here is a gap. How do we fill it?”

**Kirsty Keywood:** I do not have the answer, but I do have some thoughts. On the interface between the Mental Capacity Act and the Mental Health Act, as a lawyer I am very drawn to the safeguards that are present in the Mental Health Act. However, what was really interesting about the engagement exercise that the Department of Health did with people with learning difficulties, and also family members and informal carers, was that they preferred the Mental Capacity Act to the Mental Health Act. It could be, of course, that the Mental Health Act was the vehicle for the majority of the appalling treatment that happened at Winterbourne View. But there is something there that we have to acknowledge. There is
something about the Mental Capacity Act that family members seem quite drawn to, when faced with a choice between the two pieces of legislation.

**Baroness Shephard of Northwold:** I think that in people’s minds, the Mental Health Act may be the equivalent of detention.

**Kirsty Keywood:** Yes, and quite stigmatising.

**Baroness Shephard of Northwold:** Yes, in the mind but not necessarily in reality.

**Kirsty Keywood:** Indeed. One of the things you talked about really struck a chord with me. We are going back to the issue of training. Very often we are dealing with people who are extremely poorly paid for the very important work that they do.

**Baroness Shephard of Northwold:** Exactly so. This is why I mentioned care assistants.

**Kirsty Keywood:** Quite. We need a more effective scheme to regulate the professions, including care assistants. I know that work has been done to introduce and develop NVQs in caring. Certainly mental capacity training has to be part of that. In that context, I would add one rider to the discussion we have had about training. Most of the training that I have been aware of that has happened around mental capacity has been about giving people knowledge. Lots of people will know a bit more about mental capacity after they have had a training session than they would if it had not taken place. But what a lot of training does not do is equip people with the skills that might be useful to undertake a determination of capacity and, from that, formulate an assessment of best interests. So it is not just about training but about skills-based training that will be appropriate to the particular professional groups that are working in those areas.

**Lord Swinfen:** Ms Mackintosh suggested that she had designed a form that might be useful. Perhaps we could see it.

**Nicola Mackintosh:** No. I suggested that it would be possible to devise such a form. It would have to be very simple. One problem that we will probably get on to in relation to DOLS is complexity. A key issue is keeping things simple but making sure that they work.

**Q33 Baroness Barker:** I declare an interest; I should have declared it last week. I own a consultancy which works with charities. From the discussion this morning, and also from last week, I think it would be fair to make the assumption that the principle-based approach to the Mental Capacity Act is one which, with the possible exception of the statutory presumption of capacity, has worked fairly well, and that is what people see as being part of the success of the Act. On the other hand, the area of practice has not been as successful. Those of us who were involved in the legislation all those years ago believed that going down the route that we did, of principle-based legislation, we were constructing something which would endure.

My question to you is: do you think that is right, and that the principle-based approach has given us a piece of legislation which is sufficiently flexible to deal with a changing world? There are two changes I would point to: one is the increase in dementia. You will know about the Prime Minister’s challenge—the idea that there should be dementia-friendly
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communities. Well, dementia-friendly communities have to have people who, in the course of their everyday work, are capable of dealing with that dementia. The other is the rise of technology. We did not think of technology when we did this legislation years ago, but technology is so much part of people's lives now. I think that throws up some very interesting questions, and I would like to hear your views on that.

Professor Richard Jones: I think you are being slightly sanguine in terms of the principles being applied, apart from the exception you note. We do not really know, because we do not really know that well how the Act is operating, but there is some evidence to suggest that the least restrictive alternative principle is not being complied with. I am thinking particularly of the research that I think the Alzheimer's Society published recently, which showed that 60% or thereabouts of patients with dementia who were admitted to hospital were admitted from their home, but only 30% were discharged back to their home. That raises the question of whether sufficient attention was given to a robust care package being put in place to support somebody at their home. Obviously, cost comes into this. Because of the general low level of knowledge about the Act, we cannot really say that the principles are being applied as you—as legislators—hoped.

Kirsty Keywood: I think that is right, is it not? People I speak to on the ground report really positively about the principles—there is no doubt about it. They say that they find it very useful. So on one hand I have this very positive feeling, and on the other hand I look at the research that is being done on decision-making—and that does not form a solid national picture either, but we know, for example, from the research literature, that people tend to conflate issues of capacity with best interests, as we have seen already. That is a huge problem, that in some circumstances the desire to be protective can mean that the most restrictive alternative is not always adhered to. There will always be challenges in implementation. I am not really sure how to answer your question, except that I know that the people I have engaged with on a professional level report very positively. Symbolically, it was a very important thing that the legislation did, and I, for one, am very glad that they are there.

Professor Richard Jones: They are a bit motherhood and apple pie, are they not?

Kirsty Keywood: Yes, they are, and the devil is in the implementation, as we have seen.

Katie Johnston: As I said, we think the principled approach is very good. When you have legislation that involves principles a problem comes in how they are applied on the ground when there is a lack of specificity in the primary legislation. If the Committee wanted to recommend one simple and relatively easy thing to do it would be to update the code of practice. Quite often the legislation is great but it is just not implemented correctly, or the code of practice is wonderful but is just not followed. This is particularly important given the breadth of the powers that are granted in Sections 5 and 6 for carers to take best-interests decisions. Really, quite urgently a review of the code of practice would be really helpful.

Nicola Mackintosh: I completely agree with that. The principles are great; there is a slight concern about Sections 5 and 6 being geared towards protection of the carers rather than the rights of the vulnerable person being absolutely at the centre of all these decisions. I completely agree that the code of practice needs updating. I would say that the code of practice in many areas, in its case examples, is motherhood and apple pie. A dispute arises
but over time, having talked together, everybody sorts everything out and everybody is happy. My experience—obviously, I only see those cases which present more significant problems—is that perhaps that is not always the case.

Often, talking is a great way of sorting things out, but sometimes it does not work.

**Baroness McIntosh of Hudnall:** We did raise the question of the code of practice and the potential it has for being reviewed last week with the department, as at least Professor Jones will know. The answer they gave seems to me one that perhaps you might want to reflect on for us. That is, the issue is not that the code of practice needs to be reviewed—that may or may not be true—but that it is to do, as you have said yourselves, with how it is implemented on the ground. I wonder whether a lot of work going into a revised code of practice, without there being some further pressure put on the people whose job it is to implement that code to do so, is really going to make any significant difference.

**Katie Johnston:** I think you are right. There is a problem of implementation, but there is also a problem with the code. One example is the definition of deprivation of liberty—this is about DOLS. There have been at least 16 or 20 cases that redefine deprivation of liberty which are not reflected in the current definition that is given.

**The Chairman:** That is the subject of litigation at the moment.

**Katie Johnston:** Yes. In the autumn.

**The Chairman:** I think the Supreme Court will be adjudicating upon that in October, so we may get some guidance on that.

**Katie Johnston:** I hope to be able to comment on that today.

**Q34 Lord Patel of Bradford:** I am going to take you back to the deprivation of liberty safeguards. It seems we have two opposing views at the moment. Last week I asked the question to the departments whether, as some practitioners have said, the DOLS was a bit of an add-on to the Mental Capacity Act. It is there with a very different ethos. Their response seemed fairly unequivocally, “No, that is not the case, because there is too much focus on the deprivation bit and not enough on the safeguards element”. You are obviously saying some different things. I will play devil’s advocate a little bit and say, if we did not have DOLS, what we would have is probably thousands of people who are de facto detained. The other option is to section them all, get second opinions, provide Section 117 aftercare—the resources are just not there. Is this the best of a bad job?

**Professor Richard Jones:** I would say the better alternative, which in fact was flagged up by the Department of Health when the consultation exercise on DOLS went through, would be to amend the Mental Health Act—amend the guardianship provisions in the Mental Health Act, which to all intents and purposes at the moment allow for detention—to incorporate the DOLS population, so they would not be subject to the same mechanisms as a detained person would be subject to, but they would have the protections of the tribunal system and they would have the protections relating to monitoring of correspondence if the Act was amended properly. So you could tailor the guardianship provisions to meet the DOLS population but without full-blown sectioning being required.

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The Law Society, Liberty, Professor Richard Jones (Cardiff Law School) and Kirsty Keywood (University of Manchester) – Oral evidence (QQ 25 - 44)

Yes, there would be expense, but in my opinion it would not be as expensive as the current DOLS system, which is extremely expensive, because a whole new structure has been set up.

Katie Johnston: The situation that you outline where thousands, if not tens of thousands, are being de facto detained unlawfully is what is going on at the moment. Liberty’s main problem with the Act from a human rights point of view is that there are thousands, perhaps tens of thousands, of people who are deprived of their liberty in the sense of Article 5 of the European convention, and who are not subject to the safeguards guaranteed in Article 5.4 of the convention or even in DOLS because for a number of reasons, which I can go into, there is a great lack of awareness among people who should be assessing whether a DOLS order is required, when it is required and if it should be applied for. It has proactively to be applied for by the people in care homes. So, for various reasons, people are being detained at the moment, which is the one of the biggest problems.

Kirsty Keywood: I think there is a real irony with DOLS, which is that it was brought in precisely because our common-law regulation of this issue was in breach of European human rights law because it failed to offer clarity to individuals who need to know in advance what their rights are. Quite what clarity the DOLS provisions offer to anybody is a mystery to me. We may well have a legal solution to a problem which is still in breach of human rights law.

I absolutely agree with Professor Jones. Guardianship would have to be revised to accommodate some of the issues that relate to deprivation of liberty, but that is doable. Interestingly, my colleague Neil Allen at the University of Manchester is working in the Isle of Man to review its response to DOLS. The Isle of Man is working up a suggestion that guardianship is used as the mechanism to authorise deprivation over there.

Q35 The Chairman: Do you know how far that has got?

Kirsty Keywood: It is hoped to have legislation by 2015, I understand.

Nicola Mackintosh: We all know that there are major problems with DOLS, but I have experience of cases that have come to court because the RPR, on behalf of the incapacitated person, has made the application or has assisted the person to make the application to court. I have seen examples of where it has worked in at least two cases, both of people placed in care homes after having been discharged from hospital who had consistently expressed a wish to go home to their own homes. In one case, the judge of the Court of Protection felt that the strength of feeling of that person was so important in his decision-making that he visited her in the care home, which is an example of very good flexible practice, which is what you need from the judiciary in this area. So there are examples of where it works very well, but I completely agree that the vast majority of my clients in care homes are being deprived of their liberty without any protection at all.

Whether guardianship is the right way forward—and I have some concerns about a single person being appointed as a guardian, which dates back to the Mental Health Act 1959 and the paternalistic approach which was taken then, which is precisely why the powers in guardianship were narrowed in the 1983 Act—I do not know. I certainly think that the current safeguards have an important element to them. The crucial element is that there is

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an independent person who is funded and whose responsibility is to review with the vulnerable or incapacitated person and if necessary to assist them in bringing the case before the court. However, even so, only a very small percentage of those cases are raised before the Court of Protection.

Obviously, there is some need for some research on the reason why that is the case. I suspect it will be because if you have a vulnerable person detained in a care home who is physically or verbally expressing a wish to leave, those cases are more likely to be raised before the court than cases involving a compliant, incapacitated person. That was the case in the Bournewood case. I do not think the DOLS scheme has cured the illegality.

**Lord Patel of Bradford:** Can I just take this a little bit further? If this was an ideal world and the training and implementation were there and we saw more of the cases that you are dealing with where it has been a success, is there actually a problem with the legislation? Would you bother to change the legislation then or is it still flawed?

**Professor Richard Jones:** I defy anyone to read Schedule 1A to the Mental Capacity Act and say, “I understand this. Gosh, it’s straightforward”. It is devilishly difficult to understand. Judges have complained about the impenetrable nature of the legislation, so even if the structure was right, the wording would need to be substantially changed so that it is not just people like us who understand it. The citizen should understand this legislation that is concerned with depriving them of their liberty. It should not be so impenetrable.

**Q36 Lord Swinfen:** The Mental Capacity Act applies to Wales with different implementation arrangements. Northern Ireland and Scotland have different legislation entirely. Are there any lessons that can be learnt from that different legislation or, indeed, from international law or other nations’ laws? If so, what?

**Professor Richard Jones:** Speaking as a Welshman, I do not think there is anything, I am afraid, that you can learn from Wales. It has been implemented in Wales in exactly the same way as it has been in England, fortunately, because if you look at the Mental Health Act, there are different regulations, different forms and a different code of practice which leads to its own complications, so the fact that it applies in Wales as it does in England means there is nothing you can learn from Wales.

**Lord Swinfen:** What I meant was: is there anything that you can learn from Scotland or Northern Ireland or from, say, France, Germany or the United States? I know that, in the eyes of the Welsh, Wales always lead the English, and I would not argue with you on that—you are bigger than me—but what can we learn from the other nations of the world?

**Professor Richard Jones:** I think Kirsty is the expert on this.

**Kirsty Keywood:** I think there is an awful lot we can learn from what is happening in other jurisdictions. Your special adviser can tell you more than I can about the UN Convention on the Rights of Persons with Disabilities, but that signals some important changes that are ahead. Northern Ireland, as you know, is going through a very lengthy process of law reform in the field of mental capacity and is proposing to have a fused piece of legislation that incorporates mental health and mental capacity law, so the concept of capacity will have
far greater significance in mental health decision-making than it has at present in Northern Ireland or in English mental health law. That is a very interesting approach to think about.

More specifically, the Mental Capacity (Health, Welfare and Finance) Bill, as it is currently framed, is anticipating a more robust set of safeguards for certain sorts of decisions, and I find that quite appealing in view of some of the concerns that I have mentioned here. For example, under the current Bill, where a person is objecting to an intervention that is not routine or urgent, a nominated person has to be involved—an advocate of some sort—and there has to be a referral to a multidisciplinary panel.

Northern Ireland is taking an interesting approach, which is almost to tier decision-making. You have the informal decision-making that will happen at home, the very routine sorts of interventions, such as bathing, cleaning and dressing, and then you have a gradation through to the more serious ones where there will be far more intervention by third parties and multidisciplinary panels. That approach appeals to me because of the safeguarding concerns that I have seen.

Scotland is quite interesting because it has produced a statutory footing to its adult protection law. It has not put adult protection and mental capacity in the same piece of legislation, but the two cross-refer to each other extensively. In consequence of that, the code of practice on mental capacity in Scotland and the guidance that has been issued by a number of the professional organisations are very alert to the need to balance capacity with adult protection. That is a really useful lesson that I am aware of.

The UN Convention on the Rights of Persons with Disabilities has a lot to tell us. I am not sure that we all entirely understand quite where it is going to take us, but certainly it talks about the importance of developing systems of supported decision-making rather than proxy decision-making. This idea that if a person lacks capacity, other people move in and make a decision on their best interests is not really within the ethos of the UN Convention, and some countries have been taken to task for having legislation that does just that. So when we think about redrafting the principles, one of the things that, if we are to take the Convention seriously, we should recognise is the importance of taking steps to support decision-making and to acknowledge the will, preferences and rights of individuals. That does not mean that they will always be respected, but they have to be the starting point for any kind of determination of what is best for an individual. That is a really important lesson that we have to take forward because legally we are required to do so.

There are other mechanisms that the UN Convention may require. It may be that we have to provide greater scrutiny by third parties of decision-making. We may have to reformulate the best-interests checklist as it currently features within the legislation to acknowledge the primacy of the person’s wishes and interests. We will get a clearer picture of what the UN Convention expects of countries such as ours when it issues its report on the safeguarding of disabled people in Australia later this year. I think there will be some lessons we can take from that, and that is due in September.

Q37 The Chairman: Baroness Shephard?

Baroness Shephard of Northwold: Well, Lord Chairman, my question is No. 5 and I feel that it has been most comprehensively discussed and answered, in so far as there is an
answer. The answer is that the implementation could be very much better across a wide range of issues. The most concrete suggestion that we have had is that it might be a good start to look again at the code of practice. I do not think that there is any more I can ask.

**Baroness McIntosh of Hudnall:** One thing we could explore a bit further is something which you raised, Ms Mackintosh, which is the question of the IMCA system and whether, in your view, it is either properly understood or accessed by the people who need to access it, and whether it is really helping to provide the voice that it should for people lacking capacity. If I recall your earlier answer correctly, you have some doubts about that. Perhaps you would like to start off.

**Nicola Mackintosh:** A bit like the Act, it is a good start. I have experience of very good quality service being provided by some IMCAs and not by others, but you will have that in any system. The difficulty is that the IMCA input is severely limited at the moment. It could positively be expanded.

**Baroness McIntosh of Hudnall:** Could I stop you for a moment? When you say it is limited, what is limiting it?

**Nicola Mackintosh:** I am not privy to the details of the commissioning arrangements between, for example, local authorities and advocacy organisations, who tend to provide the IMCA service. Anecdotally, what they have told me is that the actual time an IMCA is permitted to spend on a case which has been referred to them is limited in terms of either money or hours’ worth of work, or it is limited to a specific decision rather than being part of ongoing generic advocacy, particularly for people who have a range of difficulties and issues which might be coming up. That might be, for example, residence; it might be difficult relationships with family members and contact arrangements between the vulnerable person and their family members, within a care home, for example. There may be a plethora of quite complicated issues for a single person. The current IMCA service is very limited to just a single issue; for example, a change of residence. That might be two, three or four hours’ worth of input from the IMCA, which is not really long enough to spend time getting to know the person, listening to their wishes and feelings and really ascertaining what is going on for them as a human being. That is what it comes down to at the end of the day. The IMCA could provide a pivotal role in ensuring that independence of voice for the incapacitated person, but without so many of the artificial limits which are currently being placed on them.

**Baroness McIntosh of Hudnall:** Which, if I have understood you, you suspect may be to do with—referring to something else you said, and forgive me for a moment, but I want to get this right; I think I wrote it down somewhere—services being “outcomes led by resources”. So your suspicion is that the limitations you have just described are brought about by an unwillingness or inability by commissioners to commit those resources.

**Nicola Mackintosh:** It can be. There is also a structural change that has to take place. Currently there is a self-restriction that referral is only made for an IMCA with regard to certain decision-making. That could be expanded. There is discretion to use the IMCA service—make a referral for an IMCA—in relation to the vast majority of decisions. But in practice my experience is that it is only in relation to a change of accommodation. Even then it is not followed all the time. There are very clear cases where, for example, someone is
being discharged from hospital. There should be an IMCA in every single case where the person is assessed as lacking capacity.

**Q38 Lord Patel of Bradford:** Following on from that, obviously then the difference is with the advocates that are provided for detained patients under the Mental Health Act. Is there a quality aspect, that they are different and they need better access to them?

**Professor Richard Jones:** I do not know the answer to that question, I am afraid. It is a fairly new initiative, the independent mental health advocates, and their role is perhaps more focused on explaining the statutory scheme as opposed to that of the IMCA who identifies what course of action is in the best interest of the individual concerned. The IMCA scheme has a lot to commend it. From a negative point of view, I have not had much experience of the scheme, but the involvement of the IMCA can lead to delays in terms of the decision being reached. My own experience, which is focused on decision-making in hospitals, is that the IMCA very rarely disagrees with the best-interests decision that is being advocated. So I am not sure what actual impact the IMCA has in terms of changing minds.

**Kirsty Keywood:** I think that the issues around IMCA involvement with serious medical treatment have had that impact. We know from the research that IMCAs have said that they very much find when they are advocating for somebody who is facing a serious medical intervention that the clinicians sometimes do not feel that they [the IMCAs] have expertise to be there, offering that role. When it comes to accommodation decisions the picture is slightly different. Very much like Nicola, I have a strong sense that IMCAs can work incredibly positively to advocate for people who lack capacity. They are very much restricted to circumstances, by and large, where the person without capacity has no family member or unpaid carer. There are exceptions to that; for example, in adult protection you can have an IMCA if your local authority decides that it is appropriate, even if you have family members around. Generally, however, there has to be nobody in your informal caring network who can act as an advocate for you before you get an IMCA. As we have seen today, there are certainly circumstances where relatives may be distant and where there may be such conflict among relatives that actually an IMCA could be quite an empowering tool for some sorts of particularly complicated decision-making. I would certainly welcome the opportunity to confer the power on health commissioners and local authorities to deploy IMCAs in a wider range of circumstances.

**Q39 Baroness Browning:** Two of you have now mentioned family members. Of course, I understand that there are often disputes within families and an IMCA will be very important in those circumstances. Could I take your view on where we are as far as the Act is concerned with carers and close family members being advocates? I should declare an interest, which is in the list. I am sorry that Baroness Hollins is not here today, because she would also share this feeling. We have had some pretty shocking cases, particularly the Mencap cases that have been documented, where mothers have stood by the beds of adult learning-disabled children who have died, not because of the illness they have been admitted to a general hospital ward for, but because of neglect, because the staff have had a difference of opinion with the parent—the carer—about things like nutrition and fluids; fundamental things like that. These are not just isolated cases; there are too many of them. How do you see this Act in terms of advocacy from close relatives and carers? Is the balance right?
Professor Richard Jones: In the situation you described, the clinician has to take into account the views of the parent. The parent cannot determine the course of action that is to be taken from a medical perspective. A parent, because of their role, will advocate what they believe to be best for the child. I do not think that that needs to be given statutory form. It is what parents do.

Baroness Browning: But parents are told that once their child is over the age of 18, their views and concerns are overtaken by the view—or failure to express a view—of the newly adult child. That is something that, in particular with learning disability, autism and some chronic mental health conditions, has led to some of these tragic cases.

Professor Richard Jones: That is assuming that the patient who is an adult has capacity.

Nicola Mackintosh: I think that it depends in many cases on the outcome. I have lots of clients who are being cared for by their parents, and the parents are saying, “We are unable to cope any more, please can we work with the local authority to find a long-term residential placement where we can still have lots of contact with our loved one”, but the local authority is not listening—because it suits the authority, to be frank. So in the situation where a parent is in hospital, standing by the bedside of their loved one, it depends on what suits the professionals a lot of the time. That is the difficulty.

That is not to say that there are not disputes. There are very hotly contested disputes—I can speak from great experience. In cases that come before the Court of Protection, there is often a big clash between the family and the professionals. One thing that I try to do in my cases is mediate a solution. A lot of the time there is a misunderstanding and a clash between the family and professionals, and there needs to be more dialogue to resolve that.

Q40 The Chairman: The next issue has already been touched on. Ms Mackintosh and Ms Keywood referred to the need for understanding of the Act by people who are involved in it. Perhaps I could ask a question in particular of the Law Society, because Ms Mackintosh is speaking on behalf of the Law Society as well. I appreciate that you have a special practice, but what about a solicitor who has a general practice and is not a specialist? What steps does the Law Society take to ensure that members of the profession are aware of the Act and also know how to operate it?

Nicola Mackintosh: There is always room for improvement. However, we at the Law Society issue practice notes to guide the profession on a number of issues. One practice note is in relation to representation before a mental health tribunal. That can also include issues such as the duties of solicitors to their clients in that setting, where the clients may lack capacity. It is a double complication. We have been talking about whether there is scope for issuing a general practice note to the profession on the Mental Capacity Act. We have issued a financial abuse practice note, alerting legal practitioners to the risk of financial abuse of vulnerable clients. I think that that has gone quite a long way to improving the knowledge of the legal profession. No decision has been made yet, but the difficulty with the general mental capacity practice note is in the title. In issuing a general note, one always approximates and summarises. One cannot provide for every situation. It is a very difficult balance. One has to decide whether to issue a general note and general training, or more specific and directed training.
The Law Society, Liberty, Professor Richard Jones (Cardiff Law School) and Kirsty Keywood (University of Manchester) – Oral evidence (QQ 25 - 44)

**The Chairman:** Are practice notes by the Law Society any more effective than statutory codes of practice?

**Nicola Mackintosh:** No, they are no replacement at all. But in answer to your question about what steps the Law Society is taking in relation to its members, that is some work that we have already done and that is ongoing.

**The Chairman:** What I am trying to get at is the extent to which solicitors or lawyers in a general practice are aware of the Act.

**Nicola Mackintosh:** I think that there is great room for improvement. The problem is potentially also because of the way that cases are funded. Most of my casework is funded through legal aid because, by definition, my clients are very poor. Those lawyers who are not undertaking legal aid work may be less familiar with the types of cases and legal issues raised by representing vulnerable clients.

**Q41 Lord Faulks:** I should begin by declaring an interest as a practising barrister with some experience of mental capacity issues. Following up on the question of the Lord Chairman, on the question of mental capacity generally and the test for it, I appreciate what Professor Jones said about it not being easy. Today’s Times reports that the Court of Appeal decided that Mr Justice Hedley in the Court of Protection had got the test wrong. There were particular facts; I will not weary the Committee with them. However, that is an example of a judge with experience in the Court of Protection getting the test wrong. I wonder, looking again at the statute with the elegant solution that it provided, whether the test is too difficult, given the myriad circumstances to which it will have to be applied, and whether we should simplify it.

**Kirsty Keywood:** One way in which we could and should simplify it to some extent—I am not sure that this will satisfy you—is to get rid of the diagnostic thresholds. That is to say, currently under the legislation you have to have an impairment or a disturbance in the functioning of the mind or brain before you can be found to lack capacity by struggling with one of the other decision-making elements of the test. I think that that has to go. It is in breach of the UN Convention and it is also incredibly difficult to know exactly what is at the source of somebody’s struggle to understand, weigh up, retain or communicate information. So that is one area where I would certainly suggest that we modify the test of capacity. I have come across lots of people who did not have an evident mental health problem or a learning disability yet who struggled to make decisions because of the very complicated circumstances in which they lived their lives. The current framing of the mental capacity test hinders the ability of some services to provide imaginative, effective support to those individuals.

**Professor Richard Jones:** The task you are setting us is extremely difficult. One of the benefits of the current test, which as you know is issue-specific in the sense that somebody may be mentally capable of making decision A but not decision B, is that it allows somebody to use their maximum decision-making capability. If you simplify the test to make it more general, it will have the consequence of denying some people who could make certain decisions the power to make them. So the test is the correct one, but it just gives rise to such difficulties in practice. This goes back to what I said in my opening remarks. The Act is just ignored for most decisions. It would be a practical impossibility for all these assessments...
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

**Lord Faulks**: I would like to ask about the Court of Protection. It existed before but was given a vastly enlarged jurisdiction. Clearly, it will take some time for any court to settle down. In so far as case law has emerged, do you think that the court is getting it right? Is case law proving the worth of the Act or the contrary?

**Katie Johnston**: I will talk about one particular line of case law. The problem with DOLS is that they are not used sufficiently. One of the problems is implementation and lack of training. Another big problem is that there is a serious lack of clarity in the definition of deprivation of liberty. This is partly structural. The Act does not provide its own statutory definition. It ties it to Article 5 of the convention. That is obviously problematic in itself because it is a constantly changing object. That then flows into domestic practice. Domestic case law is constantly changing. I have been at training sessions where social workers who are not legally trained are shown extracts from judgments of the Court of Appeal on a whiteboard and told to apply them in practice. That is obviously very difficult. So the fact that it is tied to case law is difficult in itself.

The case law of the Court of Protection has been quite lacking in how it has interpreted deprivation. DOLS are not being applied as it is. But the court has narrowed the definition of deprivation of liberty so that many people who are undoubtedly detained in the sense of Article 5 of the convention fall outside the scope of DOLS. In particular, I am sure that you are familiar with the Cheshire West judgement, which is coming through the Supreme Court. It develops an unfortunate test of normality where, essentially, a disabled person would not be deprived of their liberty if the restriction that they are subject to is something that could be expected of somebody with similar disabilities—I am paraphrasing. This is obviously completely unacceptable. It narrows the scope unacceptably and turns human rights on their head. Human rights are universal. Everybody is entitled to the same protections, and if there are restrictions, they have to be justified. So we think that a statutory definition of deprivation of liberty that is not tied to Strasbourg would be a real help in increasing certainty.

The other restriction that the court has developed in its case law has been the return of the idea of reasons as going to the issue of whether there is a deprivation. This appeared in Strasbourg case law in the past but the court resiled from it. Now it has made a reappearance in the British courts. The idea is that the reason for the detention can affect the question of whether there is a deprivation in the first place. Again, that turns protection on its head. If there is a deprivation, you look at the reasons to see whether it is justified and proportionate. Those are the two big problems in deprivation case law that a broad and clear statutory definition that is freestanding would help to address.

**Q42 The Chairman**: Ms Keywood?

**Kirsty Keywood**: I think that the definition of what a deprivation of liberty is does not show the Court of Protection at its best. But in fairness, the jurisprudence and the legislation that it has to work with did not give it much to go on. With such exceptions, I have been incredibly impressed by the judges in the Court of Protection. I have been very heartened...
that they have given rulings and declarations with great humanity and compassion for the people and families whom they are supporting. When I think about the Court of Protection, one case that always springs to mind is that of Steven Neary, and Mr Neary's valiant efforts to scrutinise and challenge the circumstances surrounding his son's deprivation. The judges have been remarkable in their ability to communicate some very complex and difficult issues to an audience that goes beyond the person lacking capacity and their family, including wider communities that have been quite anguished about some of these things. Lord Justice Munby said that the Court of Protection offers a Rolls-Royce service. That is absolutely right. The difficulty for me is that it comes with a Rolls-Royce price tag that many local authorities cannot afford.

Nicola Mackintosh: It is important to remind ourselves of the breadth of cases that come before the Court of Protection. There are very few DOLS cases at the moment. I agree that the line of judgments on what is a deprivation of liberty has been extremely unhelpful to everybody applying the Act on the ground, and also to all those people who in my view remain detained in hospital without any protections. But there is also a wide range of cases that concern other issues such as where somebody should live. That is not an easy question at all, particularly if the issue is whether they should live with their family or in care, which is the most common scenario. Issues around contact with relatives, especially where there may have been a history of abuse, are complicated. Issues of forced marriage, removal from a jurisdiction and capacity to consent to sexual relations all come before the court.

The court works well in many cases, even though only a tiny proportion of disputes come before it. One of the major issues that I have is that where there is a serious dispute about a serious issue, whose responsibility is it to place it before the court? That is unclear. For example, if a statutory organisation is purporting to make a decision on behalf of an incapacitated person where there is a clear dispute about a serious issue, in my view that statutory body has and should have the responsibility for placing that dispute before the court for determination. In my experience, what happens is that the statutory body just goes ahead and makes the decision, and leaves it either to an advocate, if the person is lucky enough to have one, or to some other person, to bring the case before the court. Often that simply does not happen. So that is a serious shortcoming that could be plugged.

The court definitely could be improved. It is more expensive and unwieldy than it needs to be. I could make a number of practical suggestions that would help. There should be very prompt access to a suitable litigation friend for the incapacitated person. We are all aware of the difficulties that the Official Solicitor’s Office has had in relation to providing the services of a litigation friend in some cases—it is now operating a waiting list—because of a lack of resources. The minute you have a waiting list for a litigation friend, or you do not have prompt access to a suitable litigation friend, the case comes to a halt. That is in no one’s interests. If we had very tight case management, with cases allocated to individual judges who run the case from the beginning to the end wherever practically possible, that would make great sense. We should take out the plethora of court hearings that we have. Every time you have a court hearing, you are incurring enormous expense and raising the expectations of relatives that this will be a final decision and a final hearing. Wherever possible, try to reach an agreement on the papers that is then placed before the allocated judge. There may not be a need for a hearing at all until the final hearing to determine the underlying dispute. There may be room for a practice direction to streamline the court process, which may reduce the costs and make the court more accessible. The court needs
to be much more flexible. I talked about the judge who visited my client in the care home. That made all the difference. The courts need to go to where the person and the family are. We should not have a situation where everybody has to travel very large distances to turn up for a hearing that starts at 10.30 am, only to still be waiting at 4 pm and maybe not even to go before a judge. That is not acceptable. Sometimes things go wrong, but often the whole structure of the court process can be streamlined so that the focus is on the incapacitated person and their family, on the time that the professionals are taking in attending court, and on the entire cost of the process.

Q43 Lord Faulks: Perhaps I can ask you about the way the court does not always work satisfactorily. I base this on a number of solicitors who have spoken to me, and on articles in the press quoting judges. I am referring in particular to the out-of-hours provisions. The court has to be available at all times and in any place. That is a great aspiration, of course, but there is a suggestion that local authorities are often using the out-of-hours service inappropriately and making applications as a matter of urgency for judges—one of whom was at the zoo, I believe—to make a particular order. Mr Justice Hedley said, “There are very few cases which can’t wait until Monday morning”. In your experience, when you are talking about serious decisions that must be taken, is there a danger that some of them are being taken out of hours when they should not be?

Professor Richard Jones: I have never come across that.

Nicola Mackintosh: My experience is that Mr Justice Hedley’s comments have been largely taken to heart. I cannot speak for every local authority—there may well be cases that fall outside that clear guidance—but certainly I have not come across the inappropriate use of the out-of-hours service.

Lord Faulks: I am glad to hear it. The other question I want to ask is about legal aid. We heard from the officials that there was absolutely no problem with legal aid, and that despite the LASPO Bill and the consultation, legal aid would be available as before. I dare say that at least one of you may have some comments on that. Is there any difficulty in getting legal aid for necessary and relevant applications to the Court of Protection?

Nicola Mackintosh: The short answer is yes, but it is a little more complicated than that. There is a dearth of expertise in this area. As I said, most—though not all—cases are funded by legal aid. Legal aid is available, but it is limited. One of the categories of case for which it is not available in the Court of Protection is where a vulnerable, incapacitated person is being psychologically abused. Physical abuse is included but psychological abuse is not. Only one-third of Article 8 situations are included. For example, residence or a change of accommodation is not included. In practice, when one is faced with a disputed decision about a change of accommodation, it may also involve contact disputes and the deprivation of liberty. It may involve issues of physical abuse. Therefore, the person is caught—and entitled to legal aid—through those other headings. But it is quite strange that those two headings are excluded from LASPO, which mirrors what happened before.

The other thing is that legal aid is means tested. LASPO introduced new, much more stringent means tests. Previously, if the person was claiming what are called passported benefits such as income support or guaranteed state pension credit, they were, subject to a merits test, automatically entitled to legal aid on the basis of means. That has now changed.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
With LASPO, the new eligibility regulations effectively passport a person on income but not on capital. For example, if the person has more than £3,000, a contribution will have to be made until such time as their savings fall below that limit. There is also the latest Transforming Legal Aid consultation paper, which was issued only seven or eight days after LASPO was implemented. It includes a proposal for a new residence test. In order to qualify for legal aid, every single person will have to prove to a legal adviser that they have been lawfully in the UK for at least a year. It is difficult enough for us to act for mentally incapacitated persons who do not have ready access to files of their bank statements that we need to show to the Legal Aid Agency to prove that they are eligible. It is difficult enough to obtain that evidence, but trying to obtain evidence that somebody has been lawfully here for a period of at least 12 months in order to qualify for legal aid is going to be impossible. It will actively provide a complete barrier to access to legal aid for many if not all vulnerable people.

Deprivation of liberty cases are non-means tested as long as the deprivation of liberty issue before the court is a Section 21A application. Many cases start off as a challenge to a deprivation of liberty, whereupon the court authorises the deprivation of liberty. At that point, under Section 16 of the Act, the person moves from a non-means tested system to being means tested. So in practice many people are excluded. We know that very few Section 21A applications come before the court. In the vast majority of cases that come before the Court of Protection, people may be eligible for legal aid, subject to their means, but if they have even a small level of capital, they will not be eligible. So things are very different to how they were before 1 April. That is the short answer.

**Katie Johnston**: Perhaps I could add one thing. I agree with everything Ms Mackintosh said. This area of law highlights another problem with transforming legal aid, which is the removal of a client’s choice of solicitor. Obviously, mental health law is an incredibly specialised area of law. If the proposals are implemented, legal aid clients will have absolutely no choice of who their solicitor is. If you do not get a solicitor who specialises, for example, in this area of law, it will affect your ability to make an arguable, plausible case and have it executed correctly.

**Nicola Mackintosh**: Could I make one additional comment? One of the Government’s proposals just over a year ago, which may well come back, was to channel all potentially legally aided clients through the telephone gateway. We made very strong representations against that, because we felt that it discriminated against people who might find it difficult to communicate over the telephone, who might not be able to use a telephone or who might not have access to a telephone. These cases are funded either under a community care legal aid contract or under a mental health legal aid contract. If the Government’s promise to roll out all areas of law into the telephone gateway is implemented, it will act as an effective barrier in all areas of law for anybody with difficulties using a telephone, which will include people in mental capacity cases.

**Q44 Baroness Barker**: I will wind up with the Office of the Public Guardian, and LPAs. The intention with the Office of the Public Guardian was that abuse would be protected against by the use of Court of Protection visitors. Has that worked out in practice?
Professor Richard Jones: I have not come across a case where there has been a problem getting a Court of Protection visitor, but I know that there are very few of them. Certainly it has not come on to my radar.

Nicola Mackintosh: My expertise is in health and welfare cases, although in almost all cases, even where the incapacitated person is in receipt of benefits, there is some level of abuse by family members. To what extent the Court of Protection visitor service assists with that I do not know.

Baroness Barker: Who would know? Where would it come up?

Nicola Mackintosh: As I said, all the cases that I have dealt with involve some abuse. Perhaps local authority money-management departments—those that still exist—might be well placed to comment on that. So might charities. My experience is that the use of appointeeships is patchy. We pick it up in health and welfare cases and try to deal with both sides.

Baroness Barker: To be fair, appointeeship was patchy before the Act. Is the registering of LPAs understood? Are they being taken out as widely as we anticipated? Last week we were given some figures. I will not quote them, but we got the cumulative figures for the time since the Act came into force.

Professor Richard Jones: My impression is that they are being used by the same people who used the enduring power of attorney option under the old legislation. I hear lots of cries of concern that applications are being sent back to people because of some minor error in the form. That appears to be a problem. This goes back to some of the points that were raised at the beginning of our session this morning. It is a question of knowledge. Do people know that the option to make an LPA exists? The knowledge is certainly there among the middle classes, but whether it goes wider than that I am not sure.

Baroness Barker: Are professionals in memory clinics, for example, raising awareness of LPAs?

Professor Richard Jones: I just do not know. Perhaps, if the memory clinic is being used, you are getting to the end of the timeframe when there is an option to execute an LPA.

Baroness Barker: That is a fair point. At the time the legislation went through, some of us predicted that the cost would be prohibitive. Was that worry right?

Professor Richard Jones: I do not think that it is prohibitive, but certainly it is a disincentive.

Nicola Mackintosh: I think that the forms could be simplified. I am all for simplification and removing all duplication.

Baroness Barker: The forms are enormous.

The Chairman: Have you given any thought to what the forms should contain—both the earlier forms you mentioned and these forms?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Law Society, Liberty, Professor Richard Jones (Cardiff Law School) and Kirsty Keywood (University of Manchester) – Oral evidence (QQ 25 - 44)

**Nicola Mackintosh:** I could have a bash. It would be a very initial bash, but I could have a try. And it will not be perfect.

**The Chairman:** It would be a useful start. Thank you very much to all of you. We are very grateful for the time you have given us. It has been a very useful and interesting session.
The Law Society – Written evidence

Introduction

The Law Society of England and Wales is the independent professional body, established for solicitors in 1825, that works globally to support and represent its 166,000 members, promoting the highest professional standards and the rule of law.

This response has been prepared by the Society’s Mental Health and Disability Committee and Wills and Equity Committee and supplements the oral evidence given to the Select Committee by Nicola Mackintosh on 25 June 2013.

Summary

Safeguarding the dignity and wellbeing of people with impaired capacity should be a priority for government. The Mental Capacity Act (MCA) is an important piece of legislation which provides a generally sound framework for the assessment, treatment and care of those with impaired capacity. Yet every day, thousands of informal decisions affecting the lives of those without capacity are made without any recourse to the protections offered by the MCA.

Although it is argued by some that proper implementation of the Act would place unrealistic demands on both professional and lay carers, the greater problem is the lack of awareness and understanding of the Act among professionals, lay carers and service users. There have been shocking failures to observe even the bare minimum safeguards, leading to tragic episodes of chronic abuse and neglect such as that uncovered at Winterborne View.

While community, residential and hospital care has become more and more complex, professional training for key front line staff, particularly social workers and healthcare professionals, does not appear to have kept pace. Practitioners need a level of understanding sufficient to enable them to recognise their duties and responsibilities in practice. We believe that it would be useful if more time were spent in social work training on the legal framework and practical application of mental capacity, Deprivation of Liberty Safeguards (DoLs), and community care assessments. A good example is provided by Approved Mental Health Professional’s (AMHP) who receive in depth post-qualification training, over many more hours than in their pre-qualifying training; this level of understanding should arguably be required of social workers who are making decisions about mental capacity and DoLs.

In our response to the consultation questions, we emphasise the need to accelerate a shift in culture from substitute to supported decision-making in health and welfare cases. We also highlight the increasing demands on those with the responsibility to support people in exercising their legal rights under the Act, including the pressures upon the Official Solicitor and the Court of Protection (COP), and the obstacles which prevent individuals from participating in COP proceedings.

We have significant concerns about the DoLs regime and agree with the Department of Health that it needs to be reviewed urgently. DoLs protections should be extended to those who are in ‘supported living’ placements, and there should be a mediation practice direction.
to encourage resolution of the issues that led to the DoLs being used. Consideration should also be given to combining the MCA and DoLs guidance to underline their inter-relationship. We urge that the Hague Convention on the International Protection of Adults should be ratified for England and Wales.

**Responses to questions**

1. **To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?**

In his foreword to the 2006 Code of Practice, Lord Falconer described the MCA’s aims as:

- To empower people to make decisions for themselves, wherever possible
- To protect people who lack capacity by providing a flexible framework that places individuals at the heart of the decision making process
- To ensure that those with impaired capacity participate as much as possible in any decisions made on their behalf and these decisions are made in their best interests
- To allow people to plan ahead for a time in the future when they may lack the capacity to make decisions for themselves

Only the first limb of the second and the last of these four aims have been achieved.

**Which areas of the Act, if any, require amendments; and how?**

2. **Deprivation of Liberty Safeguards**

See our response to questions 16 to 18.

**The international position as set out in Schedule 3 of the Act**

This is deeply unsatisfactory given the increasing numbers of people who own a property or retire abroad but continue to own property in the UK and then return when ill health strikes.

Although the UK has ratified the Hague Convention on the International Protection of Adults for Scotland, it has not ratified it for England and Wales. This means that the mutual recognition of ‘measures of protection’ that the Convention is intended to provide does not benefit citizens of England and Wales. We recommend strongly that the Convention should be ratified for England and Wales.

In addition, Schedule 3 lacks any supporting Code of Practice or rules as envisaged by the Act.

**MCA Code of Practice**

The Code should be updated and made more accessible to groups that rely upon it as an authoritative source of guidance. Consideration should also be given to combining the MCA and DoLs in order to highlight their co-dependence and to ensure fully compliant decision making.

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3. **At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?**

The principles and definitions are appropriate.

The substantive and persistent problem is lack of awareness and implementation of the principles in daily practice by professionals and lay carers. We have discussed this below.

Occasionally the principles can be applied perversely – such as using the presumption of capacity to negate the need for a capacity assessment, with the implications for associated support and resources.

4. **To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?**

Our members’ experience is that implementation and awareness of the five MCA principles in frontline practice has been mixed.

There is little recent research evidence to enable an assessment to be made about the extent of MCA implementation. Research of this nature is urgently needed in order to shape further initiatives to embed the MCA more fully.

There is evidence to suggest that social workers and other local authority professionals who frequently encounter impaired are more likely to adhere to the principles than other professionals including those in healthcare. This is likely to be due to the availability of training and compliance with established protocols requiring the formal consideration of capacity. That said, from legal practitioners’ perspective, the quality of capacity assessments can be poor.

In the primary healthcare, hospital and private care settings our experience shows a serious and widespread lack of knowledge and understanding.\(^{137}\)

A particularly stark example is the case of a young woman with a mild learning disability *(A Local Authority v K and others [2013] EWHC 242 (COP))*.\(^{138}\) In this case neither the local authority nor the health professionals were aware that consent for medical treatment must be authorised by the court. Such lack of awareness is far from isolated.

The situation becomes even more serious if a patient (P) needs specialist care unrelated to their disability – for example, treatment for a broken limb. Patients who are frightened and

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\(^{137}\) This is supported by the conclusions of the recent Cambridge University study ‘Understanding the Interface between the MCA’s Deprivation of Liberty Safeguards and the MHA – July 2013, Dr Isabel Clare and Professor Tony Holland

\(^{138}\) K’s parents had asked a consultant obstetrician to carry out a sterilisation of their daughter as a form of contraception. The consultant was wholly unaware of the requirements of the MCA, and despite misgivings agreed to carry out the procedure simply on the request of K’s parents without addressing her best interests, much less seeking the court’s authority. This took place in 2011: proceedings were not issued until July 2012 and even then it was clear that neither the local authority nor the health professionals were aware that a non-therapeutic sterilisation for a patient who cannot consent must be authorised by the court. Such lack of awareness is far from isolated.

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confused are often not recognised as having capacity problems and may be regarded as simply obstructive, so that the provisions of the Act are not even brought into play.

We understand that the Department for Health is amending No Secrets to focus more clearly on empowerment than protection. Even if protection is sufficient as a principle to manage a crisis initially, once a person has been identified as a victim of abuse, the goal should be to address the power imbalance. A greater emphasis on supported as opposed to substitute decision making is needed in order to move towards greater compliance with the UN Convention on the Rights of Persons with Disabilities (UNCRPD) as well as improve the journey of those with impaired capacity.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

The Government’s implementation plan has not been effective in embedding the Act’s principles or in making them widely accessible.

The provision of information to professionals and lay carers about the Act began with a well-written but overly long Code of Practice. Although the Code is well-known among professionals it is inaccessible to large sections of its intended audience. There should be abridged versions of the Code which are designed to provide relevant information to carers and family members.

There should be more specific guidance in the Code to assist decision-makers. This should draw on the significant amount of case law that has developed since the Act’s inception. The Code’s provisions should be tailored separately for healthcare professionals and social care professionals to ensure appropriate targeting of information and provide practical examples for specific professions. There should also be a requirement for care homes and hospitals to provide relevant persons with the Code of Practice or summary document.

The Government’s implementation plan had no effective scheme for monitoring the implementation of the Act or mechanism to ensure compliance: without some level of monitoring or compulsion it is difficult to see how sustainable change can be effected or appraised.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

Our response to question 4 covers the health and social care sectors.

The application of Lasting Power of Attorney’s (LPAs) and Enduring Power of Attorney’s (EPAs) in the banking sector has generally been very poor. Many bank staff do not understand these documents, how they operate, or the differences between them. Practice varies between the banks, so an individual’s experience of a matter at one bank may be quite different from the experience of exactly the same issue at another. As well as extensive problems with the use of LPAs and EPAs, there is also an inadequate understanding of other routine matters, for example on notifying a bank of proceedings in the Court of Protection.

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The Law Society – Written evidence

The MCA’s structure puts banks and financial institutions in a difficult position. Unlike the previous EPA regime where the banks at least knew whether it was the attorney or the donor who was entitled to operate the account, now each transaction should be decided on a case by case basis. How is the bank to know when to refuse, and when to accept an instruction from someone who has impaired capacity, but has not totally lost capacity?

It would be unfair to regard this as simply a matter of problems with banking practice and training. The law at the intersection of banking and mental capacity is scanty, mostly quite old and some of it ill-adapted to modern circumstances. The Act offers little assistance with the most basic of practical needs of someone with impaired capacity: access to their own funds for their day-to-day expenses or care. People who have mental capacity problems are in some cases discriminated against because not all banks will allow their attorney access to the full range of accounts and products which are available to other customers.

The Law Society, interested charities, the Office of the Public Guardian (OPG), the British Bankers’ Association, the Buildings Societies Association and certain of the banks have worked together to produce guidance for bank staff when dealing with for those wishing to operate a bank account for someone else. A simpler version has been produced for use by the public which is intended to be made available in banks and building societies. Over time, use of these documents by bank staff will result in improved training of staff and better service to people with capacity problems.

Most mandates signed when an account is opened do not envisage situations where capacity is in question and an EPA/LPA may need to be used. A document that a person signs at a time when they have no thought of incapacity might have a very negative effect on their position if a time comes when they lack capacity and are no longer in a position to change it.

Joint bank accounts present a serious practical worry for those with impaired mental capacity and for their carers, and the Act offers no assistance. At worst, the joint account holder with capacity may find that the account has been frozen, putting them in a position where they cannot access the couple’s only funds. Banks may justify this on the basis that they must protect the funds in the account until it becomes clear who is entitled to operate the account and in what way. Although they may still allow standing orders to be paid for essential services many older people do not set up standing orders or direct debits. Additionally essential living costs, such as food, are not paid by standing order.

With regard to legal professionals, knowledge and implementation of the MCA is generally good but we are aware that improvements could be made. The Law Society plans to issue guidance to the profession in 2014 to enable solicitors in a variety of practice areas to improve the services they provide to those with impaired capacity. The Society is also considering the roll out of voluntary standards for those practitioners whose practice entails frequent contact with clients who have impaired capacity or who work within the mental health or community care law.


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7. **Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers?** To what extent does the Act provide protection and reassurance for informal carers? Has the right balance been struck between protection of the carer and protection of the individual lacking capacity?

Awareness of the Act amongst carers is low and may only be triggered by a crisis event or a conflict with professionals. Much depends upon the carer’s assertiveness; those who are less assertive in seeking information and advice will be less likely to challenge decisions when perhaps they should be doing so.

Carers need to understand whether they are simply consultees or substitute decision makers for social care decisions, even if there is no LPA or deputyship order in existence.

Conflict between carers and professional who have made best interest decisions on behalf of the impaired person is commonplace in social care decisions being made in the local authority or hospital setting. Professionals are inclined to think that for social care decisions, where P is in hospital or a care home, that they are the decision makers and not family members. Greater clarity is needed on who is a best interest decision maker outside of the formal processes of deputyship and attorneys under LPAs.

8. **Has the Act ushered in the expected, or any, change in the culture of care?**

4. There is evidence to suggest that some professionals evaluate capacity rigorously as they are well aware of the impact of a finding that a person lacks capacity. Similarly, there are examples of good practice by professionals who use a model of engagement and consultation with P and their family members to reach agreed decisions in P’s best interests. However, there are also too many examples of inconsistent practice in consulting P or relevant family members, other paid carers or professionals from another field. Sometimes consultation with a family member who is perceived to be in conflict with the professionals is simply avoided and no attempt made to use mediatory processes.

5. There is no uniform practice as to how a welfare appraisal of the pros and cons of making a particular decision for P should be conducted, despite guidance from case law. Without a robust process, poor quality decisions and implementation are likely to follow.

Partnership working with other professionals needs to be improved, with better information sharing and decisions being made more promptly on P’s behalf - for example, when there is a dispute about discharge from hospital as to whether P returns to their own home or moves to residential or nursing care, a multidisciplinary approach can enhance both the quality and timeliness of the decision-making.

9. **Is there any evidence that the provisions of the MCA affect some groups disproportionately?** If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

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There is some research available\textsuperscript{140}. The experience of our members suggests that those from disadvantaged socio-economic groups and BME groups have lower levels of awareness of and engagement with the Act. We also know that these groups are disproportionately subject to compulsory powers under the Mental Health Act and little headway has been made to address this.

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

6. Although the Act provides an effective framework for supported decision-making in varied settings a significant number of informal decisions are made without any recourse to a formal capacity assessment.

Where capacity assessments are undertaken, the focus continues to be on protection rather than enablement, and on best interest decision making as opposed to supported decision-making by the impaired person. We believe the reasons for this include the lack of education, training, time and resources that would be necessary to enable those with impaired capacity to exercise their legal capacity along the lines envisioned by the UNCRPD.

7. A risk-averse culture combined with straitened resources does hinder professionals to allow those without capacity to have the dignity to make the choices and take the risks that others can.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

There is no research available as to the use of advance decisions in decision making in the healthcare setting. There is some evidence from the Care Quality Commission (CQC) that some advance decision making is being encouraged, particularly in the mental health setting. In this setting patients can be encouraged to express their views about their treatment preferences at a time when they are unwell whilst recognising that the MHA 1983 compulsory powers can override a valid and applicable advance decision. However, the issue of capacity to refuse treatment is a significant one when considering the impact on the patient. Trusts could do more to ensure that their staff use the MCA best interests decision making process to address that issue.

There are a number of initiatives which members can look to as supporting advance decision making, which include:

- An opportunity to make an advance decision within a health and personal welfare LPA;

\textsuperscript{140} http://www.mentalhealth.org.uk/content/assets/PDF/publications/BME_MCA_final_report.pdf?view=Standard

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The Law Society – Written evidence

- Increased involvement of the patient in their care plan with the patient at the centre of their own care, particularly end of life care pathways, where advance decision making is encouraged. The evidence from members is that this is used to best effect where there is a recognised terminal illness such as cancer;

- Better assessment of capacity so that individuals can make advance decisions about refusal of treatment;

- More use of tools such as treatment escalation plans which help the doctor/patient agree the limits of medical treatment in individual cases (see the Devon TEP initiative141);

- The BMA/ Law Society "Assessment of Mental Capacity, a practical guide for doctors and lawyers", edited by Penny Letts published in 2010 provides a valuable guide on the Act itself and contains a useful Chapter on consent and refusal of medical treatment which is a resource for doctors

- Guidance from the Royal Colleges on end of life care and;

- DH Choices website:

  http://www.nhs.uk/CarersDirect/moneyandlegal/legal/Pages/Advancedecisions.aspx

However, the numbers using advance decisions is likely to be proportionately very low compared to the potential number who could make an advance decision. Raised awareness of considering an advance decision at the time of entering into an LPA could assist. Also encouraging a more positive approach to this question being raised between doctor and patient at an appropriate stage in the care pathway may encourage more use.

Members’ experience, particularly those working with healthcare providers is that the medical profession will respect an advance decision which is valid and applicable. However, often the difficulty is confirming that a decision is valid or applicable to the treatment which is the subject of the decision. Individuals need more support to make clearer advance decisions and medical practitioners need support in interpreting them. A greater engagement between the individual making the decision and the treating clinicians at the time the advance decision is made will support decisions being followed.

There is also widespread misunderstanding of the effectiveness of advance decisions as compared to advance statements and how these are taken account of by professionals and the extent to which the medical profession can be required to adhere to the patient's wishes.

12. Has the MCA fostered appropriate involvement of carers and families in decision- making?

141 See http://www.devontep.co.uk/

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The Law Society – Written evidence

The MCA, principally via the Code of Practice, gives the strongest encouragement to professionals to include carers and families in the making of best interests decisions. Nevertheless, especially in informal care settings, consultation can be overlooked or only loosely complied with, especially if carers or family members are perceived to be obstructive.

More directive guidance supported by examples to emphasise the importance of sections 3 and 4 of the Act in the Code of Practice would be useful in reminding professionals that consulting and involving relevant family members and carers are mandatory steps before a sound best interest decision can be made.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

Yes, when and if an IMCA is appointed, they contribute significantly to ensuring the MCA’s aims are attained. IMCAs are a valuable but finite resource and their appointment in appropriate cases is far from guaranteed: automatic referral criteria are urgently needed.

When IMCAs are able to accept a referral they are often limited to providing assistance in specific decisions, for example a change of accommodation, and are not able to provide ongoing generic advocacy or have the time to deal with other issues associated with the specific decision such as contact or care arrangements.

There is a paucity of accessible information on IMCA services and a lack of formal triggers to their appointment even in the most deserving of cases. Accessible standardised information in a range of formats (including Easyread) would help to ensure that referrals are made, and there should be a duty to provide such information. The MCA Code should be revised to clarify the circumstances in which an IMCA should be appointed.

IMCAs are often involved in complex disputes involving family members and professionals, which is outside their statutory role. They may also be required to challenge local authorities in a formal court setting, for which they are ill-equipped. Adequate training and resources for IMCAs is essential, but unfortunately does not appear to be a funding priority, to the detriment of many vulnerable individuals.

There is a lack of oversight on the part of commissioning bodies to ensure that where IMCA services are funded, they are able to meet the demands of the locality.

There is a question mark over how 'independent' IMCAs can be when they are commissioned by the local authority, particularly as commissioning is now centred on a small number of providers. The need for truly independent IMCA services has been highlighted in the aftermath of Winterborne View.

We agree with the Department of Health’s recommendation\(^{\text{142}}\) that MCA leads in CCGs

\(^{142}\) The Fifth Year of the Independent Mental Capacity Advocacy (IMCA) Service - 2011 /2012

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should monitor compliance with the requirement for making referrals to IMCAs. The Department’s 5-year review of IMCA services revealed the stark variations of safeguarding referrals to IMCA services: we recommend that there should be automatic referral to IMCA services where there is an allegation of abuse or neglect.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

No, we do not believe current levels of referrals are indicative of the true demand or need for IMCA services. This may be due to heavy filtering of requests on grounds of limited resources. This is highly evident in safeguarding cases where we believe there is a lack of appreciation that IMCA’s can and should be involved as well as an inability to resource this area of increasing focus in social welfare. The apparent decrease in safeguarding referrals is disconcerting.

Specific reference has been made by IMCAs to the low level of section 39D (5) referrals to support relevant persons, where the need for an IMCA appointment is unarguable.

The Department of Health has suggested that the reason for regional disparities is that in certain areas the duties under the Act are not ‘well embedded’: this is consistent with our broad concern that those charged with implementing the Act are frequently unaware of it.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

No. An increased focus on the adequate commissioning of IMCA services is necessary in order that services are able to meet increased demand and the increasingly onerous requirements placed upon IMCAs themselves (including the increasing incidents of requests for IMCAs to take on a role as litigation friend in the Court of Protection). In areas where there are high referral rates IMCAs are challenged in fulfilling their statutory role in the DoLs processes including meeting urgent authorisations in time.

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLs) adequate?

There are significant problems with the DoLs scheme, most of which were identified prior to its implementation by the Joint Committee on Human Rights (JCHR). They include:

- the scheme’s complexity;
- the lack of a definition of deprivation of liberty;
- and the lack of Article 8 safeguards.

Further concerns raised during the passage of the Mental Health Act 2007 included the use of the COP as the forum for appeals (the majority of those responding to consultation having preferred the Mental Health Tribunal which would be far more accessible as well as local).

It is important to state that the over-arching problem - as with the MCA generally- is that DoLs are not always used when they should be. There is effectively a post-code lottery for

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The Law Society – Written evidence

patients. The CQC’s report, ‘The Operation of the Deprivation of Liberty Safeguards, 2010/2011’ found wide regional variations in the use of the safeguards. The CQC also had concerns about the complexity of the safeguards. We agree, particularly in relation to the interface with the MHA as a result of the convoluted drafting of Schedule 1A.

The interface issues with the MHA 1983 and decision making as to the least restrictive regime which should operate for the incapacitated, compliant patient is also a difficult area for decision makers and tribunals considering appeals against MHA detention. Justice Charles has provided some recent guidance in the recent case heard in the Upper Tribunal in the case of AM v SLAM and DH [2013] UKUT 0365 (AAC). What this case reveals is the complexity of the overlapping regimes for deprivation of liberty and the difficulties faced by Approved Mental Health Professionals and doctors in applying the law.

The continued uncertainty about the engagement of Article 5 is a further deterrent to the correct use of the safeguards. Section 64 (5) MCA provides that references to deprivation of a person’s liberty for the purpose of the Act have the same meaning as in Article 5(1) ECHR. It has been persuasively argued that this requires the interpretation to follow the Strasbourg definition, but it remains to be seen if the Supreme Court will provide any clarity when the linked appeals of the Official Solicitor in Cheshire West and Re P and Q are heard later in the year.

The legal limits of DoLs are becoming clearer through development of case law, for example DoLs should not be used to impose a change of residence:

- London Borough of Hillingdon v Neary & Anor [2011] EWHC 1377 (COP)

- C v Blackburn with Darwen Borough Council [2011] EWHC 3321 (COP)

The lack of Article 8 safeguards was commented on in J Council v GU (1), J Partnership NHS Foundation Trust (2), CQC (3) and X Limited (4) [2012] EWHC 3531 COP where ‘George’s’ placement involved severe restrictions on his correspondence and contact with others.

143 See Lucy Series ‘Statistical Guide to the MCA’
http://thesmallplaces.blogspot.co.uk/2013/06/your-statistical-guide-to-mental.html

144 This suggests differing interpretations of what a DoLs actually is, as well as a significant lack of awareness in some regions. Less than 5% of the NHS Hospitals inspected had made any applications at all and both the report into DoLs and the CQC’s report into the use of the MHA found evidence of ‘de facto’ informal detention of patients, some of whom lacked capacity to consent, in 19% of its visits, suggesting that the Bournewood Gap is alive and well. However, in its third report on DoLs covering 2011-12, the CQC highlighted a rise in DoLs applications from 7157 in 2009 to 11,393 in 2012 which may suggest increasing awareness but gives no real picture of the quality of assessments. The impact of the abolition of PCTs is not yet apparent.

145 ibid

146 See ‘Tying ourselves into (Gordian) knots?’, Alex Ruck Keene 2012

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George’s placement not only constituted a deprivation of his liberty but also curtailed his rights under Article 8, and had to be ‘in accordance with the law’ (Article 8(2)).

Had George been detained under the MHA in a High Security Hospital the Safety and Security Directions 2011 would have applied. As the court observed:

‘In contrast (it might be thought surprisingly), there are no equivalent detailed procedures and safeguards stipulated anywhere for persons detained pursuant to orders made under the Mental Capacity Act 2005.’ (para 14)

The judge commented that ‘not every case where there is some interference with Art 8 rights in the context of a deprivation of liberty authorised under the 2005 Act needs to have in place detailed policies with oversight by a public authority. Sometimes, particularly where the issue is one-off (such as authorising an operation), an order from the Court of Protection will suffice …But where there is going to be a long-term restrictive regime accompanied by invasive monitoring of the kind with which I am concerned, it seems to me that policies overseen by the applicable NHS Trust and the CQC akin to those which have been agreed here are likely to be necessary if serious doubts as to Article 8 compliance are to be avoided.’.

DoLs can be used only for those detained in hospitals and care homes. They cannot be used to protect the Article 5 rights of the increasing numbers of people placed in ‘supported living’, which may increase still further as a result of the proposed response to the Winterbourne View scandal. This leads us to urge the extension of the DoLs protections or any successor regime to those in ‘supported living’ placements. This is underlined by the experience of our members who work for local authorities who tell us that scrutiny of ‘supported living’ placements is critical in order to ensure that individuals are not in fact placed a hybrid or unregistered care placement which avoids regulation.

For all these criticisms of DoLs, there is anecdotal evidence that, in areas where the MCA and DoLs are properly embedded the use of DoLs as a legal framework has had positive effects on the culture of health and social care professionals. The advantage of DoLs is that their use requires consideration both of best interests and of the least restrictive alternative and this can encourage managing authorities to put greater thought in to planning how they deliver care, and to avoid blanket restrictions. Best Interests Assessors (BIAs) can, when they discharge their role properly, bring an approach focussed on individual rights which in turn can improve P’s quality of life.

Conditions inserted by BIAs can be useful in encouraging compliance with the MCA by managing authorities. Although arguably neither the BIA nor the supervisory body may have legal power to make or enforce them, they are valuable tools in trying to follow the least restrictive alternative principle.\\47\\

17. Are the processes for authorisation, review and challenge of DoLs sufficiently clear, accessible and timely?

\47\ http://sscr.nihr.ac.uk/PDF/SSCR-project-outline_4-DoLs_web.pdf

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8. No. With regard to authorisation and review, mental health assessors need to provide more narrative information when completing mental capacity and mental health forms: a tick box approach is not appropriate considering the consequences for the person to be detained. A nationally consistent approach to this is essential, but there is no umbrella group of supervisory bodies and the Department of Health’s ability to co-ordinate supervisory bodies is declining. There is little publicity about the fact that supervisory bodies can initiate their own review: this can be useful when a capacity assessment is inadequate.

There should be more scrutiny of why care homes are issuing urgent authorisations which were created as an exceptional measure, because some care homes predominantly apply for DoLs after issuing urgent authorisations. This limits the time for the assessors to consult the relevant person and their family to seven calendar days or if extended, 14 days.

In respect of appeals against the DoLs authorisation in the COP, there are practical difficulties in getting through to the court office in London, while the significant costs attached to a COP review are out of the question for local authorities on a routine basis.

The lack of any consistent mechanism to allow P to participate effectively in the COP process is particularly acute in DoLs appeals as the Relevant Persons Representatives (RPRs) are increasingly expected to make such applications because the Official Solicitor is insufficiently resourced to represent P and act as litigation friend.

Although P is entitled to non-means tested legal aid, the RPR acting as litigation friend may not be resourced to put in the time needed to run a COP appeal. The responsibilities of the litigation friend in an Article 5 challenge are also unclear (we have recently raised these issues with the Department of Health and await its reply).

Significantly, there is no mediation practice direction to encourage resolution of the issues that led to the DoLs being used or for wider reasons eg family disputes with professionals. This should be considered seriously by the COP to ease the burden on itself and the parties whose resources are already stretched to breaking point. The benefit to P and his family carers would also be significant, should agreement be reached.

The COP does not have the resources to process challenges to DoLs authorisations in a timely fashion. There is an urgent need for an accelerated process to review detentions, which could be the COP, if it were properly resourced and had a sufficient cohort of district judges able to hear the cases quickly. Another option is a multi-disciplinary Tribunal or extended use of the Mental Health Tribunals.

Only a tiny proportion of DoLs authorisations result in challenges to the COP (0.8%). This is unlikely to accurately reflect the number of detained people who would like to challenge their placements. By contrast, patients detained under the MHA have their cases automatically referred to the Tribunal periodically if they do not apply. A similar scheme of external review during a DoLs application would provide a valuable opportunity for those lacking capacity to apply for an independent body to scrutinise the continued need for detention and who could trigger a move to a less restrictive setting which might otherwise never have been considered.

18. Are the Court of Protection and Office of the Public Guardian
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sufficiently understood and accessible to all? Are they operating effectively and successfully?

The COP’s accessibility depends mainly upon P’s financial status. For the great majority of individuals, the Court effectively provides no service at all unless, exceptionally, a public service (e.g., a hospital or local authority) makes an application. For most, the cost of an application to the Court is prohibitive, so they muddle through as best they can. For those who can afford access to the Court, whether through legal aid or their own resources, proceedings are case managed by the judge and the Rules provide for a clear procedure. Hearings by telephone are popular and increase efficiency and accessibility. The Official Solicitor's involvement as litigation friend for P can be helpful in bringing parties to a solution, although he is only involved where there are sufficient assets to meet his costs from P or from legal aid.

The underfunding of the Court leads to long delays, even in urgent cases - our members are aware of delays of up to six months between an application being issued and a first hearing. Often these are matters in which the parties do not have the luxury of time.

There are also concerns about the accessibility and the efficiency of administration by an under-staffed Court. Even those with a day-to-day presence at the Court find it difficult to get applications dealt with (including urgent ones).

OPG response times for registration have reduced significantly over the past year from around 10 -12 weeks to around four weeks, which is encouraging. However, as with the Court of Protection, there are concerns with under-funding. Some staff appear to lack experience or sufficient training, sometimes leading to arbitrary responses, suggesting a lack of understanding of and empathy for the client.

18. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

The use of health and welfare LPAs has risen and is likely to increase further.

The OPG takes many cases to the Court of Protection (for examples, see the article by Denzil Lush, Senior Judge of the Court of Protection [2013] Eld LJ 144) for severance of invalid clauses in LPAs. The fact that similar invalid clauses appear persistently in LPAs indicates that there are clauses that individuals wish to include which the restrictions in the Act make impossible.

19. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

The cost of registering an LPA is £130. For some, the cost of registration is off-putting. In the case of health and welfare LPAs where the level of assets is not an issue, an application can be made for a fee reduction but we understand that it is difficult to obtain this.
There are serious concerns about the LPA Registration System with a particular focus on fee remissions and delays. We will write separately to the Clerk about examples where the delays are so long in trying to get the payment issue sorted out that clients are dying during the process.

For those with modest assets it is simply unthinkable to seek the assistance of the Court of Protection to resolve a problem.

If more cases are to be processed without cutting corners cut or infringing rights, the court process needs to become a more localised service which is quicker and cheaper. Regular use of the Court of Protection as it is currently set up is beyond the means of most local authorities who cannot meet litigation funding costs routinely. The fees for independent social work and consultant psychiatric reports, updates and visits are beyond their means.

The ability for P to participate in COP proceedings is seriously impaired. The Rules provide that P should be joined as a party only if the court so directs. This means that in many cases significant decisions are made by the court with no involvement of the person at the centre of the case. We are aware of cases involving significant welfare issues that have been in progress for many months before P is joined. Part of the difficulty is the failure to resource arrangements for P's litigation friend.

20. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

On the face of it legal aid for proceedings in the Court of Protection has emerged relatively intact from the LASPO Act 2013 However, there are significant anomalies and barriers to justice.

The current scope of legal aid for advice and representation before the COP is limited to the types of cases listed in Schedule 1 of Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPOA). This reflects the previous position under the Lord Chancellor’s Authorisation which had the effect of bringing cases within the scope of legal aid but subject to certain restrictions on case type, and the need for P to be represented at an oral hearing. There have been longstanding concerns that the scope of legal aid for MCA matters excludes the following:

- cases where P is suffering psychological or emotional harm (as opposed to physical harm)
- cases which engage P’s Article 8 rights regarding right to respect for P’s home (contact issues and right to family life are within scope).

Although most cases engage other issues such as deprivation of liberty or risk of physical abuse, there may well be cases which fall outside the scope of legal aid. Such cases will be rare but it is important that they are included.

Prior to 1 April 2013 clients claiming the means tested welfare benefits for income assessment purposes did not have to undergo a means test on their capital. Since 1 April, even if clients receive one of the basic welfare benefits they are nonetheless means tested on their capital.

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Anyone who is in receipt of the basic income benefits but who has more than £8000 in capital is no longer eligible for legal aid. If a person has between £3000 and £8000 they must pay the excess over £3000 to the Legal Aid Agency (LAA). It is incomprehensible why the government considers that for basic income benefits a person can retain up to £16,000 capital but for access to legal services the threshold is £8000. Many people who may lack capacity have accrued incapacity benefit above that threshold, particularly if they have been living in hospitals or NHS funded placements. The result is that either they are ineligible for legal aid or have to pay out of these accrued benefits for essential legal advice.

The LAA requires an applicant to produce detailed evidence of their capital including bank statements for the last three months (with additional requirements such as copies of the statements having to be certified by a solicitor as being true copies of the originals). This is a deterrent to access to justice for clients who often do not have organised paperwork and whose families are barely managing to provide extensive amounts of care. There are increasing numbers of reports of the LAA requiring family members to provide evidence of their own means and being asked to complete full means forms, even though the legal issue concerns P, not them. This can cause lengthy delay which can be extremely damaging to a vulnerable person where urgent steps may be needed to protect their interests.

There is no consistency about the availability of non-means tested legal aid for cases concerning deprivation of liberty. Although proceedings about a deprivation of liberty under DoLs will attract non-means tested legal aid for P or the RPR while the authorisation is in force, many cases concern ‘court authorised deprivation of liberty’ which is means tested. So, for one group of detained persons legal aid is free; for another, because the court authorised the detention, it is not free and P may be prevented from accessing legal advice because their means exceed the restrictive capital and income limits.

A person deprived of their liberty in supported living where DoLs cannot be used may well have to pay for their representation. This is an unjustifiable barrier to P’s rights under Article 5(4).

There are anomalies between the availability for legal aid for child care proceedings and for proceedings before the COP. A parent with a 16 year old with a learning disability who is taken into care will get non-means tested legal aid. If the same child turns 18 and lacks capacity to decide where to live and a local authority seeks an order to protect them, the same parent will their means assessed and may not get legal aid. This distinction is unjustified.

A further comparison with family proceedings, though less directly connected to legal aid, is that a child who is made a party to a family case will have a guardian, who is effectively a free independent social work expert. P may have to pay for expert evidence about his capacity or about the issues before the Court.

The removal from scope of any form of advice about the preparation of advance decisions and LPAs is a false economy which will make miniscule savings but lead to avoidable challenges to poorly drafted ‘DIY’ LPAs.

For obvious practical reasons, any extension of the mandatory legal aid ‘telephone gateway’ beyond than the existing three pilot areas (special education needs, debt/mortgage

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repossession and discrimination) could have a detrimental impact on access to justice for those who lack mental capacity and their families.

9. ‘Transforming Legal Aid’ includes the proposal that clients must satisfy a 12 month continuous ‘lawful residence’ threshold to qualify for legal aid, which means that even if they are at immediate risk of harm or death, those who cannot satisfy the test will be ineligible. Clients will have to provide written evidence of the continuous lawful residence (a minefield for even the most exceptional lawyers and judges). For clients and their families who are under stress, often with heavy caring responsibilities, or with chaotic lifestyles, finding this paperwork at the time of seeking legal advice is likely to be nigh impossible.

10. As a final point, the cumulative effect of the recent cuts, the reductions in fee rates over the years and the increasing administrative hurdles faced by practitioners, is that the number of providers offering a legal aid service in what is, on any view, a complex area is dwindling.

21. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

The CQC should have enhanced powers to regulate the use of the MCA generally and particularly the application of the DoLs regime.

22. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Regulatory clarity is essential as overlapping regimes cause confusion. Whoever regulates this important area must have the power and appetite to effect change, and will need to be resourced accordingly. The CQC would be the most obvious regulator to assume responsibility for the regulation of the MCA in various settings It would certainly require more extensive powers to investigate and police the care of those who lack capacity.

23. How well is the relationship with the mental health system and legislation understood in practice?

The interface between the mental health legislation and DoLs is complex, and causes practical problems for DoLs assessors, care homes and hospitals. The MCA Code of Practice needs updating to reflect case law and to furnish examples to help professionals to choose the most appropriate approach for P.

24. Does the implementation of the Mental Capacity Act 2005 differ significantly in Wales?

We do not see any material differences in the implementation of the Act in Wales. A local Tribunal Wales would probably serve to elevate and enhance care and protection in this jurisdiction.

25. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

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We are unable to comment on this question.

26. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CPRD for the successful implementation of the MCA?

For the reasons given in our answer to question 20, it is arguable that the MCA is not compliant with the UNCRPD, although the framework for compliance is there. Providing support to P of the nature envisaged within the Convention will require a careful appraisal of current practices and funding for IMCA/IMHA services, local authority social welfare teams, the Official Solicitor and importantly, 3rd sector organisations. An expanded role for advocates allowing for more structured support processes for adults to make their own decisions would be the starting point. Professionals would need to change their practices to recognise the implications of the Convention for their decisions; the courts also have a part to play.

6 September 2013
The Law Society of Scotland – Written evidence

Introduction

The Law Society of Scotland aims to lead and support a successful and respected Scottish legal profession. Not only do we act in the interests of our solicitor members but we also have a clear responsibility to work in the public interest. That is why we actively engage and seek to assist in the legislative and public policy decision making processes.

The Mental Health and Disability Committee of the Law Society of Scotland ("MHDC") welcomes the opportunity to contribute from a Scottish perspective to the review of the Mental Health and Disability Committee of the Law Society of Scotland ("MHDC") welcomes the opportunity to contribute from a Scottish perspective to the review of the Mental Capacity Act 2005 ("the 2005 Act"). At an early stage of the original consideration of the (then) proposed legislation on mental capacity for England and Wales, evidence was given to a joint committee of both Houses by Adrian D Ward, who was then and still is convener of MHDC. This response has been drafted by him at short notice following a meeting of MHDC on 28th August 2013. It therefore offers brief comments on salient points. MHDC would be happy to expand on these, or answer relevant questions, if desired. On the foregoing basis, our comments are as follows:

Comments

1. On the previous occasion referred to, we submitted that one of the successes of the equivalent Scottish legislation, the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act"), was the statement of principles applicable to any intervention contained in section 1 of the 2000 Act. That remains the position. So far as we are aware there continues to be complete support for the Scottish option to base every intervention under the 2000 Act upon application of the section 1 principles rather than upon a best interests test. There continues to be full support for the reasons expressed by the Scottish Law Commission for this approach, which were as follows:

“Our general principles do not rely on the concept of best interests of the incapable adult … We consider that ‘best interests’ by itself is too vague and would require to be supplemented by further factors which have to be taken into account. We also consider that ‘best interests’ does not give due weight to the views of the adult, particularly to wishes and feelings which he or she had expressed while capable of doing so. The concept of best interests was developed in the context of child law where a child’s level of understanding may not be high and will usually have been lower in the past. Incapable adults such as those who are mentally ill, head-injured, or suffering from dementia at the time when a decision has to be made in connection with them, will have possessed full mental powers before their present incapacity. We think it is wrong to equate such adults with children, and for that reason would avoid extending child law concepts to them. Accordingly, the general principles we set out below are framed without express reference to best interests.”

2. Another feature of the 2000 Act which has proved to be valuable is section 3(3) under which the sheriff may be asked to give directions to any person exercising functions under the 2000 Act as to the exercise of those functions and the taking of decisions or action in relation to the adult. This provision has been used, for example, by attorneys seeking directions as to how they should act in circumstances of doubt and difficulty, and by the Public Guardian seeking directions as to whether she should or should not register Powers of Attorney or revocations of existing Powers of Attorney in circumstances where
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3. A major concern from a Scottish perspective is that the Hague Convention on the International Protection of Adults of 13th January 2000 has been ratified by the United Kingdom government in respect of Scotland but has still not yet been ratified in respect of England and Wales. Coupled with this, it is gravely unsatisfactory that there continues to be doubt about the position in cross-border issues. It is completely unacceptable, for example, that there should be any doubt whether Scottish continuing and welfare Powers of Attorney are fully effective in England and Wales. The converse issue of the effectiveness in Scotland of an English Enduring Power of Attorney (“EPA”) was recently decided in an unreported case in Airdrie Sheriff Court (C Applicant, 2nd April 2013). The donor of an EPA had come to reside in the area of a Scottish local authority which disputed the attorney’s authority to make decisions about self-directed support on behalf of the donor. The attorney sought a direction under the 2000 Act. The local authority opposed. The Public Guardian entered the process. The sheriff held that the EPA had automatic recognition in Scotland under the 2000 Act; that in terms of Schedule 3 para 4(3) of that Act the manner of exercise of the EPA should be governed by that Act; and that when exercised in Scotland the EPA had like effect as a Scottish continuing Power of Attorney. The sheriff directed the attorney that she might rely on the general powers in the EPA including, without prejudice to that generality, power to claim and administer a direct payment.

4. We are aware that there has been judicial criticism in England of section 44 of the 2005 Act, which creates an offence of wilful neglect of a person without capacity. We understand that the criticism focuses upon the difficulty of interpreting and applying the requirement to demonstrate lack of capacity. The equivalent Scottish offence is contained in section 83 of the 2000 Act, which does not require any element of incapacity. Section 83(1) provides that: “It shall be an offence for any person exercising powers under this Act relating to the personal welfare of an adult to ill-treat or wilfully neglect that adult”. We are aware of no suggestion that the wording of this section is inappropriate or that there ought to be a requirement to establish an additional element of incapacity.

5. The Scottish Law Commission recommended that jurisdiction in adult incapacity matters should lie with the Sheriff Court but that cases should be allocated to designated sheriffs. A provision to that effect was included in the draft Bill annexed to the Scottish Law Commission’s Report on Incapable Adults (Report No 151, September 1995). No such provision is contained in the 2000 Act. There have been increasing and widely expressed concerns at the resulting lack of consistency both procedurally and in terms of outcomes, and great variations in the efficiency and effectiveness of exercise of the jurisdiction. In our view a significant strength and advantage of the English mental capacity jurisdiction is that it is vested in the Court of Protection. We would recommend that the specialist expertise of the Court of Protection be retained, with only judges with sufficient expertise and able to undertake substantial caseloads within the jurisdiction being designated to exercise it.

6. Following extensive consultation, the Scottish Law Commission is currently considering what amendments should be made to the 2000 Act to meet the requirements of the developing jurisprudence of the European Court on Human Rights in respect of deprivation of liberty in relation to people with impairments of capacity. The Commission has been concerned to try to avoid what are perceived as significant problems and
disadvantages under the 2005 Act. The Commission’s report on this topic, when issued, is likely to be of interest to the Select Committee.

7. A recently developing issue is the relationship between incapacity and mental health legislation in Scotland. There is a lack of clarity, for example, regarding the status of decisions made by welfare attorneys and guardians with welfare powers in relation to various provision of the Mental Health (Care and Treatment) (Scotland) Act 2003, and the general status of attorneys and guardians under that Act. We understand that there are some similar concerns in England and Wales. The Select Committee may find any Scottish developments in this context to be of interest. Some such points may be addressed in the Mental Health Bill forming part of the Scottish Government’s programme of legislation for 2013-14 announced on 3rd September 2013.

8. Following the passing of the 2000 Act an Implementation Steering Group was established which oversaw many aspects of the implementation of the Act, including training and publicity, the formulation of codes of practice and guidance, and so forth. Following review of the 2000 Act, various amendments were introduced by the Adult Support and Protection (Scotland) Act 2007. In retrospect, the Implementation Steering Group ought to have been re-constituted to oversee in a similar way the implementation of the reforms, and indeed to renew and reinforce the publicity, awareness and education which had taken place following original passage of the Act. If in due course significant amendments to the 2005 Act are to be proposed, we would suggest that consideration be given to the need for such oversight of publicity, training and other aspects of implementation. Generally, our view and experience is that there can never be too much publicity, public information and professional training in relation to any incapacity (mental capacity) jurisdiction.


10. In contentious cases, the Scottish adult incapacity jurisdiction would benefit from the availability of mediation services. So far as we are aware such mediation has not been used and is not available.


11. It is currently unsatisfactory that in Scotland non means-tested Legal Aid is available for any guardianship application where welfare powers are sought, but there is significant difficulty in obtaining any form of Legal Aid, and reasonable remuneration under any form of Legal Aid, for preparing Powers of Attorney. Certainly in Scotland, there are major potential advantages in encouraging people to grant Powers of Attorney, thus reducing the need for guardianship and – of course – reducing the very substantial costs to the Legal Aid Fund of supporting guardianship applications, in relation to the cost of facilitating granting of more Powers of Attorney which would reduce the number of guardianship cases.

12. Issues have arisen in Scotland, and may well have arisen in England, from the lack of clarity of language – or at least lack of understanding of that language – in documents such as The UN Convention on the Rights of Persons with Disabilities of December 13, 2006. “Capacity” and its converse, “incapacity”, have two distinct meanings: an ambiguity which has caused increasing confusion in recent years. Both meanings are encompassed in the classic definition of “capacity” in the Oxford Companion to Law (OUP 1980), which commences: “One of the attributes of a person or entity having legal personality, denoting legal ability to bear and exercise rights or to be affected by legal duties or liabilities”. In this definition “bear” and “exercise” reflect the two meanings which can be attached to “capacity”. Scots law, in common with many other developed systems, has for several decades taken it for granted that all adults, including those with intellectual disabilities, have the same rights and status. “Capacity” is thus used in the same sense as “mental capacity” in English law, namely the ability to exercise and assert rights and status. Consistently with this approach, “incapacitation” has no place in Scots law, either as a term or as a concept. “Incapacitation” refers to a procedure by which “capacity”, in the first sense of rights and status, is limited by legal procedure. The UN Convention uses “capacity” in the first sense, meaning an individual’s rights and status, thus declaring in Article 12.2 that “States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”. Lack of clarity and understanding as to this limited usage has had some unfortunate consequences. The concept of supported decision-making, in fact already well established, has been seized upon as if it were a new revelation, sometimes at the expense of the equally vital counterpart of recognising limitations of capacity (in the second sense) and providing for them. Rather more unfortunately, The Legal capacity of persons with intellectual disabilities and persons with mental health problems, European Union Agency for Fundamental Rights, published only in 2013,150 seeks to review adult incapacity regimes by measuring the extent of incapacitation, a concept eliminated from Scots law and other developed systems some decades ago.

13. Additional Comments:

The rules which Local Authorities follow are contained in guidance issued by the Scottish Government. Basically if an adult has capacity and wishes to move from one local authority area to another in Scotland and does so of their own volition then the Local Authority accepts that they have moved their ordinary residence and the new Local Authority is


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responsible for whatever care they are assessed as needing. The same would apply if they have a guardian or attorney who can make those decisions for the adult. However if an adult lacks capacity and has no one who can make decisions for them and is moved to another local authority area, then their ordinary residence does not and cannot change as there is no voluntary adoption of the change in residence. This means the original local authority would continue to pay for and be responsible for assessment of their care in the new area. The same does not however seem to apply in cases where an incapable adult moves from an English local authority area into Scotland.

The English local authorities appear to follow a different rule that even if the adult is not capable of making a decision to move voluntarily due to mental incapacity they will move the adult, if that is deemed the most suitable position for the adult, and then argue after a short period of time that the adult is settled in the Scottish local authority area and that if the move is intended to be permanent (e.g. to be nearer family) then the adult has moved their ordinary residence and the Scottish local authority will be responsible for payment of care costs and ongoing assessment and care management.

This position has been challenged by Scottish local authorities by referring the matter to the responsible Secretary of State for England and Wales to determine the dispute and the Secretary of State has upheld the English local authorities’ position. Indeed in one case it was clearly stated that even if the person lacked capacity to make an informed decision about their residence, then based on the fact she was physically present in Scotland with the intention of the various parties (who at a case conference all agreed this would be the best move for her albeit she could not form that intention) of this being her settled residence for the foreseeable future then she had moved her ordinary residence. This would seem to go against the leading case on ordinary residence of Shah where Lord Scarman opined

“ordinary residence refers to a man’s abode in a particular place or country which he has adopted voluntarily and for settled purpose as part of the regular order of his life for the time being whether for short or long duration”.

The English determination despite quoting that reference goes on to rely on the case of Vale which actually involves the residence of a 28 year old adult who was incapable and the judgement refers to following the decision of the parent as to the adult’s residence as the adult did not have capacity to make that decision. This does appear to suggest that if there is someone who can take a legal decision for the incapable adult that, and not the mere factual presence of the adult in a particular area, would be effective.

The above disparity in views between the two jurisdictions gives rise to anomalous situations where adults who lack capacity in Scotland remain ordinarily resident in their original area even if they move for care or other reasons to another area (including England) whereas adults who lack capacity in England and move to a Scottish local authority appear to move ordinary residence based on where they actually reside and the intention (of someone else) for them to remain there. We would suggest that it is essential that there be consistency in, in both law and interpretation in these matters.

We should also mention that there is an exception to the rule that ordinary residence changes if the adult chooses to move area and that is where they move into a residential care home as this is exempt from a change in ordinary residence due to the deeming provisions of the National Assistance Act 1948 which disregards time spent in residential care. In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
accommodation – arranged by a local authority. The cases where most problems are encountered are therefore cases where the adult is supported to live in the community and moves cross-border.

9 September 2013
Alix Lewer – Written evidence

Background:

1. The following is a common scenario in the field of adults with learning disabilities:

A person with a learning disability is admitted to hospital with a chest infection / pneumonia. A swallowing disorder is noted / assumed / diagnosed.

2. Doctors have to make a decision whether oral intake is the best way for the person to receive nutrition and hydration. The primary alternative is PEG (percutaneous endoscopic gastrostomy) feeding, where nutrition / hydration is provided directly into the stomach via a tube. A surgical procedure is required to insert the tube, and training and ongoing support is required from Home Enteral Feeding teams and District Nursing.

3. This is a complex decision and one which affects all aspects of the person’s life, as removing / minimising oral intake of food may remove a significant pleasure for the person. It is a prime example of a medical procedure where the Mental Capacity Act is needed to ensure the person’s quality of life as well as health is considered. In the first instance a Capacity Assessment should be carried out to ascertain whether the person is able to make the decision for him / herself. If the person is not deemed to have the capacity to make that decision, there should then be a best interest process, to ensure that the people who know the person best can contribute their expertise to the decision which will determine

4. As a speech and language therapist for adults with learning disabilities, I have encountered this situation with 10 or more service-users over the last 7 years.

5. The outcome of these situations and the observation of the Mental Capacity Act have varied in each case, but in the majority of cases, the Mental Capacity Act has not been followed, without considerable pressure from Community Learning Disability Teams, often with the support of hospital safeguarding Vulnerable Adults Teams.

Case Study 1:

6. B, a lady with a mild learning disability and severe anxiety disorder developed dysphagia (swallowing difficulties) as a side-effect of long-term psychotropic medication. This caused multiple chest infections and put her at high risk of aspiration pneumonia (pneumonia caused by food / fluid entering the lungs). She was referred to the Learning Disability Team Speech and Language Therapist (SLT) who diagnosed dysphagia and recommended thickened fluids to reduce (though not eliminate) the risk of aspiration.

7. B took the thickened fluids and modified diet without complaint, but residential support staff were concerned that restricting the intake of thin fluids constituted a risk to her quality of life. A Mental Capacity Assessment was carried out by the speech and language therapist and an advocate (not an IMCA, as they are not available for this level of procedure) and B was found to have the capacity to make decisions about the way she took food and fluids. She was able to say that she was happy to drink thickened drinks, because it reduced the chance of her going into hospital. She also stated that she did not want to take food / fluid

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via a tube into her stomach (PEG). This decision was recorded in her file, and a copy sent to the GP.

8. B continued to eat and drink this way for over a year supported by her staff team, SLT and Community Nursing. She then succumbed to aspiration pneumonia and was admitted to hospital; the community learning disability team were not aware of her admission. Doctors made the decision to insert a PEG (percutaneous endoscopic gastrostomy) to reduce the risk of aspiration. The residential staff team were informed that the procedure would take place, but did not feel able to question the doctor’s decision, although they were aware that B had been clear that she did not want to eat and drink via a PEG in the past. They were not clear on how the Mental Capacity Act should be implemented in hospitals, and assumed the doctor’s decision was the only decision needed.

9. When the learning disability SLT became aware of the situation, she visited B, who was not aware that she had a tube into her stomach and repeatedly asked for a drink. The SLT queried whether a Mental Capacity Assessment had taken place and could find no record in the notes. An addition to the notes was later made which recorded ‘B does not have capacity to consent to this procedure’ but there was no description of the process by which this had been determined, or any best interest process.

10. B died two days later in hospital. The case was recorded as a ‘serious incident’ and a Serious Case Review requested, but this did not take place.

Case Study 2:

11. D, a gentleman with Downs Syndrome and late-stage dementia was admitted to hospital with aspiration pneumonia. The hospital contacted one of his sisters and recorded that she gave her consent for a PEG to be inserted. When the Learning Disability SLT asked whether a Capacity Assessment / Best Interest Process had been carried out, she was informed that the matter had been discussed with the family member, who had given consent. D underwent the PEG insertion, and pulled the tube out within two days, a concern which had been voiced by the staff at his home, who cared for him on a daily basis and knew him well. The PEG was re-inserted without discussion with the family, Care Staff or wider MDT including the Learning Disabilities Team.

12. D pulled out the PEG for a second time. Under request from the Learning Disabilities Team, the consultant held a Best Interest Meeting at which the Learning Disabilities SLT, Home Manager and 4 of D’s 7 brothers and sisters attended. It was decided that a PEG would not be re-inserted; this decision was guided by the feelings of D’s family, the Home Manager and information from the SLT citing the NICE guidelines which state that a PEG rarely prolongs life in end-stage dementia and is generally contra-indicated.

13. D was discharged back to the residential care home and died two weeks later.

Case Study 3

14. A was admitted to hospital in respiratory distress. He had a longstanding dysphagia as a result of cerebral palsy, but this had recently deteriorated. The Learning Disability Team, who had been supporting him for many years, discovered he was scheduled for a PEG
procedure the following day. Their opinion was that this would be beneficial for A, who had not obviously demonstrated enjoyment of food and drink for some time.

15. However, the LD team queried whether a Mental Capacity Assessment and Best Interest Process had been observed or the Residential Care Staff had been involved in the decision, as the home A lived in had no experience of administering PEG feeds and had demonstrated difficulties following medical advice for their residents in the past. The concern was that, without proper planning, the discharge or placement could fail, and A would be readmitted to hospital or required to move to another service. The hospital explained they had gained consent from A’s brother, who had last seen him 6 years ago.

16. The LD team contacted the Hospital Safeguarding Vulnerable Adults Team with concerns about the lack of best interest procedure, and discharge planning, and a Best Interest Meeting was held, in which the procedure was explained to the care staff, and a plan for ongoing support for A at home drawn up. Ten days later, he is still in hospital waiting for the PEG procedure.

**Case Study 4**

17. C is a gentleman with Downs Syndrome and Dementia. He was admitted to hospital with pneumonia, caused by his swallowing difficulties. The palliative care team were involved and C’s Home Manager worked hard to ensure staff consulted with C’s Care team in all aspects of his care.

18. The Palliative Care Consultant judged that C did not have capacity to make a decision about his treatment and called a Best Interest meeting attended by his Home Manager, Social Worker, Learning Disabilities and Acute Speech and Language Therapists. The decision was made that a PEG would not be appropriate in this case, taking into account the views of the Care staff and a close friend, who felt that it would cause unnecessary distress. They also felt strongly that C would prefer to spend his final days at home, so when he was medically stable, he was discharged with ongoing support from the learning disability and palliative care teams. The Consultant also recorded decisions about future intervention, so the staff felt supported to deal with C’s health issues at home, without further hospitalisations.

19. C is still living in his residential care setting and all staff are aware of the best ways to minimise risks to his health. The GP provided regular support, and 8 months later, another hospital admission has so far been avoided.

**Summary**

20. There are many more examples of my experience of the Mental Capacity Act in different contexts, working as a Speech and Language Therapist in a Community Learning Disability Team. However, these Case Studies illustrate some of the barriers I, and other colleagues have routinely encountered. A significant amount of time and resources are spent in trying to ensure that vulnerable people’s needs are considered holistically, decisions made in their best interest, and the legal frameworks observed. Case Study 4 illustrates an improved outcome brought about by implementation of the Mental Capacity Act, and demonstrates how the Act can be used effectively when all team members are informed and work cooperatively.

The Case Studies provide evidence in support of my responses to the following questions:

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

21. These cases illustrate that frequently, acute health teams do not demonstrate a clear understanding of the Act. The response to requests for thorough Capacity Assessments and Best Interest Procedures is frequently met with hostility. The roles of Doctors are extremely demanding, and the Act appears to be seen as an additional stressor, and an add-on as opposed to a routine part of practice. It is rare that capacity assessments are detailed, or involve total communication strategies and resources required to genuinely assess a person’s capacity. Many people with learning disabilities do have capacity if the information is provided in a visual, experiential or multi-media format, but these strategies are not routinely used. There seems to be little flexibility in the implementation of a best interest process. Large MDT meetings are difficult to arrange due to time pressures and may not always be needed. Improved communication between Acute and Community LD teams, families and care staff could fulfil the legal requirement, ensure the person’s needs are at the centre of decisions and reduce time, effort and the risk of distress or failed discharges.

22. Community Learning Disability Teams receive continuous reinforcement of the Act and, in my experience, work hard to implement it as automatic practice (e.g. consent and capacity regularly recorded within notes, and best interest processes undertaken regularly (And relatively informally). Speech and language therapists in particular regularly play a supporting role in capacity assessments for other professions (e.g. social services). It would be useful to have more opportunities for sharing understanding of the implementation and barriers of the Act across the different services, to identify time and cost saving procedures which could be implemented, and ensuring that the Act is followed proactively, rather than reactively.

23. Support Staff’s knowledge of the Act varies widely and depends a great deal on the quality of the service they work for and its dedication to training. Very few support staff I have worked with have had a clear understanding of the Mental Capacity Act in medical contexts. Many have had minimal training and little support in how to implement the Act meaningfully. They frequently report that they feel they are viewed as ‘only a carer’ by the acute medical teams and do not feel they have an automatic right to speak on behalf of the person they know well, if they do not have the capacity to make their own decisions.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

24. In my experience, very few people with learning disabilities have knowledge of the Mental Capacity Act. As a concept it is abstract and would require careful presentation and consistent reinforcement to be meaningful to many people. The same is true for families; some do not understand why other professionals (e.g. carers / learning disability teams) should be involved in decisions about their relatives, and this view is often fostered by lack of implementation of the act in medical settings. Other families appreciate wider support in making complex decisions - but rarely have I encountered a family member who was familiar.

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with the Act. I feel that wider dissemination of information about the Acts and people’s rights in a meaningful form (e.g. through multi-media packs and genuinely accessible information) is a piece of work which is urgently needed.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

25. As illustrated by the case studies above, when followed, the Act has clearly fostered involvement of carers and families in decision-making, but there is still a tendency for medical teams to feel that recording ‘no capacity’ in the notes and contacting one member of the family before proceeding is sufficient to observe the Act. I have witnessed this causing strife amongst families with differing opinions, alienation of professional carers and resulting in outcomes which could not be deemed to be in the best interest of the person who lacks consent.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

26. It is hard to comment on this as the very limited IMCA services mean that few of my service-users have ever qualified for IMCA services - either because the medical procedure was not deemed sufficiently significant to require an IMCA, or because there was a family member involved - although the relative had limited contact with the person with a learning disability and would have welcomed support around decision making.

27. I have only worked with an IMCA once in 7 years, despite attending multiple Best Interest meetings and carrying out Mental Capacity Assessments. On this occasion, they had very limited understanding of the receptive language limitations of the person with a learning disability and what strategies (e.g. signing / visual supports) could be used to support their understanding to facilitate making a decision.

28. Advocacy services have been cut significantly in the last few years, and there is currently no advocacy service for people with learning disabilities that I know of in my geographical area. Wider and more consistent access to IMCAs (perhaps even when family are involved) would be very helpful, although I also believe the role of the IMCA / Advocate can only be successful if they are an established part of the wider support network for people with learning disabilities and have access to improved levels of training to ensure they are capable of maximising the decision-making potential of their clients.

Summary

29. In my experience, the Mental Capacity Act is a valuable and important piece of legislation for people with learning disabilities, or other cognitive impairments, and it has prevented some negative outcomes for vulnerable people. However, until everyone involved, including acute medical teams, families and care staff genuinely understand the purpose and implementation of the act, it will continue to take a huge amount of time and resources to ensure that it is followed.

30. I feel that much more meaningful multi-disciplinary engagement across different teams would help us all to learn from each others. Service-users and families as well as care teams
Alix Lewer – Written evidence

who have experience of implementing the Act regularly can support each other in finding a way to ensure the legislation is followed meaningfully to protect the service-user but does not obstruct people in their work or negate a common sense approach

31. Thank you for providing the opportunity to feed back on some of my professional experiences of the Act. There is so much more to say and I hope that people affected by the Mental Capacity Act, as well as Health and Social Care Professionals who are involved in regular implementation of the Act will be involved in any revisions of this valuable piece of legislation.

Evidence submitted on an individual basis:

30 August 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Liberty – Written evidence

Dear Chairman,

During the Committee's oral evidence session on 25 June 2013, the Committee inquired about Liberty's prior correspondence with the Ministry of Justice and the Department of Health. I can now confirm that Liberty did not make representations to these or any other departments before sending our letter of 15 October 2012, addressed to the chair of the Joint Committee on Human Rights, requesting an inquiry into the treatment of individuals under the Mental Capacity Act 2005.

We were, and continue to be, of the view that the legislative framework in this area is in need of revision and, in some areas, a significant overhaul. We were also of the view that the practical implementation of the legislation to date needed independent scrutiny. Therefore, we believe that a parliamentary scrutiny inquiry is the more appropriate means for examining the issues we raised in our letter.

I hope this satisfies the Committee's question. Please do not hesitate to contact us if we can be of any further assistance to the Committee on this matter, or in relation to any other aspect of our oral evidence. We will be submitting written evidence to the Committee by the September deadline.

Yours sincerely,

Katie Johnston
Policy Officer

23 July 2013
Introduction

1. In October 2012, Liberty wrote to the Joint Committee on Human Rights, asking that an inquiry be established into the position and treatment of individuals under the Mental Capacity Act 2005 (MCA). State arrangements to govern the lives of individuals who lack capacity to make decisions about their care and treatment raise significant human rights issues. The operation of the 2005 Act, as substantially amended by the Mental Health Act 2007, has seen regular engagement as well as breach of articles 3, 5, 6 and 8 of the European Convention on Human Rights (ECHR). During parliamentary scrutiny of the relevant legislation several of the JCHR’s reports called for robust procedures to safeguard the rights of incapacitated individuals. We believe that in many instances the procedural safeguards remain inadequate to satisfy the requirements of the Convention as incorporated by the Human Rights Act 1998 (HRA).

2. We are therefore pleased to have this opportunity, alongside individuals and groups who work in this area, to submit evidence on the operation of the MCA. We hope that, even if the Select Committee will cease to exist once it has published its report, steps will be taken to ensure that some other appropriate body, such as the Joint Committee on Human Rights, will be able to monitor the response to and implementation of the recommendations made by the Committee.

3. The callous treatment of residents at the care home Winterbourne View has brought the vulnerability of those in care into sharp focus. Sadly, this incident does not appear to be isolated. Liberty welcomes the broad scope of this inquiry to review the operation of the framework and address the serious human rights issues which have arisen, in particular, around the use of Deprivation of Liberty Safeguards (DoLS).

4. Liberty believes that the core problems in treatment of incapacitated individuals stem from the legislative framework itself, as well as its implementation. At the very root of the problem is the assumption that safeguards embedded in the Act are adequate.

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In practice they are not. The MCA permits a range of major life decisions to be made by medical and social care professionals for an incapacitated individual where deemed in their best interests, from where they should live to major medical decisions and whether to use restraint in their care – without effective external oversight. While recourse may be had to the Court of Protection, in practice families will face a myriad of insurmountable obstacles from significant delays to lack of knowledge of when it might be appropriate to apply to the Court and lack of legal aid to do so.

5. The law on mental capacity has the potential to touch all people at some point in their life; it affects the rights of a huge range of individuals with a wide variety of different conditions, from persons born with learning disabilities; people who develop dementia as they grow older; to persons temporarily or unexpectedly incapacitated by illness or injury. It is therefore essential that the law is constructed to function properly in these different contexts, and that it does function well in practice.

The framework of the Mental Capacity Act 2005

6. The MCA contains a number of progressive elements that are a welcome addition to the UK’s legal framework. The principles in section 1 include a presumption in favour of capacity unless proved to the contrary; a requirement to take practicable steps to help a person to make a decision before they can be found to lack capacity; an expression of the principle of “best interests”; and a commitment to the use of minimum restraint. The MCA also effects a sea-change in the philosophy underlying the UK mental health framework through its move away from paternalism, and the recognition that “a person is not to be treated as unable to make a decision merely because he makes an unwise decision.”

7. The Act therefore goes some way towards the implementation in UK law of the UN Convention on the Rights of Persons with Disabilities (CRPD), to which the UK is a party. In particular, procedures concerning capacity decisions will engage Articles 12 and 13 of that convention, which address equal recognition before the law and access to justice respectively. However, even on a cautious reading of the Convention, it is unlikely that the provisions of the MCA are sufficient to discharge the UK’s obligations under international law. This is discussed further below.

Lack of safeguards on the general defence/authorisation

8. Section 5 MCA contains a broad authorisation for a person (D) to act in the care or treatment of a person (P), where that person lacks capacity and D reasonably believes that it is in P’s best interests for the act to be done. Section 6 contains a similar authorisation for the use by D of restraint, where the restraint is necessary and proportionate to prevent harm. If the act meets the criteria in the statute, D is protected from liability for an act that would otherwise be unlawful without a

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151 Mental Capacity Act 2005, s1(4).

person’s capable consent. This ‘general defence’ is the most common source of authority for decisions, particularly medical and welfare decisions.

9. This power has been used to provide authorisation for major decisions on a very wide range of matters which can seriously affect the human rights of the individual concerned. For example, the general power has been used to authorise surgery; the prescription of medicines, including powerful anti-psychotic drugs; decisions about where a person should live; who they should have contact with; and, under section 6, the use of restraint.

10. Such ‘best interests’ decisions, up to and including those involving restraint, can only be challenged by an application to the Court of Protection. There is therefore a worrying lack of oversight for these frequent, everyday decisions, which may nonetheless have a huge and determining impact on the lives of individuals lacking capacity, particularly when the cumulative effect of many such minor decisions is considered.

11. There is no statutory requirement for the routine internal or external review of these day-to-day best interests decisions, even those which involve restraint. There is no automatic assessment, for example, of the frequency with which restraint is used or the type of restraint employed. The Care Quality Commission’s report monitoring use of the DoLS for 2011/12 also expressed concern that restraint was being used without consideration of an individual’s capacity to consent to such treatment, and that restraint was often not recognised as such, nor was it adequately recorded. In the absence of adequate reporting and reviewing, it is all too easy for the use of restraint to become routine, with no consideration of means that are less restrictive of the rights of individuals. For example, practitioners report the blanket use of restraint, where a policy of restraint is adopted for an entire ward or entire group of individuals.

12. This lack of safeguards is a significant problem of the Act. While the accompanying Code of Practice fleshes out the obligations of those availing of the general defences, including for example requirements to keep records, it seems that often this detail is disregarded in practice. A considerable degree of discretion is given to those who care for individuals lacking capacity, leaving them vulnerable to abuse in the worst cases and, even where treatment is not abuse, risking that their autonomy and ability to make choices about their lives will be unduly limited, in violation of their rights under the HRA and the CRPD.

13. The MCA should be amended to introduce robust statutory safeguards on the broad powers in sections 5 and 6, which allow carers to act in the best interests of people without capacity, particularly where these involve the use of restraint.

153 See CQC report, Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2011/12, at page 6.

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14. There should be a statutory duty to carry out compulsory, regular reviews of the types of decisions made in relation to each individual; stringent reporting and record-keeping requirements; and, in the case of decisions involving restraint, there should be frequent review of how and how often restraint is being used within an institution. Reporting requirements for the use of restraint should also include a duty to record the less restrictive options that were considered, and reasons why these methods were not employed. These requirements should be on the face of the statute, to emphasise the importance of compliance for ensuring that the restraint or detention is lawful. While similar provisions are currently included in the Code of Practice, anecdotal evidence suggests that these are not always followed. The Committee may also wish to consider recommending that persons working in care homes and hospitals receive particular training before being allowed to use restraint against a person without capacity, or that there should be a system of prior authorisation by a superior within the care home or hospital before restraint may be used.

15. The assessment processes laid out in the Act, such as capacity assessment and best interests assessment, are complex, but they are key steps which must be taken if lawful decisions about the care of persons lacking capacity are to be made. The capacity assessment will determine if a decision is a capable (but perhaps unwise) one which cannot be impugned, or an incapable and thus invalid one which can be legitimately substituted by the carer’s best interests assessment. The capacity assessment is thus key to the treatment of individuals under the Act and it is essential that they are carried out properly. Yet practitioners report that there is widespread misunderstanding of the importance of individual consent and the requirement for capacity assessments before even minor decisions (for example, to bathe an individual) can be made, and that carers cannot simply leap to doing what they believe is in the best interests of the individual without first establishing lack of capacity.

16. While the principles laid out in the Act are progressive, there is a lack of specificity in the statute, which means that, to a large extent, the procedures used and action taken will be determined by guidance, such as Codes of Practice. The statute does not make clear how these tests are to be applied when carers are faced with the common, but more complex, situation if capacity that fluctuates over time, or steadily deteriorates. This lack of detail in the primary legislation results in an over-reliance on policy and guidance and creates a clear risk that conventions and practices will develop which diverge from the requirements of the MCA itself, with the result that carers will end up acting unlawfully and individuals will not benefit from the protections of the Act. This lack of understanding of what the MCA requires is due in large part to the inaccessible nature of the MCA Code of Practice, which in some parts is scarcely easier to understand than the statute itself.

154 For example, sections 3 and 4 MCA outline the legal tests for capacity and best interests assessments. While the legal criteria are clear, the statute gives no indication of how this test should be carried out in practice, nor how its requirements could be met.

155 See, for example, paras 6.26-6.34 of the MCA Code of Practice, available at http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf The inadequacy of the Code of Practice has created a demand for unofficial guides to the legislation, which are frequently much more helpful than the official guidance. See, for example, S. Richards and A. F. Mughal, Working with the Mental Capacity Act 2005.

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17. As a first step, an urgent review and reissuing of the MCA Code of Practice should be carried out, to update the Code and make it more accessible and easier to apply for persons working in this area.

18. The repositioning of consent and autonomy at the heart of the legislative framework was one of the great achievements of the MCA, but it appears that these values have not yet been fully internalised by those working in the sector. More than five years after enactment of the MCA, it can no longer be claimed that this is merely a problem of implementation.

The Deprivation of Liberty Safeguards (DoLS)

19. One of Liberty’s chief concerns relates to the operation of the Deprivation of Liberty Safeguards (DoLS). It is worth going back to the principles expressed in HL v UK – better known as the Bournewood judgment, which was the trigger for the introduction of the DoLS regime.

20. Mr HL, an autistic man, was readmitted to the Bournewood Hospital in July 1997 after living in the community with paid carers, Mr and Mrs E. Mr HL lacked capacity to consent to readmission, but the decision was taken not to section him under the Mental Health Act 1983 as he had not resisted admission. The ensuing dispute between the carers and the hospital resulted in judicial review proceedings in the UK courts. The carers lost at first instance and in the House of Lords,\(^{156}\) in the latter case on the basis that the circumstances were covered by the common law doctrine of necessity. This overturned the decision of the Court of Appeal,\(^{157}\) which had found that Mr HL had been unlawfully detained. The case was then taken to the European Court of Human Rights, which unanimously found that common law necessity did not suffice as a legal basis, and that the detention was both arbitrary and not prescribed by law, and did not comply with Article 5(4). The key passage from the judgment reads:

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\text{‘the Court considers that the further element of lawfulness, the aim of avoiding arbitrariness, has not been satisfied…In this latter respect, the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitiated persons is conducted…In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions…As a result of the lack of procedural regulation and limits, the Court observes that the hospital’s health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit…While the Court does not question the good faith of those professionals or that they acted in what they considered to be the applicant’s}
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\(^{156}\) [1999] AC 458
\(^{157}\) [1998] 2 WLR 764

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21. The DoLS schedule was intended to plug this gap in the UK's human rights protections. However, it is questionable whether compliance with the requirements of the ECHR has in fact been achieved.

22. The DoLS apply to people in hospitals or care homes who have a mental disorder, who lack capacity to give informed consent to their care and treatment and where the hospital or care home managers consider it in their best interest for them to be deprived of their liberty to receive that care and treatment. In order to deprive someone of their liberty under the Act the hospital or care home manager is required to apply to the local authority for a DoLS authorisation. The supervisory authority is then required, ostensibly at least, to keep that deprivation under review. The individual – or their deputy – is technically able to apply to the Court of Protection for their deprivation to be reviewed, although the practical reality of their ability to do so is extremely limited.

23. The Bournewood decision was handed down in 2004, when the Mental Capacity Bill (now Act) was before Parliament. The Act was therefore passed in the knowledge that the new regime was not ECHR-compliant. The Mental Health Act 2007 was thus used to amend the 2005 Act to patch over this gap in human rights protection that had been identified in the MCA and introduce the present regime of Deprivation of Liberty Safeguards (DoLS), contained in Schedule A1.

Poor implementation

24. Since the DoLS came into force a number of issues have arisen. Research – most recently in the Winterbourne View Hospital Report – has shown, among other problems, unexplained low rates of applications to local authorities, complete lack of awareness from care providers about the Safeguards and an inability to identify when an authorisation is even required under the MCA.

25. The evidence suggests that, because the DoLS mechanism is not being used appropriately, huge numbers of people across the country continue to be detained unlawfully, in the sense of Article 5 ECHR, without legal authorisation or access to the safeguards required by Article 5(4). There is therefore a very real possibility that the UK is in breach of its human rights obligations on a massive scale, both its international obligations under the ECHR, and its domestic legal duties under the Human Rights Act.

26. Those who work with and in local authorities and hospitals report a widespread lack of awareness of the role of the MCA, the types and degree of restraint it covers and, in particular, a lack of understanding of the kind of situations where a DoLS order is


159 Available at http://hosted.southglos.gov.uk/wv/report.pdf

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There is a perception that a DoLS order is only required for ‘serious’ cases, where a person is deprived of their liberty in the classic sense (such as being locked up), when in fact a huge range of care options and treatment could potentially require DoLS authorisation to be lawful. For example, restrictions on visits from friends and family, or severe restriction of trips outside the accommodation may, even if the individual is not locked in the accommodation, amount to a deprivation of liberty.

This lack of awareness is said to be particularly acute in care homes, and in hospitals, where doctors and psychiatrists, used to working with the Mental Health Act, fail to consider the option of detention or restraint under the MCA. This lack of awareness is exacerbated by the fact that a DoLS authorisation can only be made if the managing authority of the care home or hospital proactively make an application to the supervisory authority. Authorities are understandably reluctant to invite scrutiny of their actions, and greater provision needs to be made to protect and support whistleblowers within the NHS. If a DoLS order is not made when a deprivation of liberty is in fact occurring, there is little pressure to apply for one. The only weak safeguard is in paragraphs 68 and 69 of the DoLS schedule, where a request can be made to the supervisory body to assess whether or not a deprivation of liberty is occurring.

Earlier this month, the Health Select Committee published its post-legislative scrutiny report on the Mental Health Act 2007. The committee included DoLS (enacted in a Schedule to that Act) in its terms of reference, and its damning conclusions echo our concerns:

"The committee found that application of the safeguards is variable and on many occasions those responsible for ensuring patients are protected by them have failed to do so. There is considerable confusion around the scope of the safeguards and how and when to apply them in practice."

Fundamentally, it seems that in areas of practice where DoLS are used (or should be used) there has been a failure to develop a genuine human rights approach, where the rights and autonomy of individuals are placed at the heart of decision-making in care homes and hospitals. Undoubtedly, rhetoric coming from the highest levels of Government that


161 MCA Schedule A1 Para 22(a)

162 There is a similar reluctance on the part of local authorities to go to the Court of Protection to seek a court order authorising detention, or action which engages an individual’s article 8 rights. This perhaps stems from a view that court and legal proceedings are a negative outcome, and something to be avoided, rather than a means of obtaining legal authorisation and protection.


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devalues and mischaracterises human rights law will do little to help this situation. The result is that huge numbers of vulnerable individuals throughout the UK are being detained without legal authorisation and, as a result, without procedural protections to review and challenge their detention. This situation is not only a violation of the UK Government’s obligations under the HRA and the ECHR, but creates a serious risk that, without robust safeguards, the kind of horrific abuse and human rights violations that occurred at Winterbourne View could easily happen again.

29. Many of these issues could be resolved by better training, including training for managers responsible for supervising and authorising the use of DoLS in care homes and hospitals. It is important that the DoLS regime is fully understood in all settings in which it applies, including hospitals and care homes. In particular, it seems that doctors and psychiatrists do not receive sufficient training on the meaning and importance of mental capacity, nor on when the MCA applies instead of the MHA. 164

30. Given that a DoLS order must be applied for proactively, Liberty believes that a new statutory duty should be imposed on supervisory authorities to plan for and carry out regular reviews and inspections of the care homes and hospitals for which they are responsible, to ascertain whether unauthorised deprivations of liberty are occurring, and to ensure that DoLS orders are being sought where necessary. This would provide a much more practical and effective safeguard than relying on third parties to request such an assessment under paragraphs 68 and 69.

**Structural problems**

31. However, the problem is not merely one of implementation or lack of training. The hastily-drafted DoLS regime has a number of weaknesses inherent in its structure, which create an environment in which such rights violations can occur. In general, the Schedule is widely criticised as being difficult to understand; Byzantine; bureaucratic; and requiring overly intricate assessments to determine if it applies. In particular, the interface between the DoLS schedule and ‘sectioning’ under the Mental Health Act 1983 is particularly difficult to understand, even for those with legal training.

32. The sections below highlight problems of the DoLS regime, and suggest discrete changes that could be made to address them. However, there is a strong case for the complete repeal of the much-criticised Schedule A1, and its replacement with a newly-drafted legal regime governing the deprivation of liberty of those lacking mental capacity. Many of the problems identified, such as the inadequacy of review procedures, are fundamental flaws in the design of the DoLS regime and could not easily be remedied by non-legislative action, nor by surgical amendments to either the MCA or the DoLS schedule. Similarly, the tensions created by the UK’s obligations under the UN Convention on the Rights of Persons with Disabilities (discussed further below) point towards a radical overhaul of the

164 Anecdotal evidence suggests that, even where such training is offered to medical staff, frequently it is not taken up.

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UK’s regime regulating the care of those with mental disabilities or illnesses, which may prove to be necessary in the not-so-distant future.

Definitions

33. There is no statutory definition of “deprivation of liberty” in the MCA; subsection 64(5) simply provides that it shall have the same meaning as under Article 5(1) ECHR, tying the definition to the interpretation of that article by the British and Strasbourg courts. The constantly-changing, and sometimes conflicting, case law on the meaning of “deprivation of liberty” means that this loose, referential definition creates significant uncertainty for those who work in this area. This is clearly illustrated by the fact that the Supreme Court has recently granted permission for two DoLS cases, each with a different analysis of whether article 5 has been breached, to be heard. Social workers are put in the difficult position of having to keep up with and read the most recent judgments handed down by the Court of Protection and appellate courts to determine how they can lawfully discharge their duties, and then apply the legal concepts in practice. At one training session for best interests assessors that we attended, the instructor showed slides with extracts from recent Court of Protection decisions. The social workers attending the course were then asked to apply the passages from the judgments directly to case studies that they might encounter in their work.

34. This uncertainty is particularly acute in relation to the distinction between “restraint” (which can be lawfully employed under the general authorisation in sections 5 and 6 MCA) and a deprivation of liberty, which to be lawful requires a DoLS order. This confusion around when restraint reaches the level of a deprivation of liberty is another factor contributing to the low level of DOLS applications in some areas, as carers may not realise that the level of restraint used requires DoLS authorisation.

35. The absence of a clear and stable definition of a deprivation of liberty obviously produces uncertainty; inconsistency in practice across local authority areas; and a risk that social workers may end up acting unlawfully because of a lack of understanding of what they are permitted to do under the MCA. This problem is compounded by the fact that the DoLS Code of Practice is badly in need of updating: since the guidance was drafted there have been at least 16 published judgments clarifying the meaning of “deprivation of liberty”, with the result that its guidance is no longer accurate. Even when it was published, the guidance was, if accurate, at best extremely vague:

165 P & Q v Surrey County Council [2011] EWCA Civ 190; Cheshire West and Chester Council v P [2011] EWCA Civ 1257. See the judgment of Baker J in the recent Court of Protection case CC v KK [2012] EWHC 2136 (COP), for an example of how the changing and sometimes inconsistent case law on this issue creates uncertainty and difficulty even for the judges who are forced to apply it, particularly pending Cheshire West going to the Supreme Court.

166 It seems that case law does filter down to those who have to implement it, even if it does result in uncertainty. Following the decision in J Council v GU [2012] EWHC 3531 (COP) local authorities have shown an awareness that detailed policies will be required where Article 8 rights are interfered with.

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“The question of whether the steps taken by staff or institutions in relation to a person amount to a deprivation of that person’s liberty is ultimately a legal question, and only the courts can determine the law… decision-makers need to consider all the facts in a particular case. There is unlikely to be any simple definition that can be applied in every case, and it is probable that no single factor will, in itself, determine whether the overall set of steps being taken in relation to the relevant person amount to a deprivation of liberty.”167

Restrictive judicial interpretation

36. Where courts have had to consider the proper definition of ‘deprivation of liberty’, judicial interpretation of the extent of the application of Article 5 in these types of cases has been restrictive, further narrowing the application of the Safeguards to a very small number of cases.

37. In Cheshire West, Lord Justice Munby held that if a person was subject to restrictions that a person with similar disabilities might be subject to, they were unlikely to be deprived of their liberty.168 We respectfully disagree with this interpretation. The use of a different “comparator” for disabled people is unprincipled and undermines the autonomy of the individual. It disregards the philosophy underlying human rights protections: that all individuals are guaranteed the full protection of all the rights in the Convention and, while their application will obviously differ depending on individual circumstances, this does not reduce an individual’s entitlement to enjoy these rights to the fullest measure possible. The Cheshire West approach distorts accepted methods of human rights analysis by allowing an individual’s particular characteristics (in this case, their mental impairment or disturbance) to determine whether or not the particular right is engaged in this instance, rather than introducing these factors at the second stage of the analysis, which considers whether restriction of this right can be justified.169 The wording of Article 5 of the Convention clearly supports the traditional approach, as subsection 5(1)(e) clearly contemplates being “of unsound mind” as a reason potentially justifying restriction of the Article 5 right, not as determining whether that article is engaged in the first place. Article 4 of the Convention on the Rights of Persons with Disabilities also makes clear that a State’s duty is to “ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability” [emphasis added].

167 DoLS Code of Practice, at pp.16, 18.

168 “In determining whether or not there is a deprivation of liberty, it is always relevant to evaluate and assess the ‘relative normality’ (or otherwise) of the concrete situation…In most contexts (as, for example, control order cases) the relevant comparator is the ordinary adult….But not in the kind of cases that come before the Court of Protection…Some adults are inherently restricted by their circumstances….In such cases the contrast is not with the previous life led by X (nor with some future life that X might lead), nor with the life of the able-bodied man or woman on the Clapham omnibus. The contrast is with the kind of lives that people like X would normally expect to lead. The comparator is an adult of similar age with the same capabilities as X, affected by the same condition or suffering the same inherent mental and physical disabilities and limitations as X.” Munby LJ, Cheshire West and Chester Council v P [2011] EWCA Civ 1257, at para 102.

169 To use an analogy: we say that depriving someone of their liberty pursuant to a criminal sentence is justified because that deprivation is sanctioned by a court of law and for the legitimate purpose of punishing and deterring law-breaking. We do not say that the prisoner was for those reasons never being deprived of his liberty to begin with.

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38. In practice, this highly controversial approach means that people lacking capacity may be subject to high levels of unscrutinised restriction on their liberty before the DoLS safeguards are engaged. Holding that a deprivation of liberty is not occurring in these cases would exclude whole swathes of individuals from the scope of the ECHR and its protections. Furthermore, in an era of cuts to welfare and local authority budgets, this analysis also raises the possibility that the level of ‘normality’ provided for persons with, for example, learning difficulties, who reside in local authority care homes, may be dependent on ever-tightening resource constraints, with the result that ever greater restrictions on and deprivations of liberty become acceptable.

39. Cheshire West also saw the unwelcome resurrection of the use of the ‘reasons’ for the detention to determine the preliminary question of whether or not a deprivation of liberty is occurring, influenced by domestic ‘kettling’ case law. Again, this approach turns the accepted approach to human rights analysis on its head: the purpose of the detention may be relevant to whether or not it can be justified, or whether it falls within one of the exceptions listed in Article 5, but it should not be used to determine the initial question of whether a deprivation of liberty is actually taking place. Allowing the motive behind the restriction to influence whether or not the individual’s Article 5 rights are actually engaged in the first place risks significantly reducing the level of protection for those detained or restricted by the state for treatment or their own safety. As with the normality test, such an approach excludes whole categories of individuals from the scope and protection of the HRA and ECHR.

40. The DoLS schedule should be amended to introduce a statutory definition of “deprivation of liberty”, that is broad enough to satisfy the requirements of the ECHR’s jurisprudence, but which will also provide clarity and certainty for those working in this field. The definition should be free-standing, and not directly dependent on the fluctuations of Strasbourg case law.

5.

41. It is likely – and to be hoped - that at least some of the more controversial aspects of the Cheshire West decision will not survive scrutiny by the Supreme Court in the autumn. However, it should be stressed that any new statutory definition should not create a separate, lower test for deprivation of liberty for disabled persons (the approach followed in Cheshire West) but start from the presumption that disabled persons are entitled to the same individual freedoms as anyone else. The reasons for the restrictions should be considered only when assessing whether the deprivation of

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170 Cheshire West and Chester Council v P [2011] EWCA Civ 1257, at para 77. Munby LJ’s reasoning on this point is based on a rather elusive distinction between ‘reason,’ ‘purpose,’ and ‘motive.’ In Austin v Commissioner of Police of the Metropolis [2009] HL 5, the House of Lords held that a public safety/order purpose for the detention (in this case, kettling of protestors) could be relevant in deciding whether or not a deprivation of liberty existed. However, the ECtHR has cast serious doubt on this approach, see note 20.

171 In particular, the ECtHR’s decision in Austin v UK casts significant doubt on relying on an “underlying public interest motive” to determine the question of whether a person has been deprived of his liberty. See Austin v UK [2012] ECHR 459 at para 58-59 of the majority judgment. See also Baker J’s judgment in CC v KK [2012] EWHC 2136 (COP), where he struggles to apply the Cheshire West tests in a post-Austin context.

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Liberty – Supplementary written evidence

liberty is justified, not in determining whether such a deprivation exists. From this starting point, which respects the universality and integrity of human rights protections, the courts will then be able to consider whether the restrictions in question are necessary and proportionate given the particular circumstances of the individual lacking capacity.

42. **The DoLS Code of Practice should be urgently reviewed and updated.** Updates to the guidance and Code of Practice should be issued more regularly, taking account of, and explaining, the impact of subsequent case law interpreting the statutory definitions.

**Review**

43. There have been very few challenges made to DoLS authorisations under the MCA, reflecting the difficulty for these individuals in challenging their care arrangements and the low number of DoLS authorisations applied for. Given these obstacles to challenging an individual’s detention under DoLS, there are serious concerns that the DoLS regime may be in violation of article 5(4) ECHR.

44. Unlike detention under the Mental Health Act 1983, there is no periodic review of detention under DoLS – even though a standard authorisation may have a duration of up to one year. The first means of challenge is for the detainee to apply to the supervisory body for a review of any of the 6 qualifying criteria for the DOLS order, to see if they are still met. However, it is that same supervisory body that authorised the application for an order in the first place. Therefore, where the review hopes to challenge the basis of the original order, the review is neither independent nor external.

45. An individual can challenge the detention by applying to the Court of Protection under section 21A MCA, but there are significant obstacles. At present, under section 39D MCA, a person detained under DOLS has the right to request appointment of an IMCA by the supervisory body, and the body has a duty to appoint one in some, but not all cases where a person is detained under DOLS. In addition to the obvious practical problems that a person with, for example, learning disabilities, may experience in communicating their intentions and contacting a solicitor, local authorities have been accused of inappropriate delay in appointing an IMCA to represent that person’s interests, or the representative may support the detention and not consider it to be in their best interests to bring an application.

6.

46. This was the situation in the Neary case, where there was a delay of several months in appointing an IMCA, seriously restricting Steven Neary’s ability to challenge his ongoing detention. The London Borough of Hillingdon took Steven Neary, who suffers from autism and a severe learning disability, into respite care for a few days at the request of his father in December 2009. He remained there until

172 MCA Schedule A1, para 42.

173 [2011] EWHC 1377 (COP)

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December 2010 against his own and his father's wishes, detained under a series of DoLS authorisations obtained by the local authority. Ultimately, the judge found that the local authority had breached Steven's right to a family life under Article 8 ECHR, had deprived him of his liberty and therefore breached Article 5(1), and by failing to refer the matter to the Court of Protection sooner, failing to appoint an IMCA for Steven sooner and failing to conduct an effective review of the DoLS best interests assessments, it had deprived him of his entitlement to take proceedings for a speedy decision by a court on the lawfulness of his detention contrary to Article 5(4).

47. By contrast, where persons are detained under the Mental Health Act 1983, they have relatively easy access to the Mental Health Tribunal. The tribunal has a number of advantages over either of the avenues for challenge available to those detained under DoLS: the tribunal frequently holds hearings in the place of detention (for example, the tribunal will hold its proceedings in the mental health hospital in which the individual is detained), making it easier for those detained to take part in proceedings and express their views; the tribunal is fast-moving, and when a hearing is requested it will usually be heard within 5 working days; and, as a tribunal, it is much cheaper, more flexible and more informal than equivalent proceedings before the Court of Protection.

48. A statutory requirement for regular periodic review of any detention authorised under DoLS should be introduced, similar to that provided for detained mental health patients. This review should be at regular intervals, and at least every three months.

7.

49. The MCA should be amended to provide that supervisory bodies have a statutory obligation to appoint an IMCA automatically and promptly in all situations where an individual is detained pursuant to a DOLS order.

50. If the DoLS regime is to comply with Article 5(4) ECHR, there must be an independent, external body to review challenges to detention under DoLS, which can be easily and speedily accessed by detained individuals and their representatives. One way of achieving this would be to extend the current powers and jurisdiction of the Mental Health Tribunal to allow it to hear challenges to deprivation of liberty under DoLS.

Extent

51. The DoLS regime is also structurally flawed in the limitation of its application to hospitals and care homes. Many individuals, for example with dementia or learning disabilities, are cared for in residential homes, in special accommodation or ‘supported living’, or in their own homes. These individuals may equally be subject to deprivations of liberty, for example, if their ability to go out into the community is significantly restricted, or if their lives are regimented in a particularly comprehensive or invasive way. However, as the DoLS regime does not apply, these deprivations of liberty will not be in accordance with any legislative provision, nor will the individuals enjoy Article 5 protections, which is not consistent with the UK’s obligations under the HRA.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
52. **Paragraph 1(2) of Schedule A1 to the MCA should be amended, to cover any place where a person is receiving care.**

53. The combination of a restrictive interpretation under Article 5 as offered by the courts, its limited application to hospitals and care homes, and the lack of applications for a DoLS authorisation suggest that there are potentially thousands of individuals without capacity in the UK who are being deprived of their liberty within the meaning of Article 5 ECHR, but who are not being afforded the protection demanded by the Article 5 safeguards. This is not compatible with the Government’s obligations under the ECHR or HRA.

**Access to Justice**

**The Court of Protection**

54. One of the innovations of the MCA 2005 was to create a new Court of Protection, which would have jurisdiction over not just the financial decisions made on behalf of those lacking mental capacity, but also more general care and welfare decisions. While the creation of a specific jurisdiction, which allows the accumulation of expertise by judges and lawyers is welcome, there are aspects of the Court’s structure that could be amended, to improve access to justice for those subject to the MCA.

55. Applying to the Court is a costly and lengthy process, with decisions regarding DoLS orders taking up to a year. The Court of Protection often sits in London or other regional centres, which may be far from the individual concerned (although under subsection 45(3) MCA, it may sit “at any place in England and Wales”, which would allow hearings to be conducted in the care homes or hospitals where the individual is, as is common for Mental Health Review Tribunals). In addition, as DoLS cases will usually be heard by a member of the senior judiciary, the instruction of counsel will often be required, further increasing costs. The result is that cases before the Court of Protection are frequently many times more expensive than appearances before an equivalent tribunal, and this can impose a significant obstacle to an individual’s exercise of their right of access to justice.

56. These problems would be made significantly worse, should the Government decide to proceed with its much-criticised proposals in the Ministry of Justice’s consultation paper *Transforming Legal Aid*. In particular, any restriction on client choice would be particularly acutely felt in the area of mental health law, a highly-specialised area of law, which requires lawyers with expertise in this area. Given the severely limited avenues of challenge for persons subject to the MCA, particularly those detained under DoLS, any restriction of access to legal aid will directly impact the adequacy of their access to justice and their human rights under the HRA and ECHR. In particular, any cuts in this area will increase the already-high likelihood that the DoLS regime is in violation of the review requirements in Article 5(4).

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Litigation capacity

57. Several European Court of Human Rights rulings on Article 6 have found that deprivation of legal capacity must have similar procedural safeguards to Article 5. Strasbourg case law has also suggested it is unacceptable for a person to be deprived of their capacity to litigate where the judge has had no contact with the person and is merely acting on the evidence of those who allege incapacity. The Court has also emphasised the importance of the quality of the medical evidence, and of the judge giving reasons for a determination that a person lacks capacity.

58. Litigation friends make a range of decisions about how litigation should be conducted on behalf of P, including whether it should be conducted at all. Although a settlement or compromise cannot be reached on behalf of P without the consent of the court, it seems possible under the Criminal Procedure Rules that a litigation friend could decide to discontinue proceedings brought by P. This effectively means that P’s access to justice, to obtain a remedy for interferences with their rights, is at the discretion of his litigation friend who, in certain cases, may be a public official such as the Official Solicitor. If a litigation friend were to use this discretion to discontinue proceedings challenging P’s detention under DoLS, P’s article 5(4) rights could be subject to discretionary restrictions which may be incompatible with the ECHR.

59. The discretion of litigation friends is just one example of how persons lacking capacity may be unable to have their case advanced in the Court of Protection. Litigation friends, such as the Official Solicitor, may bring proceedings, but not advance the case desired by P. For example, if P believes she has capacity, but her litigation friend does not and refuses to advance this argument, the issue of her capacity (or lack thereof) will not be tested fully and adversarially in court.

60. For example, in Re E (Medical treatment: anorexia) (Rev 1), where a local authority sought a declaration that it was in E’s best interests for her to be forcibly fed for up to a year to prevent her death from anorexia nervosa. E was represented by the Official Solicitor, although her counsel stated that “in the absence of contrary medical opinion he would have felt able to take instructions from E.” The Official Solicitor argued that it was in E’s best interests to have the treatment, notwithstanding her objections. However, nobody in the court was making E’s case, either that she did in fact have capacity or that force-feeding would not be in her best interests. E’s parents agreed with her, but were unable to afford independent legal representation. No counsel was making the best possible case for what E wanted to the court. All the experts were instructed by the local authority.


177 Re E (Medical treatment: anorexia) (Rev 1) EWHC 1639

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61. Similarly, in the case of D v R (Deputy of S),\textsuperscript{178} S had given money as a gift to D. S’s deputy, R, asserted that S lacked capacity, despite S’s protestations to the contrary. Therefore, it was left to D, the alleged donee of the gift, to make the argument that S had capacity in Court. It is unclear how a person, deemed to lack capacity, can proceed where their litigation friend refuses to challenge that finding of incapacity. This situation is clearly unsatisfactory and represents a depressing return to paternalism via the back door, which contrasts with the emphasis on autonomy in the MCA itself.

62. One way to address this problem would be to introduce provision to the MCA to impose a duty on the Court of Protection to consider, of its own motion, whether they should examine and/or hear argument on the question of whether P does in fact lack capacity.

United Nations Convention on the Rights of Persons with Disabilities

63. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) came into force on 3 May 2008 and currently has 114 States Parties. The UK ratified on 8 June 2009 and is therefore bound by its international obligations under the Convention. The CRPD has been widely hailed as a ‘paradigm-shift’ in thinking about the rights of persons with disabilities. The Convention places weighty positive obligations on States Parties to ensure that persons with disabilities are able to fully realise the rights they are guaranteed by the general human rights treaties, such as the ICCPR and ECHR, which were drafted in the immediate post-war period. As a result, there is a real possibility, not only that the UK’s mental health law does not comply with the requirements of the CRPD, but also that the UK’s obligations under the CRPD and its obligations under the ECHR are in conflict.\textsuperscript{179} The interaction of these international treaties is extremely complex. However, there are some potential points of conflict between English mental capacity law and the CRPD, which should be highlighted, and may need to be addressed in future.

64. Article 12 CRPD guarantees equal recognition before the law for persons with disabilities. British mental capacity law may be in conflict with this provision for two main reasons. First, article 12(4) sets out a number of safeguards to prevent abuse where persons with disabilities are exercising their legal capacity. The objections to the UK system here are the same as those outlined above in relation of deprivation of litigation capacity and access to justice. However, secondly, and more fundamentally, the “paradigm shift” effected by the CRPD is clearly evident in article 12, which not only imposes a duty on States Parties to “recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life,” (12(2)) but also imposes a positive duty to “provide access by persons with disabilities to the support they may require in exercising their legal capacity” (12(3))

\textsuperscript{178} [2010] EWHC 2405

\textsuperscript{179} See, for example, Fennell and Khalig, Conflicting or Complementary Obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law, [2011] EHRLR 6, p662.

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and ensure that persons with disabilities enjoy an equal right to, for example, inherit property and control their own financial affairs (12(5)).

65. There are a number of aspects of UK mental capacity law which immediately seem to be in potential conflict with these requirements. For example, the system whereby persons with disabilities or who lack mental capacity are simply deprived of their ability to litigate would not seem to fulfil the duty to provide support for decision-making in 12(3). Indeed, the text of article 12(2) would seem to prohibit any denial of legal capacity simply on the grounds of disability. There are also concerns that substituted decision-making, such as the system under the MCA whereby carers can make a ‘best interests’ decision on behalf of the person lacking capacity, may be contrary to the requirement for supported decision making in article 12(3). Under section 4(6) MCA carers must consider the past and present wishes, feelings, beliefs and values of the individual, but on some interpretations of Article 12(3) it is not clear that this would go far enough to satisfy the requirements of the CRPD.

66. In addition, it seems likely that the serious flaws identified in the DoLS regime above would put the UK in breach of its obligations under articles 13 (Access to justice) and 14 (Liberty and security of the person) CRPD, as well as the ECHR.

67. The precise requirements of the duties laid down in the CRPD, and their interaction with other sources of human rights law, are still unclear. However, the UK is bound by the treaty, and it is worth bearing in mind that, should the Convention be interpreted in future in a way that would put UK mental capacity law in conflict with its provisions, a radical overhaul of both the Mental Capacity Act 2005, and the Mental Health Act 1983, may be required to ensure the UK complies with its obligations under international law.

68. The Mental Capacity Act 2005 was a well-intentioned and progressive piece of legislation, with many positive features. However, evidence since its enactment, including the horrific revelations of abuse at care homes and hospitals in recent months, show that the regime is not functioning properly in practice, with tragic consequences. The scale of the problem, and the vulnerability of the individuals placed at risk, mean that the seriousness of this issue cannot be underestimated. We have recommended a number of structural or legislative changes above, but much could be achieved relatively quickly and simply, through better training and the revision of guidance and codes of practice. We urge the Committee to take advantage of the opportunity their inquiry represents, to further raise awareness of these issues, and – more importantly - to use the weight which will be accorded to their report and recommendations to effect real change.

30 August 2013
Dr Liz Lloyd, Joan Langan, Dr Marcus Jepson, Professor John Carpenter, Dr Demi Patsios and Linda Ward (School for Policy Studies, University of Bristol) – Written evidence

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Michael Loftus – Written evidence

In response to your request for call of evidence for Mental Capacity Act I note the following

1) To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The MCA has been a wonderful piece of legislation which for the first time has empowered Patients to be at the heart of care rather than recipients of paternalistic care. In my 30 years within Health and Social care I have witnessed an evolution of rights and respect, prior to the act decisions were widely made without consultation with the Patient, this act has humanised care with the MCA by having a presumption of capacity which can only be helpful to Patients. In my experience the act has benefitted Patients however some areas ignore or do not implement the act which is of concern. The best interest principle for those who lack capacity is also a wonderful principle which again has aided Patients in receiving good quality, safe care. In Health Service scandals you can see a theme of the MCA having been ignored causing acts and omissions which work against MCA and best interests from Winterbourne to Francis.

2) Which areas of the Act, if any, require amendment; and how?

The Deprivation of Liberty Safeguards are a helpful process which when used well protect Patients who lack capacity where a DOLs needs to be authorised but one change I would make would be to change the title Deprivation of Liberty Safeguard to Liberty Safeguards. I.e. this is protecting life.

In areas of self neglect where a Patient has capacity but not the functional ability to care a greater ownership of responsibility should apply to enable individual Patients to be supported however we need to be carful not to override the first principle of the Act.

3) At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

Yes most certainly they are appropriate. The principles and definition can only aid best practice and are rightfully at the core of the Act which clearly supports safe, effective care for all Patients.

28 June 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
London Borough of Bromley – Written evidence

1. **Overview and context**

To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The MCA is a sound piece of legislation that has helped to improve standards of client centered practice.

- More professionals are thinking seriously about their interactions with incapacitated clients. However good practice and compliance with the MCA is not yet fully embedded in daily work. Training in MCA needs to be made mandatory in more organisations which will enable staff to understand the detail, not just the generalities.

- Families are often intimidated by the formalities of the Law, and by the fact that the legalities seem to intrude on simple decision making they have undertaken for years. There is confusion about the legal rights of a 'next of kin' and that their judgments can be overridden. There are perceptions that the law seems to impinge on rights to a family life. Perhaps families should be left to determine a loved one’s best interests unless there are clearly safeguarding implications.

- There is poor knowledge of the MCA remains amongst medical professionals.

2. Which areas of the Act, if any, require amendment; and how?

- DOLS is a particular issue and it is felt that sufficient procedures were in place already to potentially avert a Bournewood situation.

- DOLS authorisations could be just for the short term to resolve a crisis.

- The 7 day assessment period is far too short to allow a considered assessment to take place; this period should be doubled.

- DOLS procedures would be better incorporated in Mental Health Act with a much easier route of appeal or legal scrutiny.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

In general these areas are good. Fluctuating capacity is a difficult area in which more guidance would be helpful. There is a limit on how long decision making can be deferred.

4. **Implementation**

To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

Change occurs very slowly and gradually, and not simply because a legislative change is introduced. Although the 5 principles reflect good practice they are not always manifest in

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professional activity. The Law helps to raise their profile. Unwise decisions still get mixed up with evidence of lack of capacity; this could be covered in more detail in the Code.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

Many professionals knowledge and practice in this area need expanding and integrating into their practice, health colleagues are particularly poor at embracing the MCA (especially around consent to treatment) and it is felt that until there are more serious legal repercussions for noncompliance the rate of change will remain slow. Much of the learning about MCA comes through case law and this is not a familiar medium for many of the professionals involved. Banks appear to be making an effort to consider capacity issues.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance been struck between protection of the carer and protection of the individual lacking capacity?

Clients and families have a poor knowledge and awareness of MCA/DOLS matters, and resent their traditional practices being suddenly challenged by professionals. They find the over legalistic procedures difficult to embrace. More publicity needs to become available.

8. Has the Act ushered in the expected, or any, change in the culture of care?

Social care professionals do tend to involve incapacitated clients more in their care planning, with greater consultations with families and network. Health colleagues tend to have further to go at this point in time.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

No observations on this issue

10. Decision-making

Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

In general more efforts are being made with people who lack capacity to involve them in decision making where possible. The formalities of the legislation and of capacity assessments have helped with this as such efforts are legally required. It is worth noting that the Courts are more comfortable with best interests risk taking than professionals.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

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No observations on this point other than concern about DNAR procedures not always seeming to follow best interests procedures particularly around involving client and families.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

The procedures do seem to have increased the efforts that professionals are making to maximize the involvement of families and carers; this has always been an important issue of good practice but the Law has made it more likely to happen. However it is not always clear who is taking on the role of decision maker.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

The local IMCA service has been very effective in ensuring the client’s voice has been heard, although this has traditionally been a role that social care professionals would have taken on. They have been very effective in DOLS cases both for the client and the Representative.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

Locally there have been very few referrals for Serious Medical Treatments, and most referrals have been from social care staff making changes to accommodation. The reason for the regional variation is unclear.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

This question implies that IMCAs are involved in decision making; they are never the decision maker. Their role is to ensure that the client’s voice is heard, and the local service has been very effective in doing this.

16. **Deprivation of Liberty Safeguards**

Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

There is a comprehensive range of Safeguards for those people actually on DOLS. The main problem is more about whether more people should be subject to the Safeguards. More people could be protected if criteria were tighter, and less open to a range of interpretations. DOLS procedures have resulted in some individuals returning home to less restrictive environments. The courts are a very clumsy and expensive Safeguard; some kind of Tribunal procedure would be more effective, like Mental Health Act appeals.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

It is extremely difficult for clients and families to understand DOLS procedures, they can be overwhelmed by the bureaucracy, and this can be off-putting. Many of the forms can be integrated to reduce the huge amount of repetition.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
18. **The Court of Protection and the Office of the Public Guardian**

Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

The procedures for LPAs and Deputyships are difficult to understand, very bureaucratic and expensive. Despite good publicity on sites like www.gov.uk the public remain largely unaware of how they can plan for the future. The Government needs a strong campaign to increase awareness of what can be done.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

As above we need to increase public awareness. Very few individuals appear to have a Health and Welfare LPA. There is also great confusion for families about a simple traditional Power of Attorney which falls with incapacity and the full Lasting Power. Perhaps a change of name to emphasise a distinction would help.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

Generally families are greatly disturbed by these costs; they are unsure about the best time to register an LPA. Families need to be educated to understand that LPA, for instance, do not require legal input if things are kept simple. Many applications are begun in a time of crisis and therefore are more complicated and then require legal input. Time scales are very distressing as the necessary authority to make decisions often is not available when needed.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

No observations on this point.

22. **Regulation**

Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

The CQC already has considerable powers. The main difficulty is that this is still a new area and CQC staff need to develop their understanding of the legislation, and, particularly with DOLS, there is not likely to be any consistency in what are the acceptable standards. This requires the Law to be tightened up, and then national standards and expectations to be clear.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

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There is no need for this if CQC can develop a consistent understanding. Other regulators would face the same dilemmas in terms of knowledge and lack of experience.

24. **Other legislation**

How well is the relationship with the mental health system and legislation understood in practice?

This is confusing to many professionals. However our local s12 doctors with DOLS training have a reasonable understanding, although disagreements around Eligibility for DOLS can be tricky to resolve. This area needs to be better covered in guidance.

25. **Devolved administrations and the international context**

Does the implementation of the Mental Capacity Act differ significantly in Wales?

N/A

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

N/A

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

No observations on this point.

The London Borough of Bromley Safeguarding Adults Board organised a meeting for local stakeholders within the Council, from Health, and from local private and voluntary providers. The above reflects the views of the few staff who attended the meeting.

3 September 2013
Overview and context

To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1. The MCA provides a coherent framework of empowerment and protection of adults who have difficulty with decision-making. The MCA has partly achieved its aims; it is likely that its aims will be fully achieved if government continues to encourage organisations to uphold and promote people’s right to self-determination.

Which areas of the Act, if any, require amendment; and how?

2. The MCA in general is clear and well-drafted but schedules A1 and 1A are not, and should be amended in the following ways:

a. A re-draft of schedules A1 and 1A to make them easier to read;

b. Inclusion of a definition of ‘deprivation of liberty’;

c. The DOLS needs to be driven more by principle and less by process, although there is a place for process, but less;

d. Replacement of the current appeals process via the Court of Protection with a DoLS Review Tribunal (akin to the Mental Health Review Tribunal).

3. The main Code of Practice is very well-written and easy to read but could usefully be updated to incorporate case law e.g. we understand that Cheshire West and P and Q are going to the Supreme Court this October/November and the Code needs to be updated to incorporate these key judgments to help to clarify this confused area of case law.

At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

4. Yes, the principles and definitions are excellent. They emphasise each person’s right to make every decision for ourselves that we are capable of making; and provides a clear framework for how to determine when we are no longer able to make a decision (2 stage capacity assessment) and how a decision will be made on our behalf which is in our best interest.

Implementation

To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

5. The principles of the MCA have been embedded to some extent in front-line practice. Two of our local authorities undertook DH-funded audits but regular audits and peer reviews have not yet been established.

6. There is some very good enabling practice but professionals are sometimes still over-protecting individuals who are making an unwise decision, for example, by setting the bar for capacity too high and conflating capacity assessment with best interest decision-making. There is uncertainty about what level of information is necessary for an individual to make an informed choice; more guidance on this important area in the Code of Practice (reflecting recent case law which has consistently set the bar low) would be helpful.

How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

7. The Government’s implementation plan was effective but needs extending. Local authorities have worked well in partnership with NHS and other organisations to ensure that professionals are able to implement the Act and challenge those who are not following its provisions. Other statutory organisations, for example, the Office of the Public Guardian, have supported families in understanding the Act.

8. A lot of valuable expertise has been lost by the reduction in the central DH support in the implementation of the MCA. There is further work that remains to be done and it is important that organisations including local authorities and central government recognise this and continue to prioritise the implementation of the MCA. Successful embedding of new legislation or policies does take time and resources (Safeguarding Adults work is a useful comparison, as it took many years for public awareness and good professional practice to become widespread).

Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

9. Knowledge of the Act is still variable. Some professionals in health and social care have a very good understanding of the Act; some a very poor understanding; a lot have some understanding but sometimes lack confidence in applying it to practice.

Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

10. LPAs and advance decisions seem better understood (and have had more publicity) than the rest of the MCA. There is a lot of useful information accessible on-line, for example, the very clear summary of the Act on the Mental Health Foundation website. Implementation work by local authorities has mainly focused on supporting professionals. In the three boroughs, 39D IMCAs are routinely used to assist a person who is subject to a DOLS authorisation and their unpaid representative to understand the DOLS and their rights to challenge their detention.

Has the Act ushered in the expected, or any, change in the culture of care?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
11. The Act has partly ushered in a change in the culture of care from making decisions to supporting decision-making. It also requires professionals to ‘show their working out’ i.e. not just recording a decision, but how the decision was reached. Some professionals embrace the Act; some find it supports the way they work and think; some like the theory but find it hard to translate that into practice (particularly the fact that capacity is decision-specific).

Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

12. The Act discriminates against those who have never (in adulthood) had capacity to appoint a health and welfare attorney, and their non-professional carers, as deputyship over health and welfare should only be given in exceptional circumstances.

13. Apart from that, there is no evidence that the MCA affects some groups disproportionately, although further research in this area would be useful. No disproportionate affects have been found in our audit of general MCA practice in Adult Social Care or via the DoLS data collection.

**Decision-making**

Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

14. To a greater extent. Some professionals report that they feel empowered to support the person’s decision-making, including people who have capacity, because of the framework the Act provides. The fact that decisions can be challenged in the Court of Protection gives impetus to ensuring that the person is as fully involved in the process, and that how a decision has been arrived at is well-documented. Decision-making tools are more widely employed by adult social care staff i.e. best interest check-list; balance sheet; risk assessment.

What evidence is there that advance decisions to refuse treatment are being made and followed?

15. No comments.

Has the MCA fostered appropriate involvement of carers and families in decision-making?

16. Partly. There is an ongoing need for training and support for professionals to ensure that it is clear who the decision-maker is; what decision is being made; and that the decision-maker is required to consult with the person’s family and friends.

17. Some professionals remain reluctant to move away from the notion of ‘next-of-kin’ and can also be reluctant to consult the person’s friends in order to get a rounded view of
London Borough of Hammersmith & Fulham, the Royal Borough of Kensington & Chelsea and the City of Westminster – Written evidence

who the person is and how would they have decided for themselves, had they been able. Some professionals are reluctant to relinquish the position that they know best.

Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

18. Yes, and particularly the provision s39 IMCAs in DOLS process.

19. It would be beneficial to be able to routinely offer an IMCA to a person who has experienced abuse and has difficulty making decisions about their safety, and is the subject of a safeguarding enquiry. Clearer direction from the DH (as there has been on the use of s39D IMCAs) would be useful in this area.

Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

20. The level of referrals to IMCAs has been lower than anticipated. This is the case particularly for serious medical treatment, although referral numbers are increasing. This reflects that health agencies appear to have been slower to embrace the MCA than adult social care. Referrals for safeguarding cases are also low, as it can be hard to identify when appointing an IMCA would be particularly beneficial for the person.

21. Regional variations may be due to: demographic differences; the number of care homes or hospitals in the area; practitioners’ understanding of the IMCA role, and application of the Act to their practice.

Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

22. IMCAs are very skilled in supporting the person lacking capacity to make their own decision; and in ensuring that the decision-maker takes the person’s views into account, and considers less restrictive options.

23. IMCAs are reasonably well-resourced (although this is dependent on their local contract with the commissioning local authority) but probably not adequately resourced or skilled to make Court of Protection applications. Consideration is being given to the possibility of IMCAs acting as litigation friends in the COP. This has been done very effectively in one case but has resource implications for IMCA providers, and local authority budgets.

**Deprivation of Liberty Safeguards**

Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

24. The DoLS work well for those people who have an authorisation in place; good outcomes have been achieved for many people; e.g. people returning to live in their own home.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
London Borough of Hammersmith & Fulham, the Royal Borough of Kensington & Chelsea and the City of Westminster – Written evidence

25. The lack of a definition of ‘deprivation of liberty’ and the inconsistency in court case rulings means that there is wide variation in who different BIAs judge to be deprived of their liberty (and who managing authorities refer). An amendment to the MCA, to include a definition of ‘deprivation of liberty’, would significantly improve the consistency of access across the country to people’s Convention rights. If a definition is not possible, guidance needs to be clearer and more practically applicable.

Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

26. Authorisation process: this is not a very clear process; the fact that there are as many as six assessments confuses the managing authorities, the people being assessed and their family and friends. Managing authorities struggle to understand the standard form used to give themselves an urgent authorisation (and the form accurately reflects the legislation so cannot be significantly changed). The fact that there is no definition of ‘deprivation of liberty’ means that some managing authorities (especially if advised to put in requests by CQC) are possibly over-referring, and some are under-referring; it also means that BIAs sometimes struggle to determine whether or not the person is being deprived of their liberty.

27. Review process: the legislation makes it clear that a review is only for when circumstances have changed, therefore it is not an avenue for the detained person to challenge the authorisation. The managing authorities often do not understand that they should request a review if circumstances have changed.

28. Challenge process; the only route for challenge is the Court of Protection. Very few challenges are made. Representatives (paid or unpaid) and s39D IMCAs often judge that it is not in the person’s best interests to be subject to court proceedings, which start in a timely fashion but often take many months to be resolved. A system akin to the mental health review tribunals would be clearer, more accessible, less costly, and more timely.

The Court of Protection and the Office of the Public Guardian

Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

29. The Court of Protection is a valuable safeguard for the promotion of people’s rights and person-centred decision-making if the person lacks capacity to make their own decision. Cost of best interest hearings may impact on accessibility.

30. Published judgments are useful to guide professionals, but a centralised system of summarising how they apply to practice would be useful, for example, via annual updates to the Codes of Practice.

What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

31. There has been little impact so far as there are not many registered health and welfare LPAs. This may be because the public are not well-enough informed about the benefits. Also, cost of registration may be a deterrent.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
London Borough of Hammersmith & Fulham, the Royal Borough of Kensington & Chelsea and the City of Westminster – Written evidence

32. There has been a bigger impact in terms of clarity for professionals that they are the decision-maker for the particular care, treatment or intervention they are offering, if the person who lacks capacity to make their own decision, when the person has not appointed a health and welfare attorney.

What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

33. The 21a arrangements for non-means tested legal aid are helpful to a person or their representative wanting to challenge their DOLS.

34. However, it is unfair in the cases of s15/16 applications, where the protected party or a relative would not be eligible for public funds, if they have savings, which are above the threshold set by the Legal Aid Agency.

Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

35. Section 21A and section 15/16 MCA applications, both equally address important questions in respect of incapacitated adults, consequently there should be equality in terms of the provision of public funding in these applications.

Regulation

Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

36. It is both adequate and appropriate; the CQC inspections are an important driver in statutory organisations understanding and implementing their MCA duties.

37. CQC admitted in their annual report that they have not fully trained all their staff on the MCA; that training must be a priority.

Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

38. No, it is more appropriate for organisations to ensure their staff are able to successfully implement the MCA.

Other legislation

How well is the relationship with the mental health system and legislation understood in practice?

39. All practitioners are struggling in this area and additional clarity on this interface would be helpful

40. Schedule 1A is very difficult to understand.

Devolved administrations and the international context

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Does the implementation of the Mental Capacity Act differ significantly in Wales?

No comments.

What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

41. The Scottish Act is not as empowering as the person needs to be able to remember they have made a decision; the MCA bar for capacity is rightly set low.

42. The Irish Bill proposes that intervention only be carried out in relation to someone who lacks capacity to make their own decision if it is necessary to do so and, if possible, following that person’s previous wishes and feelings. This is the approach used for Enduring Powers of Attorney under the MHA 1983 but the best interest decision-making model in the MCA works better.

Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

43. It is compliant, including Article 12 requirements on exercising legal capacity, and Article 25 requirements on the need for free and informed consent for healthcare interventions.

2 September 2013
London Borough of Newham Adults Social Care – Written evidence

London Borough of Newham Adults Social Care – Written evidence

This response is based on the views and comments Newham’s MCA deprivation of liberty safeguards best interests assessors, safeguarding advisors, Newham’s client affairs manager, senior managers involved in the deprivation of liberty authorisation process and other adult social care staff. This report follows the questions set out in the House of Lords Select Committee information request.

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The MCA provides a clear framework for assessing and making decisions on behalf of people who lack capacity. It has made a difference to the way that vulnerable people are perceived. It provides safeguards for them and for the people who provide them with care. It is also useful when speaking to family members about legal authority to act when an individual no longer has the capacity to make decisions for themselves. However, difficulties can arise when the law clashes with different cultures and their beliefs.

There are concerns that the Act is not sufficiently ‘embedded’ in practice. In Newham audits have proved to be a useful tool in assessing the extent of the use of the MCA with vulnerable adults.

2. Which areas of the Act, if any, require amendment; and how?

Based on our experience in implementing the Act, it is our opinion that the terms ‘serious medical treatment’ and ‘deprivation of liberty’ would benefit from greater clarification. The impact of Court of Protection rulings should be incorporated in the MCA Code of Practice. Section 44 – Wilful neglect and Abuse of a person who lacks mental capacity requires guidance – problems remain re the police accepting evidence from victims who lack capacity, CPS sometimes refuses to take these cases forward.

The process for authorising tenancy agreements for those that lack capacity to sign, would benefit from a review. Ideally the process should be streamlined so that witness statements from practitioners should be sufficient without the requirement for additional information from a medical physician. It is also suggested that 21 day objection period is removed as this lengthens the time that the order is received. In some cases accommodation is lost as landlord will not accept unsigned tenancies.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

The principles of the Act are clear and provide a good foundation in terms of setting out the requirements. However with regard to applying the definitions, there is a need for greater clarity regarding unwise decision vs. inability to weigh up information, and additional guidance would be useful. The term ‘best interests’ is sometimes misused and taken as referring merely to what is seen as best for an individual. This can lead to inconsistency in decision making.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

The council has worked hard to embed the five principles into frontline practice. Evaluation has highlighted that management of risk is still an area for development and has indicated that there is insufficient attention given to the MCA on professional courses preparing people for work with vulnerable adults. There is evidence to suggest the wishes of people who lack capacity are not always given sufficient weight if these are considered ‘risky’. Similarly, their past wishes and beliefs may not be given full consideration. There can be a tendency for professionals to be ‘risk adverse. There are insufficient powers contained in the MCA to deal with abusive families who may be inappropriately restricting or restraining a vulnerable adult in their own home.

5 Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

The implementation of the Act by professionals appears to be variable. The council has identified potential gaps in hospital settings around understanding of the best interests principles with regards serious medical treatment and the use of restraint. The local evaluation suggests there continues to be a belief in health settings that doctors are the professionals who should be assessing mental capacity and making decisions on behalf of patients who lack capacity. This in turn may lead to hasty decisions, driven by time factors are not always robust. We are looking at putting in place Audits to monitor the situation and providing assurance as to how well the MCA is embedded in practice.

Some of the banks, building societies, utility companies and debt agencies have a limited understanding of mental capacity, and sometimes ask to speak with the individual who lacks capacity in order to obtain their permission to speak with a court appointed deputy.

6. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers?

Public profile of the MCA has increased, however, most customers and their families have a very limited understanding of mental capacity and best interests. The reasons for this include class and language, and cultural expectations each of which has an influence of individuals understanding. Transition – children to adults- is a particular challenge, parents often assume that they will continue to have the same role with a young adult who lacks capacity as with a child.

7. Has the Act ushered in the expected, or any, change in the culture of care?

There is an increased awareness of the importance of enabling vulnerable adults to make their own decisions. Some effective, creative outcomes are evident in the way that support is planned and delivered. However there are a number of recent cases that have shown that decision making for individuals with very complex needs eg. brain injury can be compartmentalised thus failing to see the holistic needs of the individual. As a result it can be argued the benefits may be limited, and fail to incorporate best interests principles.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Problems with communicating with the individual have also been noted. Despite the advances in technology the use of IT communication aids are limited. As a result people with severe communication problems are unable to contribute to the decision making process as much as would be expected.

8. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

There is some evidence to support the fact that there is a variation in the way the Act is used across some groups. For example Older people are more likely to be subject to DOLS, and analysis points to the fact that this may be due to a perception there are limited age related resources for creative care plans. Expectations of staff and carers about what can and should be provided for older service users are sometimes lower than for other groups. In contrast providers working with customers with learning disabilities are often able to avoid depriving them of their liberty by the use of creative, user centred care plans.

9. Has the MCA fostered appropriate involvement of carers and families in decision-making?

In Newham we have good evidence of involving families at all stages of decision making for people who lack capacity. At times when dealing with complex and challenging cases practitioners need support in decision making. There needs to be clarity about what is in the best interest of the service user who lacks capacity when family members have different views to professionals. Carers struggle to understand MCA processes at times. The MCA needs more publicity, provision of straightforward booklets etc.

10. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

The role of the IMCA has succeeded in providing a voice, giving an independent view of the facts and suggesting alternatives. This has been useful especially in relation to decisions about accommodation.

However, the issue of consistency in practice needs to be addressed. There continues to be a variable understanding of the IMCA role, particularly in respect of the safeguarding process. In Newham we are addressing this through workshops and training sessions. IMCAs vary in their ability to challenge professionals’ decisions. In terms of feedback to the House of Lords it is the view of the council, based on our experience that the IMCA remit is too narrow – it would be appropriate to extend this to ‘serious decisions’.

11. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

There are some parallels with question 10 above. There are concerns that although many IMCAs are extremely competent, some do not have the skills and training to understand the range of disabilities they encounter eg. acute mental illness. In Newham we are addressing this in contract monitoring meetings. IMCAs are offered places on BIA/ DOLS refresher courses. They also attend the regular MCA forum

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Deprivation of Liberty Safeguards

12. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

The process in Newham does provide safeguards to protect the subject of a DoLs request. A referral for a deprivation of liberty authorisation will result in a full and independent assessment of a service user’s care plan and an examination of whether any restrictions imposed are in the individual’s best interests. Feedback from care homes and hospital settings indicate that this ‘fresh look’ at residents who may be presenting with challenging behaviour is usually welcomed and can provide a basis for understanding and explaining restrictive care plans. The use of conditions and short authorisations has seen appropriate adjustments and creative approaches to care plans which mean that DOLS authorisations are no longer needed. However, for complex DOLS referrals the process remains poorly understood amongst many providers. There is little ‘pro-active’ commissioning of DOLS with provider managers anticipating in advance that a DOLS authorisation is likely to be required.

There is broad agreement that the deprivation of liberty safeguards should be extended to supported living settings.

13. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

The processes are still bedding in and there are some identified issues that need to be addressed. As stated previously the current MCA deprivation of liberty safeguards do not give a clear definition as to what constitutes a deprivation of liberty. In addition case law precedent requires regular reviews of our processes and understanding. BIAs in Newham receive regular legal updates and have revised their understanding of the point at which restraint becomes a deprivation of liberty in the light of the Cheshire West case. It would be helpful to include a clear definition of deprivation of liberty in the legislation and the Code of Practice. Evidence gained through implementation to date has highlighted that the reassessment process can be distressing for some service users, as can giving them all the reports. The review process doesn’t always address disagreements to the satisfaction of the service user and their family. It is our view that a tribunal style panel may be a preferred option in the future.

In a similar vein it is our view that the current DOLS forms would benefit from a number of amendments. The mental capacity form should have four sections – one for each of the functional areas. The forms 10, 5 and 8, plus 6 and 9 should be combined ie one form per assessor. Form 10 is repetitive – sections D7 and D8 should be combined.

There should be longer time scales for urgent authorisations. It is very difficult to complete the process within 7 days - many cases are complex and challenging.

The Court of Protection and the Office of the Public Guardian

14. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The lengthy wait for a Court of Protection hearing is unacceptable. Families do not understand the process. An enhanced Review Panel for unresolved or disputed MCA/DOLS cases would be preferable.

At present only doctors and psychologists complete the COP 3, mental capacity assessment. In line with the MCA it would be appropriate for the Court to accept COP 3s from other professionals able to demonstrate that they have been trained and competent in this area eg. best interests assessors.

The client affairs service in Newham has observed an improvement in the Court of Protection and their processing times. However, their systems would improve with the introduction of modern technology. Concerns remain about the number of applications and notifications submitted but apparently not received by the Court of Protection. In the past there was a fast track team for local authorities. There were assurances that there would be another team similar to the one under the old receivership regime. This has not materialised. It would be helpful to have a portal developed where Court of Protection applications can be submitted electronically. This would save time and reduce the number of lost applications.

A portal should also be developed where OPG 102s can be sent electronically. Payments to the Office of the Public Guardian are made by cheque as there is no method of paying supervision fees electronically.

The Office of the Public Guardian should not wait a full year to intervene on a complaint made about a new LPA or Deputyship. They should be able to randomly ask for accounts if they believe that the individual may be at risk of financial abuse. In some cases it may be identified that the lay Deputy needs additional support.

15. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

Take up of LPAs for health and welfare has been less than expected in this area. A workshop for service users and carers, where LPAs will be on the agenda, is planned for the Autumn. Newham is seeing an increase in LPAs for property and finance. Although LPAs usually have a positive impact, relatives’ motives for encouraging their family members to appoint them as attorneys can be complex. There have been concerns that the OPG is slow to intervene when attorneys are identified as not acting in the service users’ best interests.

Regulation

16. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

CQC has had an impact on organisations. It has been noted that care homes have strengthened their approach to the MCA. Concerns regarding possible deprivations of liberty appear to be highlighted during CQC inspections. Newham has received several DOLS requests from care homes following CQC visits to their units. CQC should give greater emphasis to the MCA in their inspections of NHS establishments.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
17. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

All professional competencies should reflect understanding and implementation of the MCA.

**Other legislation**

18. How well is the relationship with the mental health system and legislation understood in practice?

Some mental health professionals struggle to include full consideration of the MCA in their practice. The DOLS eligibility criteria are cumbersome and fail to reflect the complex situation of some hospital patients. Greater clarity on the use of section 135 in taking vulnerable individuals to alternative places of safety eg care homes would be useful.

5 September 2013
London MCA/ DoLS Network – Written evidence

Summary to the Response

The London MCA / DoLS Network meeting members considers the Mental Capacity Act 2005 (MCA) to be a brilliant piece of legislation and members believe it is achieving its aims. It has made a big impact relating to positive risk taking and often the Deprivation of Liberty Safeguards (DoLS) process has addressed issues of inequality and enabled more people to continue living in the community. Network members have found that the knowledge of professionals in health and care settings was improving with time. Unpaid carers and family members were often not very aware of the law. However more can be done to raise public awareness of this Act. This could empower people and carers who care for those that may lose mental capacity in the future.

DoLS was seen through the feedback to be the belt and braces of care and it acts as a check on providers, in the time of national awareness where quality care issues are vital. Members are convinced that the DoLS help keep people safe and help to prevent some individuals from premature death. Albeit that DoLS is perceived to have a major impact on resources, it is often the complex health and the requirement for appropriate specialist care provision, which is having the most profound impact.

The main change that the network would prefer is to simplify the DoLS system, by combining and reducing the forms. The supplementary DoLS Code of Practice should also be amended in light of all the case law that has developed practice over the past 5 years. The Network also advocates that Urgent DoLS should also be automatically issued for at least 7 working days, to allow six assessments on each case and give service users the best opportunity to fully participate in the assessment. This would enable professionals to consider all the person’s circumstances before conclusions are reached about their future care and safety needs. Network members advocated for a process where unresolved cases can be reviewed and ideally resolved, rather than going to the Court of Protection. The Court of Protection (COP) is considered too far removed from the average citizen and people do not necessarily want to bother a court with decision making, even when it would be in their best interests. The law needs to be amended to allow more flexible use of IMCAs, even when a person is befriended. The Network would like RPRs / IMCAs to be involved in all DoLS cases, irrespective of whether the person has family or friends, in order for the person to be well supported during the period of deprivation of liberty.

The CQC as regulator has helped to raise the profile of the MCA and providers are taking it more seriously. The Network would welcome CQC to give greater emphasis to the MCA in their inspections of NHS and health establishments. The regulatory role is vital given that inspecting officers promote better choice for service users, prompts better recording and stimulates DoLS applications.

Overview and context

1 To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1.1 The London MCA / DoLS Network meeting considers the MCA 2005 to be a brilliant piece of legislation and it is achieving its aims. It has made a big impact relating to

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
positive risk taking and often the Deprivation of Liberty Safeguards process has addressed issues of inequality and enabled more people to continue living in the community and to go home following a period of care in a care home or short DoLS. This has been more evident following the Steven Neary case. Case Law has made people pay attention to the law. It was found that where the LA has a culture of promoting human rights, then MCA, DoLS and Supervisory Bodies can be a powerful instrument to keep people safe. CQC have helped to promote the human rights and safety of service users in hospitals and care homes.

1.2 Often people with high care needs require specialist and costly placements and care arrangements. DoLS is an investment to ensure appropriate care and human rights for people with severe underlying mental and physical illness. The underlying health circumstances of service users have the biggest impact on resources. To ensure health and care providers do what they ought to do for those people, the system of independent assessments providing safeguards is important. DoLS is often used as the belt and braces of care and the safeguard acts as a check on providers.

1.3 In practice terms, the implementation and impact has been variable. Universities and Hospital Trusts were slow to embed the legislation in their practice and slow to ensure it ran across vocational training provision service delivery; but this has improved over time. The London Network considered that a public awareness campaign from Central Government would help bring the message across about the MCA and impact on how people can plan for their future, if they were ever to lack mental capacity. Resources remain at the heart of good practice and more is needed to implement it properly. The Code of Practice is fantastic, but members were concerned that the original DoH information booklets had been archived and were no longer easily accessible.

2 Which areas of the Act, if any, require amendment; and how?

2.1 An Urgent DoLS application should be granted automatically for 7 working days. The current 7 calendar days makes it virtually impossible to collect all of the relevant information, manage the required six assessments and allow two or three professionals (including IMCA) to meet with the person and family. Once completed, all assessments and information must be fully considered for the service users future care arrangements and safety. It was suggested that the Act or Code should include definitions of Deprivation of Liberty Safeguard and Serious medical treatment.

2.2 The Network felt the need for a process where unresolved cases can be reviewed and ideally resolved, rather than going to the Court of Protection. The law needs to be amended to allow more flexible use of IMCAs, even when a person is befriended.

2.3 A few Network members considered it appropriate for the DoLS to include Extra Care Sheltered accommodation schemes. A number of Extra Care Supported Living Schemes hardly differ from residential care as they provide one to one care and have care regimes that would be considered as meeting the criteria for DoLS. This would enable supervisory bodies to include such care schemes in DoLS and would make it easier than having those cases decided in the Court of Protection.

2.4 With regards to Section 44 of the MCA London Network members were concerned that it was poorly written and led to few prosecutions. Legislation was mainly being used in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
against frontline staff, who work unsupported and in difficult circumstances. Members said this section of the act should be extended to consider corporate responsibility in terms of neglect and extend to health and care providers and not just individuals.

3 At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

3.1 The members of the London MCA/DOLS Network believe the principles and definitions are very good and appropriate. Health colleagues identified that there remains a lack of clarity as to who is the decision maker. For example, where a medical procedure is planned in the community, referred by a GP, seen in a screening clinic or the person attends a pre-op appointment, before finally being seen by the Consultant – it is not clear whose responsibility it is to assess capacity, to carry out the Best Interests decision and who will undertake the procedure.

3.2 It was noticed that a number of professionals who carry out mental capacity assessments, quote the first principle of the Act and may prematurely conclude that the person has mental capacity. There is a risk that some professionals consider someone who agrees with the care or treatment to have mental capacity and someone who disagrees, may be deemed to lack mental capacity.

Implementation

4 To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

4.1 The Network considered the implementation of the MCA is patchy and varies from sector to sector. Some members are concerned that there are ‘risk averse’ practitioners and that the wishes of people who lack capacity are not always given sufficient weight, if these are considered ‘risky’.

4.2 Colleagues have found that people in mental health services know least about the Act and just focus on the Mental Health Act, thinking that it covers all eventualities for their service users. Happily, awareness is growing.

4.3 Social workers reported difficulties to network members when trying to transfer a person from their home to hospital or a care home, as police and ambulance services may not feel confident to convey the person under the MCA. Some police services have requested that a warrant is sought under the Mental Health Act, before they are willing to attend to the scene.

4.4 There is a balance between enablement and positive risk taking. The MCA is being used to empower people who have difficulty with decision-making and more people are enabled to stay or return to the community with enhanced care and positive risk taking.

5 How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
5.1 The implementation networks, in London and elsewhere were useful and helped to promote practical application of the law. DoH booklets and information was useful, albeit that some literature has been archived and is now no longer easily accessible. London Network Members reported that local authority Social Care staff had more of an understanding of the legislation than other professionals involved in a person’s care. There is still a need for on-going training as indicated by the low rates of referrals to IMCA services and the outcome of recent Court of Protection cases. The London Network advocates for a national public awareness campaign.

5.1 Many people are completely unaware of the DOL safeguards and Best Interest Assessors have to constantly explain the law to the person and their family members. Local Authorities, Health Trusts and CCGs need to continue to do what they can to raise awareness. However, as resources diminish and grants are no longer ring-fenced, experts are moving away from this specialist area of work. This has reduced the likelihood of sustainable change.

6 Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

6.1 The Act is increasingly known and understood by professional groups and people know more now than when the Act was first introduced. The London Network proposes that there needs to be a targeted campaign at health professionals and clinicians in particular. Many Doctors are of the belief that they are inherently working in the Service users ‘Best Interests’ without having to consider the MCA. In acute medical services some doctors consider Best Interest decisions will cause patients to be delayed in hospital longer than is medically necessary. A number of professionals still think they know best, without truly listening to the person and consulting with their family or friends. IMCAs are still not fully consulted for Serious Medical Treatment decisions. Some professionals do not understand that they are acting unlawfully by not involving them in such circumstances.

6.2 Some Boroughs considered the knowledge of the MCA poor in Mental Health settings.

Banks have been quite responsive to safeguard people from financial abuse, but only when local authorities have alerted them to concerns about someone lacking mental capacity. They rarely initiate communication or share information and seem reluctant to participate in Safeguarding Adults Processes by attending meetings or sending reports.

7 Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance been struck between protection of the carer and protection of the individual lacking capacity?

7.1 Knowledge about the Act is growing, but the London Network does not consider it to be widely understood. Most people affected by it are unable to understand it, due to the nature of their illness and impairment. The Act has not been around long enough to have permeated the long term memory of the individuals that may be affected by it, or some
may have been more aware, given that a number of people have problems with their short term memory.

7.2 Although the public profile of the MCA has increased, most service users and their families have limited understanding of it. Class and language has a role here. A particular challenge is the transition services for children with mental impairments who were receiving care, prior to them becoming adults. Parents often assume that they, the parents, will continue to have the same decision making role with a young adult who lacks capacity, as with a child. Also, unpaid carers (and we would not use the term non-professional carers – some of them are highly qualified, albeit not in the care profession) get quite concerned when they realize that they cannot make certain decisions regarding the person they care for. Most believe that they know best and often do not separate their own wants or needs from the person they are caring for.

7.3 Professionals are still sometimes making decisions on their own, rather than consulting with the person’s friends and family or IMCAs, especially concerning serious medical treatment decisions. Pro-active carers are applying to be court deputies for most decisions and this is proving costly and time consuming for the carer. Time constraints often add to the pressure for professionals and force them to make decisions hastily. With increasing financial pressures on the care system, specialist services and care options for people who lack mental capacity are decreasing.

8 Has the Act ushered in the expected, or any, change in the culture of care?

8.1 Some London Network members said that the Mental Capacity Act has helped to guide professional practice. People are now more empowered and their wishes and feelings are considered before any decisions made, so there has been a shift away from the culture of ‘professionals know best’. There is a level of concern over the practice of some professionals and London network members were still unclear as to how far the MCA was embedded in professionals’ training. Members agreed that the Act, and the DoLS in particular, has helped to facilitate positive risk taking and resulted in some people returning to live successfully in the community.

9 Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

9.1 The Forum considered Young Peoples’ services for 16 – 18 years old a particular concern, as Children and Young peoples’ service are often ill informed regarding the MCA. There seems to be a trend that more young people are being detained under the Mental Health Act.

9.2 In multi-cultural London, professionals may not always make use of interpreting services to communicate well with people who are likely to lack mental capacity, given the many decisions that may be needed. Such services are often costly and take time to coordinate.

9.3 Older people were often over-represented in the DoLS; many having few or no opportunity to go out, especially if they did not have family members / friends to take them on outings. Even making use of care home gardens is rarely possible due to low staffing levels. This means that people never have an opportunity to go outside. DoLS has often in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
sought to address the gross inequality in the care of older people, who have reduced care packages, compared with younger people with learning disabilities.

## Decision-making

10 Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

10.1 This law has brought power and control back to people with mental impairments, and enables them to participate more in decision-making processes. Best Interests processes and the more independent DoLS process has led to the person, their family members, friends & IMCAs being consulted before decisions are taken. More people are subsequently being discharged from care homes and given other care opportunities in the community.

10.2 When someone is officially appointed to make certain decisions, it reduces the time that professionals have to grapple and weigh options in order to make best interest decisions. In an ideal world LPAs and deputyships ensure better decisions. It is rare that problems occur that lead to serious safeguarding procedures and to the Court of Protection being asked to intervene.

10.3 There seems to be a big difference between the decisions taken by local authorities and the Court of Protection. Decisions taken by authorities are more inclined to aim to protect people, while the Court of Protection is encouraging high risk taking by discharging service users into the care of people who have not always managed the person’s care needs well. The recent Cheshire and Chester West case in DoLS had a major impact on services where the focus was the deprivation of liberty of the person concerned, rather than their safety.

10.4 The view in London is that people are consulted more in medical decisions and the person’s wishes and feelings considered before decisions are made. Most people and professionals find the different types of LPAs confusing, in that they think Financial LPAs can make health and welfare decisions. Professionals are rarely confident to conduct the appropriate checks on family members who claim they have the appropriate type of LPA. Professionals do not feel confident to ask for the court registered documents and are unlikely to contact the Office of the Public Guardian (OPG) to check if the LPA is registered with the Court as the process is time consuming.

10.5 The Network considered middle class families to have a better understanding of LPAs for Finance whereas people of minority ethnic groups are least aware. Some health services noticed that LPAs for finance were viewed as expensive to set up and that parents with adult children prefer setting up joint bank accounts with a view to achieve the same aim.

10.6 LPAs for health and welfare are an important part of palliative care, but less useful in other areas. The roles of General Practitioners in such cases are often vital, but absent. The London Forum is keen for GPs to play a much more active role to raise awareness with individuals who may have difficulty with decision-making in the future. GPs also need to discuss such options, with the person’s family and carers.

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11 What evidence is there that advance decisions to refuse treatment are being made and followed?

11.1 London Network members considered that advanced decisions are very much embedded in most health settings, but more still needs to be done. When a person is admitted to hospital, clinicians may not be aware of decisions the person made in the community and fail to check with the person’s GP. People should be reminded more often about the possibility to make and record advanced decisions and GPs should raise awareness in primary health care settings. The Network said the awareness of advanced decisions should be as public as flu jab campaigns.

12 Has the MCA fostered appropriate involvement of carers and families in decision-making?

12.1 Carers and Families are now much more part of decision-making in health and social care settings. The London Network unanimously thinks that most people want their family members and friends to be consulted. However they prefer that the clinician makes the decision, rather than overburden their loved ones.

12.2 It seems that people rarely opt for LPAs or advanced decisions. In general people believe that professionals will make best interest decisions for them, as no one can predict all future circumstances.

13 Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

13.1 IMCAs & paid RPRs are the real Safeguard for people, as they are more independent than the decision maker. It was felt the remit of the IMCA in most decisions were too restrictive. A more flexible approach in accessing IMCAs would be beneficial, even when the person is befriended. Some people may have family members who live far away and who are unable to see the person’s current circumstances in relation to the decisions which have to be made. IMCAs would be often best placed to see the person and liaise with family members.

13.3 Sometimes there are concerns regarding a family member’s motivation/ involvement. These may not meet the threshold for a Safeguarding Investigation, yet some IMCA providers are reluctant to engage in the case. Some IMCA providers have addressed this issue by providing general advocacy outside of the IMCA provisions.

13.4 The London Network would like RPRs / IMCAs to be involved in all DoLS cases, irrespective of whether the person has family or friends, in order for the person to be well supported during the period of detention. The London wide view was that IMCAs should be better empowered to challenge decision makers and to advocate sufficiently for any objecting party to access the Court of Protection.

14 Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
14.1 Overall IMCA referral levels have met the expectations across London, albeit that some South London Authorities said they were concerned with low referral levels. Regional variations may be a result of people having closer relationships with friends and families with whom professionals can consult, without the need for an IMCA.

14.2 Following case law such as the Steven Neary Case and Manchester City Council failing to identify a DoLS, some boroughs wish to amend their practice and involve an IMCA in most cases. Having an IMCA involved in all DoLS cases seems to be best practice, rather than restricting them to the criteria outlined within the law, e.g. where they are unbefriended.

14.3 There seems a disproportionately low level of IMCA consultation for the category of serious medical treatment decisions and some medical staff may be acting unlawfully by not consulting with IMCAs. They are likely to feel that instructing an IMCA may delay the medical treatment to be given or withdrawn.

15 Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

15.1 IMCAs and RPRs have been the main Safeguard, not only for the service user, but they help keep professionals in check. Some boroughs felt strongly that IMCAs did not always adequately support the detained person to apply to the court of protection to have their objections heard.

15.2 IMCA provision has been responsive with local providers. As contracts grow larger and other services are added, such as Independent Mental Health Advocates (IMHA) provision, there is a concern that IMCA service provision may fall short of the high standards expected by the MCA. Some members considered that services should be procured on a national basis. IMCAs not connected to supervisory bodies would be better placed to challenge cases.

Deprivation of Liberty Safeguards

16 Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

16.1 The London MCA Network members mostly agreed that the DoLS help keep people safe, helps promote their rights and prevents them from early death. People with high care needs often require specialist placements and care. The DoLS ensures that the person’s needs are better met. DoLS provides independent expertise and acts as the belt and braces in care provision.

16.2 It was found that where the LA has a culture of promoting human rights, then Supervisory Bodies can be instrumental to keep people safe. The DOL safeguards allow Supervisory Bodies to check what quality of care is being provided. These Safeguards also highlight which managing authorities provide substandard care.

16.3 DoLS may be an expensive system to run, but the benefits to service users outweigh the cost of the service. DoLS is often needed for people with severe impairment and serious illness. Meeting these needs well, have the highest impact on
financial resources as specialist placements and care provision is extremely expensive. The DoLS are only as good as the underlying care planning and practice. Keeping DoLS as an independent process from care providers is an additional check on what care providers do.

16.4 Two representatives from a Mental Health Trust want DoLS to be scrapped. They wish to see the Mental Health Act amended to detain people in their best interests. They believe DoLS is too complex and onerous.

17 Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

17.1 The London Network members agreed unanimously that the DoLS process is over-bureaucratic. There are ways in which it can be simplified, especially if the official forms could be reviewed. There are approximately 38 forms many of which appeared to request duplicate information. It was felt that some forms could be combined and replaced with a single form. For example the Eligibility Assessment, Mental Health Assessment and Mental Capacity Assessment could all be combined on one form, instead of three separate forms. Some free text space would be best, on Form 10, for BIAs to provide a background summary of information about the person.

17.2 Most members want the DoLS Code of Practice updated, in line with the case law that shaped DoLS practice over the past 4 years. The law must be updated to include a clear definition of what constitutes a deprivation of liberty. The tight legal timescale of 7 calendar days for an urgent application is too short. It provides too little time for all the person’s circumstances to be assessed, for family members and IMCAs to be fully consulted, their views considered, reports to be produced and available for signatories to agree or decline the detention. Managing the DOLS service is particularly difficult when there are bank holidays, especially in instances where the service users are placed out of borough. Other boroughs are rarely able to assist in the assessments.

17.3 Some members said the re-assessment process and sharing reports with the relevant person can be distressing for them. A DoLS authorisation cannot be extended and a new application would be required if a longer detention was needed.

17.4 Reviews are often not very helpful to challenge DoLS. The review process can take longer than the period for which the detention was initially granted. The London Network advocates for an enhanced review panel, where unresolved cases can be brought, rather than going straight to the Court of Protection. The Court is considered too far removed from the people and an enhanced review panel would be a better option before considering an application to the Court.

The Court of Protection and the Office of the Public Guardian

18 Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

18.1 The London Network members thought the Court of Protection (CoP) is too far removed from the people and long delays with court cases were unacceptable. The average citizen does not necessarily want to bother a court with decision making, even in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
when it would be in their best interests. Awareness raising and leaflets produced by the OPG and DOH were helpful in the past. The CoP should have awareness raising material about their services that could be given to service users.

18.2 It is very expensive for local authorities (LAs) to approach the CoP in cases of disputes. LAs would prefer to spend money on service users’ care, rather than approach the CoP in individual cases.

19 What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

19.1 Although LPAs give people the opportunity to make decisions for when they lack mental capacity, there are few people with LPAs in place. The fact that there are two different types of LPAs is confusing.

19.2 Professionals are rarely confident to ask questions and check the validity of the LPA. Family members often refer to being a ‘Power of Attorney’ and they think that this enables them to make all decisions on the person’s behalf.

19.3 BIAs think that most people want their family members and friends to be consulted before decisions are made. However people tend to prefer professionals to make decisions, rather than giving their family or friends the responsibilities of an LPA. It is likely that as time passes and future generations become more aware of the Act, that people will want more control of their future and LPAs may be more popular.

20 What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

20.1 A number of people, especially unpaid carers are concerned with the application costs of LPAs. Most advice offered about LPAs is provided by solicitors. Given that applications are made to the court most people think they should make use of a solicitor’s services. The general public may be unaware that they can complete the forms themselves and apply to the Office of the Public Guardian. Unpaid carers have mentioned that the application fees are steep and they are also concerned that the CoP is not always accessible to all.

20.2 Completing the application forms are also complex and time consuming. Many people think they should only be approaching a court if someone has done something wrong.

21 Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

21.1 We have insufficient knowledge of this and therefore not in a position to answer this question.
17 Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

17.1 The Care Quality Commission (CQC) have helped to raise the profile of the MCA and providers are taking it more seriously. The London Network would welcome CQC to give greater emphasis to the MCA in their inspections of NHS establishments, including numbers and types of IMCA referrals. The regulatory role is vital given that inspecting officers promote better choice for service users, prompts better recording and stimulates DoLS applications.

17.2 Some members were concerned that a number of CQC inspectors do not fully understand their role and that the DoLS applications recommended are not always appropriate. In London some care homes have requested DoLS for all their residents when CQC have visited, which is almost always inappropriate. Specialist training for inspectors on the subject of DoLS may help to address this. CQC should inspect outcomes relating to medication and safeguarding from abuse, on every visit they make.

17.3 It would be beneficial for CQC inspectors to be able to raise a DoLS application themselves, like they do with Safeguarding Alerts. Compliance actions should be issued for providers that do not comply with conditions set on a service user’s DoLS. CQC inspectors should observe the person and check the care provided against their care plan.

23 Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

23.1 Local authorities are doing what they can to check whether their local services adhere to the MCA. Most London colleagues reported that having locally trained BIAs who act as professional practice leads, helps to identify where practice is poor and where DoLS applications are needed. Some boroughs are using soft intelligence collected on DoLS visits to steer Establishment Concerns processes. Their input helps to identify substandard care in care homes and the occasional hospital.

23.2 Healthwatch and carers’ groups should be given more powers to help regulate services. Although self-assessments are useful, audits are the best way of checking that the MCA is embedded in practice.

Other legislation

24 How well is the relationship with the mental health system and legislation understood in practice?

24.1 The members considered the interface with other legislation was complicated. Most London Network members identified problems with the eligibility assessment. The criteria for the Eligibility Assessment that seeks to address the overlap between the MCA and MHA, is far too complex. There needs to be a simpler process where, failing the criteria of one law, there is a provision for a seamless assessment under the other.
24.2 Some members identified cases where persons were assessed and found ineligible by both the MHA and MCA DoLS processes. This left professionals confused and perplexed about how to manage the safety of the person. Some members were of the opinion that the Mental Health Act needed to be rewritten to integrate the two laws within the existing systems of the MHA. This may help to manage the pressures around the DoLS process and timescales better. Some members considered that DoLS sits correctly within the MCA, which has a different ethos from the MHA.

**Devolved administrations and the international context**

23 Does the implementation of the Mental Capacity Act differ significantly in Wales?

We have insufficient knowledge of this and therefore not in a position to answer this question.

24 What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

We have insufficient knowledge of this and therefore not in a position to answer this question.

25 Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

We have insufficient knowledge of this and therefore not in a position to answer this question.

2 September 2013
Dr Stephen J. Louw, Professor Julian Hughes, Professor John Bond, Dr Helen Greener, Marie Poole, Professor Louise Robinson and Charlotte Emmett – Written evidence

Submission to be found under Professor Julian Hughes in Volume 1.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Aisha Lowry – Written evidence

As the parent of son who is mentally disabled for whom I am a deputy through the Court of Protection. I should like to make the simple point that although the Court rightly requires the best quality of care and the acting in best interests at all times without quality provision and the proper funding of services by LA’s this is almost impossible to achieve.

Aisha Lowry

6 August 2013
1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The preamble to the Act

The preamble to the Mental Capacity Act 2005 states that its express purposes are:

1. to make new provision relating to persons who lack capacity;
2. to establish a superior court of record called the Court of Protection in place of the office of the Supreme Court called by that name; and

The Act has achieved its aims in (1) making new provision for persons who lack capacity, and (2) establishing a superior court of record called the Court of Protection, but it has not fully achieved the third aim for the following reason.

The Hague Convention of 13 January 2000

Although the Hague Convention of 13 January 2000 has been ratified by the United Kingdom Government in respect of Scotland, it has not yet been ratified in respect of England and Wales. The broad thrust of the Convention forms part of the domestic law of England and Wales by virtue of section 63 of and Schedule 3 to the Mental Capacity Act 2005, both of which came into force on 1 October 2007. However, paragraphs 15, 25, 31, and 32 of Schedule 3 anticipate further action, both legislative and otherwise, before the Convention can be fully functional, and no such regulations, rules or Orders in Council have been made. These paragraphs provide as follows:

15 Regulations may provide for Schedule 1 (lasting powers of attorney: formalities)

...to apply with modifications in relation to a lasting power which comes within paragraph 13(6)(c) above.

25 Court of Protection Rules may make provision about an application under paragraph 20 or 22.

31 Her Majesty may by Order in Council confer on the Lord Chancellor, the court

...or another public authority functions for enabling the Convention to be given effect in England and Wales.

32(1) Regulations may make provision (a) giving further effect to the Convention, or (b) otherwise about the private international law of England and Wales in

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relation to
the protection of adults.

In addition, Article 38 of the Hague Convention envisages that each contracting state shall designate an authority that is competent to draw up a certificate indicating the capacity in which a person is entitled to act and the powers conferred on them. This has not yet been done in respect of England and Wales, although, as a default position, the MCA 2005, Sch 3, para 6(1) provides that “any function under the Convention of a Central Authority is exercisable in England and Wales by the Lord Chancellor.”

The pre-legislative Scrutiny Committee’s report

Looking at the aims of the Act from a broader perspective, when the House of Lords and House of Commons Joint Committee on the Draft Mental Incapacity Bill reported on 28 November 2003, it suggested, at volume 1, at paragraph 28, that the purposes of the Bill were:

(1) to remedy the inadequacies of the existing common law,
(2) to promote awareness and good practice in dealing with persons lacking capacity;
(3) to fulfil human rights obligations towards persons lacking capacity;
(4) to promote non-discrimination; and
(5) to achieve a better balance between autonomy and protection for people who are unable to make their own decisions.

The principal ‘inadequacy of the exiting common law’ that the Bill sought to remedy was the lacuna that had arisen as a result of the implementation of the Mental Health Act 1959, whereby the parens patriae jurisdiction had ceased to exist for adults lacking capacity, and as a temporary expedient the Family Division of the High Court had developed a declaratory jurisdiction in health and welfare matters to plug the gap. The Mental Capacity Act has certainly achieved this aim and there has been an interesting spin-off.

The residual inherent jurisdiction of the High Court

Now that the ‘inherent jurisdiction’ of the High Court over incapacitated adults no longer exists, because it has been replaced by a statutory jurisdiction, a line of authorities has emerged over the extent to which the High Court still has a ‘residual inherent jurisdiction’ over adults who do not technically lack capacity, but nevertheless are vulnerable because they unable to make a true choice. This line of authorities was considered in DL v A Local Authority and Others [2012] COPLR 504; [2012] EWCA Civ 253, where the Court of Appeal held that:

(a) The inherent jurisdiction as described in Re SA (Vulnerable Adult with Capacity: Marriage) [2005] EWHC 2942 (Fam) had survived the coming into force of the Mental Capacity Act 2005.

(b) It may be invoked in respect of individuals who do not lack capacity but who are:

(i) under constraint;
(ii) subject to coercion or undue influence; or

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
(iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice or incapacitated or disabled from giving or expressing a real and genuine consent.

(c) The aim of the inherent jurisdiction is to enhance or liberate the autonomy of the vulnerable adult. Its use is compatible with Article 8 of the European Convention on Human Rights and any orders made must be both necessary and proportionate.

(d) The court’s powers extend beyond simply giving vulnerable individuals the ‘space’ to make decisions for themselves, but should be exercised in a facilitative, rather than dictatorial, manner.

Promoting awareness and good practice

The second purpose of the legislation identified by the Pre-legislative Scrutiny Committee was “the need to promote awareness and good practice in dealing with those lacking capacity.” Essentially, this is the function of the Mental Capacity Act 2005 Code of Practice, for which provision is made in sections 42 and 43 of the Act.

Making Best Interests Decisions

In January 2012 the Mental Health Foundation, in association with the Norah Fry Research Centre at Bristol University and the Centre for Applied Social Research at the University of Bradford, published Making Best Interests Decisions: People and Processes, which analysed the results of the first in-depth national investigation into best interests’ decision-making. The study was funded by the Department of Health.

The research team collected information about 385 best interests decisions made in four areas of England with an online survey of professionals and workers involved in making the decisions. The purpose of the study was to find out:

(a) how best interests decisions are being made.
(b) how far the Mental Capacity Act 2005 Code of Practice is followed.
(c) how helpful the Code of Practice is in real life situations.

The conclusions drawn from Making Best Interests Decisions were set out on page 7 of the lay summary as follows:

“The Mental Capacity Act gives health and social care workers a legal basis for acting when someone cannot make a decision for themselves. The research looked at the range of best interests decisions being made and the prompts to this happening, such as changes in someone’s health or the need to protect someone from harm. It also found that one decision often requires others to be made and these may need to be managed quite differently.

Identifying that the person was unable to make a decision by assessing their capacity was a concern for all the professionals in this research, although most were following the Code of Practice. We found a significant minority of best interests decisions being made for people who had either been shown to have capacity, could be supported to make decisions with help, or who had been wrongly assessed as lacking capacity. There are particular concerns in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
about the use of ineligible criteria for determining capacity in some dementia services. More clarity about key issues such as ‘unwise’ decision-making and ‘insight’ might help address some of these problems. Similarly there was some confusion about when an authorisation for DOLS should be sought.

The research has shown that there are different ways of making best interests decisions and roles that have emerged to make the process work. While these do not breach the spirit of the Code of Practice they are not currently reflected in the training and guidance that is available to health and social care workers. We found that generally the right people are involved in decision-making, although there was some confusion about the role that IMCAs play, and we heard about good practice in involving people who lack capacity in the decision making process.

Successful outcomes flowed from most of the best interests decisions we looked at, but there were delays in putting them into action in a small number of cases. Workers were also faced with dilemmas about balancing the autonomy of people who lack capacity with the need to ensure their safety and the wider needs of their family.”

The Code of Practice: attorneys and deputies

Making Best Interests Decisions focussed solely on decision-making by health and social care workers, where professional standards generally apply. The Mental Capacity Act 2005 Code of Practice also applies to (a) the donee of a lasting power of attorney (‘LPA’), and (b) a deputy appointed by the Court of Protection, who have a duty to have regard to it when acting in relation to a person who lacks capacity.

Arguably, the requirement that they should have regard to the Code of Practice applies a fortiori to attorneys and deputies, because they are respectively the first and second categories in a list of six groups of persons upon who this duty is imposed by section 42(4) of the Mental Capacity Act 2005.

We are talking about a large number of people. In 2012 the Office of the Public Guardian registered 242,000 LPAs (OPG Annual Report 2012/13, page 5) and the Court of Protection appointed 12,664 deputies (see the statistics in response to question 18 below).

I speak from my own experience that, time after time, particularly in financial abuse cases, attorneys and deputies show a distinct lack of knowledge of the Code of Practice. Most attorneys and deputies are unaware that it exists. Very few have a copy of it or have downloaded it from the Internet and, even if they do have a copy, fewer still have read it or applied it in practice. Almost none of them are interested.

The following extract is taken from a decision of mine in Re Buckley [2013] COPLR 39, which involved the financial abuse of Miss Buckley, who was the donor of a Lasting Power of Attorney for property and financial affairs, by her niece.

“The final point is one that has been made in the past, but needs to be repeated. Attorneys should be aware of the law regarding their role and responsibilities. Ignorance is no excuse. I am not suggesting that attorneys should be able to pass an examination on the provisions of the Mental Capacity Act 2005, but they should at least be familiar with the “information you must read” on the LPA itself and the provisions of the Mental Capacity Act 2005 Code of

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Practice. Section 42(4)(a) of the Act expressly stipulates that it is the duty of an attorney acting under an LPA to have regard to the code."

The Code of Practice has the potential – more than any other feature of the Mental Capacity Act 2005 – to revolutionise the way we treat members of society who are unable to make their own decisions. Over time, the standards laid down in the code should permeate and influence good practice. However, the code will only be a success if people know about it, and read, mark, learn and inwardly digest it.

It is essential that the government agencies involved, such as the Office of the Public Guardian, the Ministry of Justice and the Department of Health, put in place adequate mechanisms for ensuring that attorneys, court-appointed deputies, as well as health and social care professionals, and paid carers, are aware of and familiar with the contents of the code.

2. Which areas of the Act, if any, require amendment; and how?

There are a few areas affecting Lasting Powers of Attorney (LPAs), where I think a review is called for and possible amendments are needed. These include:

(1) the distinction between ‘joint’ and ‘joint and several’ appointments;
(2) the waiting period, in case anyone objects to registration;
(3) the appointment of replacement attorneys; and
(4) the private international law provisions in Schedule 3 to the Act.

All of these areas create problems and they are important because they affect a lot of people. As I mentioned above, last year the Office of the Public Guardian received 242,000 applications to register LPAs – over ten times the number of applications the Court of Protection received during the same period.

As regards (1) above, the main problem is that ‘jointly’ does not only mean the number of persons who must participate in the decision-making process at any one time. It also has significant implications in terms of succession and liability. If one of two or more joint attorneys disclaims, or becomes bankrupt, or dies, or becomes mentally incapacitated, the joint appointment comes to an end: as does the LPA itself, if no replacement attorney has been appointed to replace the former joint attorneys. In addition, there is a distinction between joint liability and joint and several liability: the way in which the attorneys can be sued for their defaults.

As regards (2) – the waiting period, in case anyone objects to registration - I do not believe that the waiting period serves any useful purpose and I recommend its abolition. There are remarkably few objections to the registration of an LPA and procedurally there is little difference between objecting to registration (before the waiting period expires) and applying for an order to direct the Public Guardian to cancel registration (after the waiting period has expired).

As regards (3) – replacement attorneys – the appointment of successive attorneys was traditionally regarded as a ‘no go’ area, and it creates complexities that were never properly addressed by either the Law Commission in its report number 231 on Mental Incapacity (1995) or by the Parliamentary draftsman when drafting the Mental Capacity Act 2005. The
following are some of the practical problems that arise with the appointment of replacement attorneys:

(a) When the donor or an attorney makes an application to register an LPA, the named persons are not informed of the identity of any replacement attorneys on form LPA 001; they are only given the names and addresses of the original attorneys.

(b) There is no formal registration process for replacement attorneys and no facility whereby a named person, donor or co-attorney can object to the appointment of a replacement attorney, either when the original application is made to register the instrument, or when an event under section 13(6) of the Mental Capacity Act 2005 activates the replacement.

(c) Replacement attorneys are really only viable where the donor appoints a sole original attorney or more than one original attorney to act jointly and severally.

(d) Although a replacement attorney can replace an original attorney who has been appointed to act jointly, the outcome is unlikely to be what the donor intended. For example, if the donor appointed A and B to act jointly, and C to act as a replacement attorney, A's bankruptcy, death or disclaimer would terminate A and B's joint appointment, and C would become the sole attorney, rather than act jointly with B. Although the OPG guidance refers to this at the foot of page 19 of LPA 112, the prescribed form itself does not warn donors of the implications of appointing a replacement attorney where they have appointed their original attorneys to act jointly, or jointly for some decisions, and jointly and severally for other decisions.

As regards (4) – private international law - although it contains some useful provisions regarding the ‘applicable law’, Schedule 3 to the Mental Capacity Act 2005 is unsatisfactory in terms of the recognition and enforcement of powers of representation or lasting powers of attorney. There is no mechanism for obtaining a court order to authenticate a foreign power of representation and facilitate its acceptance and enforcement.

Another area of weakness in the Act is that it focuses so heavily on the best interests of ‘P’, the person who lacks capacity that it fails to take into account the interests of anyone else and makes no provision for P’s dependants. By contrast, the Mental Health Act 1983, section 95(1)(b) enabled the judge to “do or secure the doing of such things as appear necessary or expedient … for the maintenance or other benefit of members of P’s family.” Similar powers existed under the Enduring Powers of Attorney Act 1985, section 3(4) of which provided that:

“Subject to any conditions or restrictions contained in the instrument, an attorney under an enduring power, whether general or limited, may (without obtaining any consent) act under the power so as to benefit himself or other persons than the donor to the following extent but no further —
(a) he may so act in relation to himself or in relation to any other person if the donor might be expected to provide for his or that person’s needs respectively, and
(b) he may do whatever the donor might be expected to do to meet those needs.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

There are concerns as to whether ‘best interests’ is the appropriate benchmark for decision-making on behalf of incapacitated adults.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
There has been an interesting line of reported decisions in England and Wales involving statutory wills, in which different judges have expressed their views on the extent to which it is appropriate to apply a ‘substituted judgment’ test – as was the case when making a statutory will before the implementation of the Mental Capacity Act – as distinct from a purely ‘best interests’ test.

Sometimes I think that, instead of opting for ‘best interests’, it would have been better if we had retained the concept of ‘benefit’, which existed under Part VII of the Mental Health Act 1983 and all its predecessors going back to antiquity. The judge was charged to do ‘all such things as appear necessary or expedient for maintenance or other benefit of the patient’ (MHA 1983, s 95(1)).

This avoids the polarisation between ‘substituted judgement’ on the one hand, and ‘best interests’ on the other. The notion of ‘benefit’, incidentally, was retained as the benchmark by Scotland in its Adults with Incapacity Act 2000.

The Victorian Law Reform Commission (‘VLRC’), in Australia, has recently recommended that ‘best interests’, which is the current standard for substitute decision-making in Victoria’s Guardianship and Administration Act 1986, should be abandoned. At paragraphs 6.94-95 of Guardianship: Final Report, published on 18 April 2012, it said:

“While the ‘best interests’ principle in modern guardianship laws encompasses a consideration of the person’s wishes, the Public Advocate has argued: “In common usage ‘best interests’ has come to be associated negatively with paternalism, which itself is perceived negatively as being antithetical to individual rights. Whilst this may be a misinterpretation of the Act, it creates problems in community understanding and acceptance of the legislation.”

The concept of ‘best interests’ has been judicially criticised for being unclear and reliant upon an outcome based on the values of the person applying the test. It has also been criticised on the basis that it has paternalistic connotations because it is a test applied when making decisions for children.”

At paragraph 17.107 of its report the VLRC suggested that substituted judgment was more compatible with article 12(4) of the United Nations Convention on the Rights of Persons with Disabilities than best interests, because it “provides a means to assist the person to exercise capacity in a way that respects their rights, will and preferences,” and at paragraph 17.126, the Commission concluded that “substituted judgment should be the new starting point and the paramount consideration for substitute decisions.”

I should also add that the checklist of factors to be considered when determining what is in a person’s best interests, set out in section 4 of the Mental Capacity Act 2005 does not work particularly satisfactorily in the context of abuse and safeguarding cases.

14. What evidence is there that advance decisions to refuse treatment are being made and followed?

The provisions on advance decisions were by far the most controversial aspects of the Mental Capacity Bill when it was going through Parliament in 2004/2005, and almost in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
prevented the Bill from being enacted. Surprisingly, there was no case law on advance decisions until 2012, almost five years after the Act came into force, when, like buses, three came in a row.

(1) X Primary Care Trust v XB [2012] COPLR 577.
(3) A Local Authority v E and others [2012] COPLR 441.

Anecdotally, I have been told that relatively few advance decisions are being made, and I suspect that the main reason why is that, each year approximately 50,000 Lasting Powers of Attorney for health and welfare are being registered and these enable the donor to delegate any decisions involving the refusal of treatment to their attorneys.

The prescribed form of LPA for health and welfare requires the donor to specify one of two options – Option A and Option B.

- Option A says, “I want to give my attorney(s) authority to give or refuse consent to life-sustaining treatment on my behalf.”
- Option B says, “I do not want to give my attorney(s) authority to give or refuse consent to life-sustaining treatment on my behalf.”

In the LPAs that I have seen, only 10% of donors choose Option B and do not want to give their attorneys the authority to give or refuse consent to life-sustaining treatment.

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

18.1 The Court of Protection

The following statistics show that, during the four calendar years from 2009 to 2012, the Court of Protection’s business has risen by roughly 25%.

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property and affairs applications received</td>
<td>17,068</td>
<td>18,360</td>
<td>18,708</td>
<td>21,479</td>
</tr>
<tr>
<td>Property and affairs orders issued</td>
<td>13,641</td>
<td>15,624</td>
<td>19,230</td>
<td>16,669</td>
</tr>
<tr>
<td>Property and affairs deputies appointed</td>
<td>9,982</td>
<td>9,437</td>
<td>12,042</td>
<td>12,563</td>
</tr>
<tr>
<td>Health and welfare applications received</td>
<td>1,531</td>
<td>1,283</td>
<td>1,060</td>
<td>1,285</td>
</tr>
<tr>
<td>Health and welfare orders issued</td>
<td>182</td>
<td>218</td>
<td>589</td>
<td>835</td>
</tr>
<tr>
<td>Health and welfare deputies appointed</td>
<td>112</td>
<td>106</td>
<td>136</td>
<td>101</td>
</tr>
<tr>
<td>London hearings</td>
<td>473</td>
<td>472</td>
<td>502</td>
<td>909</td>
</tr>
<tr>
<td>Regional hearings</td>
<td>783</td>
<td>757</td>
<td>575</td>
<td>643</td>
</tr>
<tr>
<td>Enduring Powers of Attorney objections</td>
<td>483</td>
<td>298</td>
<td>225</td>
<td>185</td>
</tr>
<tr>
<td>Lasting Powers of Attorney objections</td>
<td>81</td>
<td>98</td>
<td>107</td>
<td>77</td>
</tr>
</tbody>
</table>

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
It is unfortunate that the Mental Capacity Act 2005 came into force on 1 October 2007 coincided with the start of the liquidity crisis and global recession. Over the same period of four years the court’s staff has been cut by broadly the same percentage (25%) from 115 to 85. Notwithstanding the stalwart efforts of the HM Courts and Tribunals staff to reduce waste, the combined effect of an increased workload and a reduced staff has had a knock-on effect in terms of service delivery.

I am concerned that the independence of the Court of Protection is under threat and that it may be subsumed into the Family Court. These two courts are shortly to be housed in the same building in central London, which currently serves as the Principal Registry of the Family Division, and recently there has been an attempt to merge their practice, procedure and guidance.

The Court of Protection is a superior court of record and its jurisdiction is prescribed by statute. Its powers stem from the Mental Capacity Act 2005. Two specific Codes of Practice apply to the areas of its jurisdiction. Its procedure is governed by distinct rules and practice directions. It has a central office and registry and only nominated judges may exercise its jurisdiction.

The Court of Protection has a history going back to roughly the year 1270. The court’s adult guardianship jurisdiction and the jurisdiction relating to the guardianship of minors were merged from 1540 until 1660 in the Court of Wards and Liveries, following the abolition of which the court’s jurisdiction was exercised by the Lord Chancellor and subsequently by the Chancery Division of the High Court. The adult guardianship legislation in most common law countries derives from this jurisprudence. In fact, in the United States, the groundbreaking decisions on substituted judgment in end of life decision-making originated in a decision of Lord Chancellor Eldon in Re Hinde, a Lunatic, ex parte Whitbread [1816] 2 Mer 99.

As can be seen from the statistics above, of the 22,764 applications received by the court last year, 21,479 (94.35%) were property and affairs and only 1,285 (5.65%) were health and welfare, which is where the specialist input of judges with a family background has been useful. The majority of Court of Protection practitioners come from a Chancery and private client background, and have little or no experience of family work or the wider jurisdiction of the family courts. Unlike any other court, the overwhelming majority of applications to the Court of Protection (93%) are non-contentious and can be dealt with on the papers alone.

To blur the public understanding and appreciation of the separateness of the Court of Protection could lead to confusion and error with misdirection of applications, correspondence and increasing the administrative burden upon the court and its staff. Similar difficulties arose when the roles of the Office of the Public Guardian and the court were separated in October 2007. Significant confusion arose, and although a considerable amount of work has been undertaken to promote and highlight the distinct roles, it has taken almost six years for many practitioners and the public to fully understand.
There is mental capacity legislation throughout most of the civilised world, but what is unique about our system in England & Wales is that we have a specialist court, the Court of Protection, which deals with nothing but mental capacity issues. It is looked upon with envy by adult guardianship practitioners elsewhere in the world and it would be short-sighted to merge it with the Family Court.

18.2 The Office of the Public Guardian

I believe the Office of the Public Guardian (‘OPG’) is now operating effectively and successfully. However, it took several years to get to that position. The relocation of the OPG from London to Birmingham was disruptive and there was a need to recruit an almost entirely new and inexperienced workforce, for whom there was a tremendously steep learning curve.

I have been particularly impressed at the improvement in the quality of the investigations and submissions made by the OPG’s investigations team in applications to discharge deputies or revoke Lasting or Enduring Powers of Attorney, although I have been dismayed at the extent of financial abuse that is emerging, particularly abuse by close family members.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

The following statistics relate to LPA cases I dealt with personally from 1 October 2007 to 31 July 2013.

(a) Column A is the year in which the LPA was created.
(b) Column B is the number of cases in which the donor made both types of LPA.
(c) Column C is where the donor made only an LPA for property and financial affairs.
(d) Column D is where the donor made only an LPA for health and welfare.

<table>
<thead>
<tr>
<th></th>
<th>Both</th>
<th>Property</th>
<th>Welfare</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>2</td>
<td>19</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>2008</td>
<td>49</td>
<td>241</td>
<td>20</td>
<td>310</td>
</tr>
<tr>
<td>2009</td>
<td>44</td>
<td>176</td>
<td>11</td>
<td>231</td>
</tr>
<tr>
<td>2010</td>
<td>59</td>
<td>213</td>
<td>21</td>
<td>293</td>
</tr>
<tr>
<td>2011</td>
<td>94</td>
<td>523</td>
<td>78</td>
<td>695</td>
</tr>
<tr>
<td>2012</td>
<td>126</td>
<td>635</td>
<td>122</td>
<td>883</td>
</tr>
<tr>
<td>2013</td>
<td>26</td>
<td>167</td>
<td>32</td>
<td>225</td>
</tr>
<tr>
<td>400</td>
<td>1,974</td>
<td>284</td>
<td>2,658</td>
<td></td>
</tr>
</tbody>
</table>

These figures show that, of the cases coming before me, the overall percentage of LPAs for property and affairs is 77.64%, and LPAs for health and welfare 22.36%.

The uptake of LPAs for health and welfare should be contrasted with the table in my response to question 18(1), from which it can be seen that in the year 2012 the Court of Protection appointed 12,664 deputies, of whom 12,563 (99.2%) were deputies for property and affairs and 101 (0.8%) were deputies for health and welfare.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Court of Protection can appoint deputies to make decisions on behalf of persons who lack capacity but for whom there is no valid and subsisting EPA or LPA. Many applicants apply for all the powers they can get, and they make what members of the court staff refer to as “hybrid applications”, where they apply for a personal welfare deputyship in addition to a property and affairs deputyship. In approximately 80% of these cases, judges refuse permission to apply for a personal welfare order. This is because personal welfare powers are largely unnecessary because of the broad scope of section 5 of the Mental Capacity Act 2005. These refusals to grant permission occur primarily in cases involving older people with vascular dementia or Alzheimer’s disease. In most cases, the applicants, who are usually the donor’s children, put forward an extremely weak case for requiring such powers in the permission form (COP2).

In his judgment handed down on 11 October 2010, in G v E [2010] EWHC 2512 (COP), Mr Justice Jonathan Baker considered whether it was necessary to appoint a personal welfare deputy for E, and came to the conclusion that it wasn’t because (at paragraph 57):

“The Act and Code are therefore constructed on the basis that the vast majority of decisions concerning incapacitated adults are taken informally and collaboratively by individuals or groups of people consulting and working together. It is emphatically not part of the scheme underpinning the Act that there should be one individual who as a matter of course is given a special legal status to make decisions about incapacitated persons. Experience has shown that working together is the best policy to ensure that incapacitated adults such as E receive the highest quality of care.”

I agree entirely with Sir Jonathan Baker’s comments. At present, public demand for LPAs for health and welfare is not as great as it is for LPAs for property and financial affairs. The OPG is currently considering the introduction of a single prescribed form of LPA which will confer on the donee the authority to make decisions in both property and financial affairs and health and welfare. This will almost certainly result in cases in which powers over the person are granted either routinely or inadvertently and I do not consider that this is either necessary or desirable.

20. **What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?**

I do not think anyone is under the illusion that the Mental Capacity Act has resulted in savings in terms of costs. Prior to the implementation of the Act in October 2007, the court’s procedure was more informal, and applications could be made by letter. They now have to be made formally on an application form, accompanied by a witness statement, and often an application fee of £400. Where solicitors are instructed, this has inevitably notched up the costs.

I believe that proceedings in many health and welfare cases, particularly public law cases, where public funding is still available, are unnecessarily protracted.

I am concerned that an increasing number of local authorities are ceasing to undertake deputyships for property and affairs, which leaves the court little option other than to appoint a panel deputy as deputy of last resort. There are, I believe, 65 members of the panel of deputies, all but two or three of whom are solicitors, and inevitably they seek to charge a commercial rate for their services. On 4 August 2011 the OPG issued a Call for

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
evidence: not for profit delivery of deputyship services, inviting the voluntary sector to take on last resort work. I am not aware of any response to the consultation, and I imagine the response was disappointing.

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland or in other jurisdictions?

Over the past two hundred years, in England and Wales, we have tended to revise our mental health laws, of which mental capacity law has formed an integral part, roughly once in a generation. For example:

- Lunacy Regulation Act 1862
- Lunacy Act 1890
- Mental Treatment Act 1930
- Mental Health Act 1959
- Mental Health Act 1983
- Mental Capacity Act 2005

There was a ten-year delay in implementing the Law Commission’s 1995 report on Mental Incapacity, as a result of which the Mental Capacity Act 2005 reflects the policy and thinking of the mid 1990s – nearly twenty years ago – and, if history repeats itself, we shall be changing it again in ten years’ time.

The current trend in the more advanced legal systems in the world is also to revisit their adult guardianship laws about once in a generation. Here are a few examples.

**Alberta**

The pioneer in Canada was Alberta with its Dependent Adults Act 1976. Over the passage of time, even this revolutionary statute began to look a little jaded, and in 2009 it was replaced by the Adult Guardianship and Trusteeship Act (AGTA), which creates discrete regimes for supported decision-making and co-decision-making for personal welfare matters only, as well as providing for conventional guardianship for personal decisions and trusteeship for financial decisions.

**Victoria**

I have already mentioned, in my response to question 3, the report of Victorian Law Reform Commission (VLRC), Guardianship: Final Report, which was published on 18 April 2012. Victoria was originally in the vanguard in Australia with its Guardianship and Administration Act 1986, which was designed to respond to the challenges of deinstitutionalisation. It is now about to receive a major overhaul following the publication of the report of VLRC’s report.

Although the VLRC concluded that much of the existing legislation was sound, it has proposed reforms that reflect the monumental change of emphasis, often referred to as ‘a paradigm shift’, required by the United Nations Convention on the Rights of Persons with Disabilities. For instance, at paragraph 4.60 of the report, it said:

“The Convention represents a movement beyond providing protection for people with disabilities to taking positive steps to maximise their participation in all aspects of life. In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
stresses a state’s obligation to promote active participation by championing equal access to different aspects of community life, and recognising the right of people with disabilities to enjoy legal capacity on an equal basis with other people. In the Commission’s view, this means that disability alone should never constitute a ‘capacity disqualification’ and that all reasonable efforts should be made to assist people with impaired capacity to participate to the fullest extent possible in decisions about themselves.”

The VLRC recommends that greater participation could be achieved by the introduction of schemes for supported decision-making (discussed in chapter 8 of its report) and co-decision-making (discussed in chapter 9) for both personal and financial decisions.

I mentioned earlier, in my response to question 3 that the VLRC has recommended the abandonment of ‘best interests’ as the standard for substitute decision-making.

I also said earlier that the more advanced legal systems tend to revisit their legislation in a generation, and in the case of Ireland I must eat my words. The Lunacy Regulation (Ireland) Act 1871 is still in force. However, on 17 July 2013 Ireland published an Assisted Decision-Making (Capacity) Bill. What is particularly interesting in the Bill is the absence of any reference to ‘best interests’, or any alternative benchmark in terms of substitute decision-making, and the provision of regimes for assisted decision-making and co-decision making.

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

I have written two articles on this topic, over the course of which I have changed my mind on the extent to which the MCA is compliant with the CRPD. The articles are:


In the first article I stated that:

“In England and Wales, the Mental Capacity Act 2005 provides for assisted or supported decision-making in the following ways:

(1) Section 1(3) says that “A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.”

(2) Section 3(2) says, “A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means.”

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Once it has been established that P lacks the capacity to make a particular decision, section 4(4) requires that the person who is determining what is in P’s best interests must consider all the relevant circumstances and “must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.”

Chapter 3 of the Mental Capacity Act 2005 Code of Practice, “How should people be helped to make their own decisions?” provides practical guidance on how to support people to make decisions for themselves or play as big a role as possible in decision-making.”

I concluded the first article with the following assessment:

“On balance, therefore, I am confident that the provisions of the Adults with Incapacity (Scotland) Act 2000, and the Mental Capacity Act 2005 and the burgeoning jurisprudence in England and Wales, are compliant with Article 12 and, so far as is consistent with P’s best interests, respect his or her rights, will and preferences. However, there is no cause for complacency. If one disregards for a moment all this hype about dismantling traditional adult guardianship systems, which inevitably puts those of us who are familiar with and work within these systems on the defensive, maybe there is scope for re-evaluating our legislation with a view to accommodating the needs of people with intellectual disabilities in a better manner.”

After attending the 2nd World Congress on Adult Guardianship, in Melbourne, Australia, on 15-17 October 2012, I changed my mind about the extent to which the MCA is compatible with the CRPD. This was mainly as a result of hearing a presentation by Professor Ron McCallum, who at that time was the chair of the United Nations Committee on the Rights of Persons with Disabilities.

In order to comply with article 12 of the CRPD, the states parties to the convention are being urged to replace their existing substituted decision-making regimes with supported decision-making systems. The UN Committee is spearheading this campaign, and the following extract from its observations on Hungary’s report at the eighth session in September 2012 gives a clear indication of the stance it is taking:

“The Committee takes note of the fact that the State party is undertaking efforts to harmonize its national legislation with the provisions of article 12 of the Convention. It welcomes the plans to provide for supported decision-making in the drafting of the new Civil Code. The Committee however remains concerned about the possibility of maintaining a modified regime of substitute decision-making in the drafting of the new Civil Code. The Committee is also concerned that the process of drafting of the new Civil Code has not been used to provide for a detailed and viable framework for supported decision-making in the exercise of legal capacity in accordance with the provisions of article 12 of the Convention. The Committee recommends that the State party use effectively the current review process of its Civil Code and related laws to take immediate steps to derogate guardianship in order to move from substitute decision-making to supported decision-making, which respects the person’s autonomy, will and preferences and is in full conformity with article 12 of the Convention, including with respect to the individual’s right, on their
own, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry, to work, and to choose their place of residence.”

I concluded the second of the articles to which I have referred as follows:

“The Mental Capacity Act 2005 predates the United Nations Convention of the Rights of Persons with Disabilities – which the United Kingdom ratified on 8 June 2009 – and it is debatable whether it would pass muster in terms of compliance with article 12. Although there are provisions in the Act – such as sections 1(3), 3(2) and 4(4) – that encourage people with disabilities to participate as fully as possible in decisions affecting them, it can hardly be said that these constitute ‘a detailed and viable framework for supported decision-making in the exercise of legal capacity in accordance with the provisions of article 12 of the convention’ in the way that, say, the recommendations proposed by the Victorian Law Reform Commission do.”

The views expressed in this response are entirely my own and do not necessarily reflect the views of other judges of the Court of Protection.
SUMMARY OF THE RESPONSE OF DENZIL LUSH
SENIOR JUDGE OF THE COURT OF PROTECTION

1. **To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?**

One of the aims of the Act was to make provision for the international protection of adults. It has not fully achieved this. A broader aim was to promote awareness and good practice. It has achieved this as far as health and social care professionals are concerned, but not the large numbers of non-professional deputies and attorneys, who are unaware of the Code of Practice.

2. **Which areas of the Act, if any, require amendment; and how?**

Several amendments could be made to the legislation on Lasting Powers of Attorney. Also the Act fails to make proper provision for the best interests of persons other than P and, in particular, the maintenance of P's dependants.

1. **At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?**

Best interests may not be entirely compliant with the United Nations Convention on the Rights of Persons with Disabilities, to which the United Kingdom is a party.

14. **What evidence is there that advance decisions to refuse treatment are being made and followed?**

Approximately 50,000 people a year choose to make a Lasting Power of Attorney for health and welfare, in which they delegate the responsibility for making decisions of this kind to their attorneys. This may account for a relative paucity of other types of advance decision.

18. **Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?**

The court is operating reasonably effectively, despite a 25% increase in workload over the last four years and a 25% reduction in staff. I am concerned that the Court of Protection may be subsumed into the Family Court. The OPG is now operating effectively and successfully, but its relocation from London to Birmingham delayed this process for several years.

19. **What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?**

Because of the provisions of section 5 of the Mental Capacity Act, in most cases there is no need for a formally appointed substitute decision-maker to make health and welfare decisions.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)?

In the last twelve months I have changed my mind on this and no longer believe that the MCA is compliant with the CRPD.

27 August 2013
Luton Borough Council – Written evidence

Summary
There is evidence in Luton that the Mental Capacity Act is making a difference. The Act has led to a culture change with practitioners now giving consideration to the MCA and the Human Rights Act. There is acceptance that people can make unwise decisions. Practitioners challenge practice where there is no regard to the Act.

The Legal framework for Deprivation of Liberty is more recognised with less unauthorised deprivation of liberty taking place. Individuals are being encouraged to make advance statements and Lasting Power of Attorney arrangements outlining the individual’s wishes before losing capacity. Social care staff try to strike a balance between protection and enablement. Individuals are taking more responsibility in taking risks.

There is a view that Social Care workers have a better understanding compared to health care workers or staff working in other areas including banking. Social care staff highlighted cases where health professionals expected social workers to be decision makers in clinical decisions. There is also a lack of understanding outside of social care that decisions are time and decision specific. The shared view is that Health professionals tend to make blanket decisions about lack of capacity and the need for specific decisions is not taken into account. Positively, the Police have taken cases to the CPS seeking prosecution for wilful neglect under sec 44 and have sometimes been successful.

There is a need to make improvements in some areas, including: information for the public/relatives, the Court of Protection, the number of IMCA’s. There is also still a lack of understanding about the MHA interface with MCA/DoLs. This is especially so in relation to informal patients admitted to psychiatric hospitals.

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1.1 There is evidence in practice to show that the Mental Capacity Act (2005) has provided a framework for assessing whether or not people have capacity to make decisions. There is evidence of social care practitioners completing Mental Capacity assessments and making best interest decisions.

1.2 There is less evidence of staff in other agencies making decisions that do not take into consideration the views and wishes of the individual who lacks capacity.

1.3 There is more consideration given to individual’s human rights. There is more involvement of people using services in the decision making process to ascertain their views & wishes.

1.4 Decisions made based on the individual’s age, illness or disability are being challenged more frequently by practitioners. There are fewer unilateral decisions being made and decisions made are now more likely to take into consideration the individuals best interests.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
1.5 There is less assumption of a lack of capacity. Consideration of capacity is made for specific decisions as opposed to blanket assumptions due to illness, age or disability.

1.6 Individuals are being encouraged to make advance statements and Lasting Power of Attorney arrangements outlining the individual’s wishes before losing capacity.

1.7 The Legal framework for Deprivation of Liberty is more recognised with less unauthorised deprivation of liberty taking place.

1.8 There is more consideration for least restrictive alternatives

1.9 There is evidence to support this in needs assessments, care planning, Best Interest Assessments and in managing safeguarding concerns.

2. Which areas of the Act, if any, require amendment and how?

2.1 The concept of making unwise decisions for individual’s who are self neglecting is an issue that can be complex in safeguarding such individuals. More thought should be given to how self neglecting individuals who are at risk of harm can be safeguarded.

2.2 Changes in the supervisory body and application of ordinary residence need to be amended accordingly.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

3.1 The core principles have been a useful guide in helping practitioners in assessing mental capacity.

3.2 As ‘best interest’ is not defined by the Act, some practitioners feel that in some circumstances, deciding what is in the best interest of the individual could be blurred, with practitioners/families bringing in their own values and thoughts in deciding what is in the individual’s best interest.

3.3 Some practitioners felt that more clarity on ‘Best Interest’ could aid in resolving this.

Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

4.1 There is more understanding of the MCA principles by frontline social care staff.

4.2 Frontline staff assessing capacity have moved away from judging the individual’s capacity based on the person’s age, disability or illness. This has enhanced anti-discriminatory practice.
4.3 Social care staff who were consulted however feel that there is still a need to improve understanding of the principles by health care staff.

4.4 There is evidence of staff consulting more with individuals & carers and involving them in the decision making process during assessments and prior to interventions. This includes taking the individuals past wishes into consideration by speaking to those involved e.g. family, other professionals and also checking for advance statements, LPA.

4.5 There evidence of involving advocates including Independent Mental Capacity Advocates.

4.6 The assessments tools used by the local authority have specific fields to capture the evidence of service user involvement in the decision making process. This has helped improve practice.

4.7 Consent for sharing information and consent prior to interventions e.g. prior to making safeguarding referrals and investigations is now widely sought and for those lacking capacity, best interest decisions are made after assessing the individual’s capacity to make specific decisions.

4.8 Individuals are being more empowered/enabled to make decisions for themselves wherever possible.

4.9 There is increased use of interpreters where there are language barriers and other aids that improve communication.

4.10 Practitioners acknowledge that people have the right to make decisions that others might regard as unwise or eccentric.

4.11 There is increased awareness and respect for the individual’s values, beliefs and preferences and an awareness that the individuals’ preferences are not necessarily the same as those involved in the care/support of the individual. Frontline staff are now more cautious about imposing their views or those of other professionals or family on service users.

4.12 Staff try to strike a balance between protection & enablement. Individuals are taking more responsibility in taking risks. There is however a view that at times practitioners can be risk averse especially if individuals lack capacity to make decisions.

4.13 The is more consideration for least restrictive options such as use of assistive technology, making environmental changes (evidence in OT assessments and care management assessments), signposting/involving other networks (family, professionals, agencies)

4.14 There is an increased use of carers assessments to identify any difficulties in order to support carers in their caring role.

4.15 It could however be argued that these changes are not solely down to the MCA, but also due to the personalisation agenda and increased need to make best use of resources.

4.16 Evidence in DoLs assessments shows consideration for least restrictive alternatives. In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
4.17 There has been an increase in Mental Capacity Assessments undertaken. The graph/figures below show an increase in numbers. In 2009, following MCA implementation, there was 1 assessment as compared to 344 in 2013.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>1</td>
</tr>
<tr>
<td>2010/11</td>
<td>73</td>
</tr>
<tr>
<td>2011/12</td>
<td>321</td>
</tr>
<tr>
<td>2012/13</td>
<td>344</td>
</tr>
</tbody>
</table>

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

5.1 There was publication of the codes of practice for MCA & DoLs which are useful in practice.

5.2 There was initial awareness raising by the government targeted at relevant key organisations such as health & social care. This led to the supervisory bodies training staff on the subject and training of Best Interest Assessors. However there was limited government led publicity/initiative to raise awareness of individuals affected by the Act, ie carers, families & the wider public. There is limited easily accessible information published by the government for individuals & their families. There is a need for the government to produce & publish information for individuals, carers etc as in the case of the Mental Health Act.

5.3 The Local Authority has made efforts to raise awareness among its staff & partner agencies, Luton continues to run regular MCA training sessions for staff but there is still a
need to continue to do this. Similarly the Luton and Dunstable hospital and the Community Health provider run sessions for staff and recognise the need to continue to do so.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

6.1 There is a view that Social Care workers have a better understanding compared to health care workers. This is based on the experience in practice of frontline social care staff who were involved in this consultation. Staff highlighted cases where health professionals expected social workers to be decision makers in clinical decisions.

6.2 There is also a lack of understanding outside of social care that decisions are time & decision specific. The shared view is that Health professionals tend to make blanket decisions about lack of capacity and the need for specific decisions is not taken into account.

6.3 There is also poor understanding among banking staff. Information given by social care workers is that individuals still experience difficulties in opening and accessing bank accounts due to banking staff making generalised judgements about people’s capacity.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

7.1 There is a general view that there is little awareness by those affected by the Act. Practitioners try to explain as much as possible. There is limited accessible information available for those affected by the act and informal carers.

7.2 The Act focuses on individual and provides protection more for the individual than the carer. It does however give carers some reassurance that the individual is protected, especially in the case of Deprivation of Liberty. Sometimes there is a conflict of opinion/interest between the individual lacking capacity and the informal carer, with some cases requiring IMCA involvement.

8. Has the Act ushered in the expected, or any, change in the culture of care?

8.1 The Act has led to a culture change in care as practitioners now give consideration to the MCA and the Human Rights Act. There is acceptance that people can make unwise decisions. Practitioners are challenging practice where there is no regard to the Act and in Luton practitioners are challenged by their supervisors if consideration of the Act has not been evidenced for example completion of mental capacity assessments for those who lack capacity. There have been fewer unilateral decisions made on behalf of the individual by family or professionals. Best interest decisions are made instead where all relevant persons are involved.
8.2 In safeguarding, there has been more action taken to protect individuals who lack capacity to direct their own care. Police have taken cases to the CPS seeking prosecution for wilful neglect under sec 44.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

9.1 There is evidence that older persons, individuals with mental health problems and learning disabilities are more affected by the provisions of the Act.

9.2 Evidence in graphs below is derived from data collected from Deprivation of Liberty safeguards applications. It is likely that there is a similar trend for those affected by the wider provisions of the Act.

9.3 There is no evidence to suggest that black & minority groups are affected disproportionately, but it can be argued that communication difficulties/ language barriers are sometimes likely to be mistaken for lack of capacity.

See Appendix 1

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

10.1 Those affected are enabled to a greater extent by assuming capacity, and completing formal mental capacity assessments where mental capacity is in doubt. Making fewer blanket decision of ‘X 'lacks capacity’”, hence more involvement in decision making based on individual ability/capability.

10.2 There are more appointments of deputies and use of LPAs.

10.3 There is however sometimes a confusion regarding the role and the need to have LPA for both welfare and finance. More understanding through information & training is required in this area.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

11.1 Frontline workers are being encouraged to involve individuals in making advance decisions. Professionals are checking existence of advance decisions.

11.2 There has been a case where I have followed an advance decision regarding an individual not wishing to be cared for in residential care.
11.3 We understand that the Luton and Dunstable Hospital has sent in an individual response to you and their response to this question is that there is still very little evidence of ADRT’s, but they do raise this in staff training.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

12.1 Yes. There is more consultation with carers & families to ascertain the individuals past wishes, checking if there is an advanced directive, also LPA consultation with interested parties during DoLs assessments.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

13.1 There is evidence of requesting advocates where required. IMCA referrals are made for change of accommodation where an individual lacking capacity is not befriended and in befriended cases where there is conflict of interest.

13.2 There have been some cases of IMCA involvement in safeguarding cases as an additional safeguard. In the cases of a standard authorisation of DoLs, a section 39D IMCA is appointed to support Relevant Person & the Relevant Person’s Representative as standard practice.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

14.1 There is a view that the role is blurred and boundaries confused as the IMCA is sometimes the same individual acting as a general advocate.

14.2 The variations in the regions could be due to poor understanding of the referral process, strict criteria for IMCA referrals and the low numbers of IMCA’s in some regions.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

15.1 There is a lack of sufficient numbers of IMCA’s. The number of IMCA’s for the region is few.

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

16.1 The safeguards are not adequate. There is lack of fast access to a tribunal as in cases for those deprived of their liberty under the MHA. The Court of Protection process to appeal is long and expensive where there are disputes or conflict.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
17.1 The 7 day period for Urgent authorisation is too short as time is lost over the weekend. 7 working days would have been more appropriate and needs to be considered. The Review process is not clear especially for the Managing Authorities. The assessment process/paperwork could be made easier by amalgamating the number of assessments required.

17.2 Challenge for DoLs is difficult as it can only be done through Court of Protection. This needs to be made easier and more accessible through tribunal and manager hearings as is the case with the Mental Health Act.

The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

18.1 There is little understanding by professionals, individuals and families about the role of the court of protection and the office of the Public Guardian. Extent of understanding depends a lot on job role and interest. More accessible information and training is required. Access is not clear and applications are expensive for individuals. There is also a view that there are long waiting periods for cases to be heard.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

19.1 This has been positive. More people are applying for this. There is now more awareness perhaps due to care costs and managing finances. But LPA can be misused hence need for more awareness for challenging inappropriate use is required.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

20.1 This is unclear to individuals, families & professions and **expensive**. It needs to simpler and cheaper to offer the required protection.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

21.1 The welfare changes will have an impact on legal aid. This will make access to CoP more unaffordable and difficult to access.

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

22.1 It is our view that CQC should monitor use of MCA more widely to ensure compliance by all as opposed to DoLs alone. This may however impact on their limited resources. In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
23. **Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?**

23.1 There should be involvement of other regulatory bodies/professional bodies in ensuring that standards are adhered to by the professionals involved. Unresolved conflicts should still be managed through CoP (or tribunals if set up) but unresolved complaints in relation to wider provisions of the Act could be investigated by the Ombudsman.

**Other legislation**

24. **How well is the relationship with the mental health system and legislation understood in practice?**

24.1 There is lack of understanding about the MHA interface with MCA/DoLs. This is especially so in relation to informal patients admitted in psychiatric hospitals. There should be more consideration in the use of the wider provisions of the Act complimented with robust care planning & review process/CPA. More training is required for all health and social care professionals involved including the CQC.

30 August 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Nicola Mackintosh and Sophy Miles – Written evidence

**Legal Aid and Mental Capacity - a briefing note**

This note has been prepared to assist the Committee on the Mental Capacity Act.

It has been written by Nicola Mackintosh and Sophy Miles of Mackintosh Law and Miles and Partners LLP respectively. Both are members of the Law Society’s Mental Health and Disability Committee, which Sophy Miles chairs, but this note has been written in our personal capacity.

**The Legal Aid, Sentencing and Punishment of Offenders Act 2012.**

Availability of publicly funded advice and representation (“Legal Aid”) is now governed by the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (“LASPOA 2012”) , which came into force on 1st April 2013 and was the biggest reform of legal aid for a generation. The Act removed a number of areas of law out of scope of legal aid altogether. The Legal Services Commission which had previously administered legal aid in England and Wales was replaced by the Legal Aid Agency. The Agency is headed by the Director of Legal Aid Casework.

The Act also changed the way that decisions were made as to whether legal aid was available for a case. Before the Act, legal aid was available for all cases unless it was expressly excluded. Under the new Act, unless a case is listed in one of the Schedules as being within scope, legal aid will not be available.

Schedule 1 of LASPOA lists those areas of law where advice and/or representation can be provided under legal aid. If an area of law is not in Schedule 1, then no legal aid in any form may be provided to a client seeking help in this area of law unless it is necessary because to deny legal aid would be a breach of the ECHR.180.

Those areas of law listed in Schedule 1 are then subject to further exclusions and criteria which appear in the regulations. These will always need to be considered in order to ascertain whether a client presenting with a particular case is eligible to receive legal aid for their problem, and what form of legal aid should be provided.

**Contracts**

All providers of legal aid must hold a contract with the Legal Aid Agency which covers the areas of law which they offer. The provider must at all time comply with the terms of the contract. Currently, providers of legal aid who hold contracts in the areas of Mental Health and Community Care may also provide legal aid in cases arising under the Mental Capacity

180 Under s.10 LASPOA legal aid (Legal Help and certificates) may be made available on an ‘exceptional’ basis if it is necessary under the ECHR. The threshold for such exceptional funding is extremely high, requiring the applicant to show that to deny them legal aid would be a breach of the ECHR. Only a handful of the hundreds of applications under s.10 made since 1 April 2013 have been granted. There is no funding for making the application for exceptional funding unless it is actually granted which is a further deterrent to the applications being made.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Act, subject to the provisions of LASPOA, and where the client can meet the merits test and the financial criteria. All of these are summarized below.

**The different levels of legal aid**

Legal aid is provided at different levels. The usual first level of funding is Legal Help, which covers an adviser taking instructions at the start of a case, writing letters etc and advising whether further action is required. It does not cover representing a client in court proceedings. Court proceedings are covered by a legal aid certificate, which is linked to specific proceedings. In the mental capacity context, this could be proceedings in the Court of Protection or by way of judicial review (eg regarding support services for a vulnerable person).

**Securing Legal Aid**

In order to qualify for legal aid at all, the following criteria have to be met. Each of these are addressed in more detail below:

1. The case must be within scope of legal aid
2. The client must meet the ‘merits test’ as to whether legal aid is warranted
3. The client must meet the ‘means test’ and be financially eligible for legal aid
4. The client must produce the relevant evidence of their means (benefits, bank statements etc) to satisfy the requirements of the Legal Aid Agency.

It is only once all four of the above are met that the client will be able to obtain advice or representation.

**Scope of legal aid**

For the purpose of legal aid in cases which touch on the Mental Capacity Act, this falls into three main sections:

- Court of Protection
- Inherent jurisdiction
- Community care/public law

The relevant paragraph of Schedule 1 of LASPOA for cases where the Court of Protection has jurisdiction is Paragraph 5 which provides that civil legal services can be provided "in relation to matters arising under the Mental Capacity Act 2005".181

181 Paragraph 5(1), Part 1 Schedule 1, LASPOA 2012.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
This means that legal aid can- provided all the other criteria are met- can be provided in respect of legal issues arising under the Mental Capacity Act.

However, this is subject to certain exclusions. Firstly, no legal advice at all can be provided about:

(a) the creation of lasting powers of attorney under the Mental Capacity Act 2005, or

(b) the making of advance decisions under that Act.\(^{182}\)

Therefore, practitioners may not provide any advice at all under legal aid to a client who wishes to prepare a Lasting Power of Attorney (whether financial or welfare) or an advance decision. However, if a client requires advice or representation about a case before the Court of Protection which concerns determinations and declarations about the effect, meaning validity or applicability of a LPA or advance decision, then it may be possible to provide legal aid, in some form, assuming that all other criteria are satisfied.\(^{183}\)

Secondly, the legal services which can be provided post-LASPO exclude advocacy unless it is in the Supreme Court, the Court of Appeal the High Court or the Court of Protection.\(^{184}\)

If the case is in the Court of Protection, there is a further exclusion. Advocacy services can only be provided if the case concerns at least one of the following issues:

(a) a person's right to life,

(b) a person's liberty or physical safety,

(c) a person's medical treatment (within the meaning of the Mental Health Act 1983),

(d) a person's capacity to marry, to enter into a civil partnership or to enter into sexual relations, or

(e) a person's right to family life\(^{185}\)

### The inherent jurisdiction

Civil legal services can be provided in relation to the inherent jurisdiction of the High Court in relation to children (persons under the age of 18) and vulnerable adults (persons aged 18 and over).\(^{186}\)

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182 Paragraph 5(3), Part 1, Schedule 1, LASPOA 2012.

183 Paragraph 5(4), Part 1, Schedule 1 LASPO 2012.

184 Part 3, Schedule 1, LASPO.

185 Part 3, Schedule 1 LASPO

186 Para 9, Part 1, Schedule 1 LASPO

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Community Care/Public Law

Cases which concern the statutory obligations of public bodies to provide services to mentally incapacitated persons are, subject to the means and merits test, within the scope of legal aid. Therefore advice or representation about cases concerning the failure or omission of NHS agencies or local authority social services departments to provide services may be funded. Legal aid in these areas, subject to meeting the merits and means criteria can be provided by those with contracts in Community Care Law or Public Law. The scope of community care cases is defined by paragraph 6, Part 1, Schedule 1, LASPO. The scope of public law is defined by paragraph 19, part 1, Schedule 1.

Merits

Once it has been established that the case is within the scope of legal aid, the next matter to be considered is whether the case meets the merits criteria. If it does not, legal aid will not be available for advice, or in the case of court proceedings, granted.

The relevant merits tests are set out in the Civil Legal Aid (Merits Criteria) Regulations 2013 and were made on 22nd January 2013.

There are general merits criteria but in some cases these are displaced by specific criteria.

Note the definition of “overwhelming importance to the client” in Reg 2:

A case with overwhelming importance to the individual” means a case which is not primarily a claim for damages or other sum of money and which relates to one or more of the following—

(a)

the life, liberty or physical safety of the individual or a member of that individual’s family (an individual is a member of another individual’s family if the requirements of section 10(6) are met); or

(b)

the immediate risk that the individual may become homeless;

There are definitions of the tests of prospects of success (reg 4-5); Public interest (reg 6); reasonable private paying individual (reg 7) and proportionality.

Legal aid may only be provided if the relevant merits test is met and it is reasonable in the light of the person’s conduct: Reg 11(7).

The criteria for mental capacity cases are as follows:

Does the case meet the standard criteria? These are set out below. If they are not all satisfied the individual will not get legal aid.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Reg 39: An individual may qualify for legal representation only if the Director is satisfied that the following criteria are met—

(a) the individual does not have access to other potential sources of funding (other than a conditional fee agreement) from which it would be reasonable to fund the case;

(b) the case is unsuitable for a conditional fee agreement;

(c) there is no person other than the individual, including a person who might benefit from the proceedings, who can reasonably be expected to bring the proceedings;

(d) the individual has exhausted all reasonable alternatives to bringing proceedings including any complaints system, ombudsman scheme or other form of alternative dispute resolution;

(e) there is a need for representation in all the circumstances of the case including—

(i) the nature and complexity of the issues;

(ii) the existence of other proceedings; and

(iii) the interests of other parties to the proceedings; and

(f) the proceedings are not likely to be allocated to the small claims track.

The cost benefit criteria and the prospects of success test must also be met (Reg 41).

The cost benefit criteria require that the Director is satisfied that (assuming the case is not for damages, or of significant wider public interest) the reasonable private paying individual test is met. If it is of significant wider public interest then the proportionality test must be met (Reg 42).

The prospects of success will be met if the Director is satisfied that EITHER the prospects of success are very good, good or moderate OR if they are borderline, that the case is of significant wider public interest OR of overwhelming importance to the individual (see definition). If the prospects of success are poor, funding will not be granted – guidance 4.1.4, which also provides that all the hurdles to a successful outcome must be considered. So it would not be enough simply to rely on the chances of the COP granting permission.

If all the standard criteria above are met, a further test still needs to be carried out. This is set out in regulation 52 and provides that full representation will only be granted if two further tests are met.

The first test is that the Court of Protection has ordered or is likely to order an oral hearing, AND that it is necessary for the individual to be provided with full representation in the proceedings. ¹⁸⁷

¹⁸⁷ Reg 52 (2) Civil Legal Aid (Merits Criteria) Regulations 2013 SI 104

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
(The Lord Chancellor’s guidance on when it is “necessary” to provide representation is considered below.)

The second test is that the case relates to

(a) a person’s right to life;

(b) a person’s liberty or physical safety;

(c) a person’s medical treatment (within the meaning of the Mental Health Act 1983[1]);

(d) a person’s capacity to marry, to enter into a civil partnership or to enter into sexual relations; or

(e) a person’s right to family life. 188

Note from the list above that the following types of cases would fall outside the scope of legal aid:

- A person’s right to psychological safety

- A person’s right to respect for their home or private life (ie the other limbs of Article 8)

Concerns about these cases falling outside the scope of legal aid have been raised, but the test remains unchanged. To obtain legal aid for these cases an application for exceptional funding would have to be made under s10 LASPOA - see the note at footnote 1. Such applications are rarely granted.

There is more information in the Lord Chancellor’s Guidance, including looking at the approach that will be taken to the definition of ‘overwhelming importance’ to the individual (4.2.10 onwards); how the criteria for investigative representation as opposed to continuing on legal help will be considered (6.11); what “other sources of funding” might be (7.14); when a case is unsuitable for a Conditional Fee Agreement (CFA) (7.16).

Importantly para 7.23 deals with when it will be “necessary” to represent the applicant for legal aid and comments: “It should not be necessary for there to be more parties legally represented than there are positions to be argued. This may be particularly relevant in a welfare case in the COP where an additional family member seeks representation…”

Section 9 of the Lord Chancellor’s Guidance deals with Mental Health cases which include advice about the Mental Capacity Act:

- Legal representation (ie a legal aid certificate) may be refused if it is premature or if legal help is more appropriate. para 9.5

188 Reg 52 (3) Civil Legal Aid (Merits Criteria) Regulations 2013 SI 104

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
• For Court of Protection work the expectation will be that “support will be available through legal help” (para 9.8).

• A case will have overwhelming importance to P’s family (ie could still be funded if the prospects of success are borderline) if they are of overwhelming importance to P.

• Accommodation cases will only be in scope if they affect P’s family life.

• Although you cannot use legal help to create an AD or LPA you can use legal help to advise on potential or actual proceedings about the validity or applicability.

Financial eligibility

Assuming the case is within the scope of legal aid and satisfies the merits criteria the next step is to ascertain if the client is financially eligible for legal aid.

This is governed by the Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013.

There is only one exception to the rule that the client must satisfy the means test before getting legal aid in the Court of Protection.

This is where person is deprived of their liberty under a standard authorisation under Schedule A1 MCA and there is an appeal against the authorisation under s21A Mental Capacity Act 2005. In this case the person under the authorisation can obtain legal aid without their means being assessed, and so can their Relevant Person's Representative (RPR).

Members of the Law Society’s Mental Health and Disability Committee have commented on the impact of the regulations in relation to S21A appeals against detention under Schedule A1 MCA in an earlier paper. The relevant regulation is below and shows when legal aid can be provided without the applicant satisfying the means test:

\[(g)\text{legal representation in relation to a matter described in paragraph 5(1)(c) (mental capacity) of Part 1 of Schedule 1 to the Act to the extent that—}\]

\[(i)\text{the legal representation is in proceedings in the Court of Protection under section 21A of the Mental Capacity Act 2005(4); and}\]

\[(ii)\text{the individual to whom legal representation may be provided is—}\]

\[(aa)\text{the individual in respect of whom an authorisation is in force under paragraph 2 of Schedule A1 to the Mental Capacity Act 2005; or}\]

\[(bb)\text{a representative of that individual appointed as such in accordance with Part 10 of that Schedule;}\]

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
It is clear from the above that the non-means tested legal aid for DOLs appeals will only be available WHILE THE AUTHORISATION IS IN FORCE. As indicated in the earlier paper this has effects which we consider to be perverse. If a detainee applies to the Court of Protection against their detention under Schedule A1, and the court authorises the deprivation of liberty instead, meaning that the original authorisation may well be discharged, then that person will lose their non-means tested legal aid and so will their representative. We understand that there may be a policy change in this area, following a case heard recently by Charles J, but have few details at this stage.

In some cases, if the applicant for legal aid is in receipt of certain benefits, then their income will not need to be further assessed\(^\text{189}\).

However (and this is a significant change from the position pre April 2013) in all cases at all levels of legal aid an applicant for legal aid must have their capital assessed.

**Evidence of financial eligibility**

The approach of the Legal Aid Agency to evidence of financial eligibility for legal aid has radically changed in recent months. The means test itself has become more stringent, with all clients needing to provide their capital even if they are in receipt of ‘passporting benefits’ where the DWP has already undertaken an assessment of their capital in order to decide that they qualify for benefits.

The proof which a client has to provide of financial eligibility is extensive, including 3 months of original bank statements (or certified copies of the originals), evidence of benefits received etc. However in addition explanations are often required to be given as to small amounts of money received or withdrawn from bank accounts, without which legal aid will not be granted.

Mentally incapacitated clients are already at a significant disadvantage in a myriad of ways due to their disability however the extensive documentary requirements mean that it is even more complex and problematic to confirm eligibility. The DWP takes many weeks, if not months, to respond to requests for confirmation of benefits claims. Banks asked to provide original bank statements often cite data protection issues as a reason for not disclosing relevant information, leading to satellite disputes, all of which result in a delay in obtaining legal advice. Where Court proceedings are already in existence it may be possible for an order to be obtained requiring disclosure of relevant financial information however often this will not be possible. The consequence for the person is that their representation is delayed, sometimes for weeks or months, whilst the evidence is obtained, and in some cases they will not access legal aid at all because the evidence cannot be obtained.

**Transforming Legal Aid**

We are extremely concerned about the impact on those without capacity of the proposed new residence test. The test provides that legal aid will not be available for persons unless they have been lawfully in the UK for a continuous period of 12 months.

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\(^{189}\) Reg 6, Civil Legal Aid (Financial Resources and Payments for Services) Regulations 2013.
The Government has indicated that this will not be imposed in "detention cases": but there are many cases involving vulnerable people in disputes about where they should live, or who should see them, or whether they should have medical treatment, that do not involve detention. Moreover there are many cases of people who need legal advice related to their incapacity which do not involve proceedings before the Court of Protection. Will people who lack capacity to make decisions have to prove their immigration status before being able to get legal aid? It seems that this is the case. Given that many people who lack capacity will not have passports, or other documentary evidence of lawful residence, and because their paperwork is often being managed by others (who could be in a position of conflict) this is of significant concern because very vulnerable people at risk of abuse or neglect will be left without protection.

Current problems in securing legal aid:

R (Moussa) v Legal Services Commission [2013] EWHC 2804(Admin), was brought prior to LASPOA. The case concerned a dispute between a family and Local Authority as to where their son who had significant difficulties would live. The son was being cared for in residential care. The family wanted him to return home. The Local Authority commenced proceedings in the Court of Protection to determine P’s best interests in terms of his residence. His mother was named as a respondent on the form COP1 and pursuant to Court of Protection Rule 73 she automatically became a party.

The Court has the power to join other persons if “desirable for the purpose of dealing with the application” (COPR73(1)). The Court may also remove parties: COPR73(3). In this case the mother was financially ineligible. She had an amount of equity in her home that took her over the capital limits. In this particular case the home was where the family wished to accommodate P. Mr Justice Charles agreed to join P’s brother as a party. P’s brother was a student and was financially eligible for Legal Aid. It was made absolutely clear to the Court of Protection that the reason for joining the brother was to ensure that there was one family member who was eligible for public funding. That member would then become the voice of the family. It was only ever anticipated that one party would be legally aided.

The Legal Services Commission refused the brother funding on the basis that the mother could reasonably bring the case. It was argued that a refusal to fund the brother simply made it impossible for anyone to argue the family’s position with the benefit of Legal Aid, because the mother could not access the funding in her home, and the home was the place where the family wished to accommodate their son. It was unrealistic to consider for example the sale of that property to allow the mother to realise some of her capital. Whilst the judge expressed some sympathy to the family the application for judicial review was refused.

Due to the way in which the scope of legal aid has changed from ‘it’s available unless it is excluded’ to ‘unless a case falls within the list it will be out of scope’, it is likely that some cases which were previously within the scope of legal aid may now fall outside. This is not due to a deliberate policy change, because the Government has made it absolutely clear in its response to the consultation which preceded LASPOA that it recognised the importance of continuing to make available legal aid to vulnerable people in capacity and community care cases. Any such change would therefore be unintended, and presumably lead to remedial action to ensure that people for whom the Government intended to make legal aid available were not then excluded.
However the consequence of making the system much more complex for clients to navigate, with the reduction in practitioners able to undertake legal aid work, enhanced means assessments and high thresholds for providing evidence of means and residence in the UK is that clients are less likely to be able to access legal advice than before.

It should also be noted that what we have sought to describe in this paper is simply the process of obtaining legal aid in the first place. Once a certificate has been granted it will have a financial limit and a scope limit, possibly limiting the legal aid to covering the next hearing and no further. Therefore at each stage in the case the provider needs to make an application to extend the certificate to cover each stage of the case. Applications to extend both the work covered and the overall costs limit have to be strictly justified.

Sophy Miles
Nicola Mackintosh

2 December 2013
Mira Makar MA FCA – Written evidence

The witness thanks the House of Lords for the opportunity to provide this evidence. As requested, the evidence draws on experience without being case specific. It deals with abuse only.

Summary

1. The MCA is dangerous. It replaces one person for another in respect of decisions which are properly made by the first, the person affected. Identity, rights, entitlement to be heard, to be able to challenge, to be able to choose, to be able to benefit from rights already won or to which there is entitlement, all disappear. The MCA can be, and is, used abusively including in particular where there is no evidence.

2. Perversely, the MCA facilitates a judicial forum and process from which a person is excluded. A process can start and reverse purportedly under the MCA, with no evidence. This is the exact opposite of the objectives of the MCA to facilitate inclusion and access, even if decision-making capacity is inadequate, and there is a surrogate or deputy required, to mimic the outcome, had there been capacity.

3. That forum in itself, by exclusion of the victim, facilitates an opportunist not replying to previous challenges (eg on the jurisdiction of the court) which have been made by the victim (and/or their representatives) and to making up evidence without it being subject to challenge by the victim.

4. There is no obligation on the person seeking to trigger the MCA against another being required to identify themselves or assert their complaint, prejudice which they have suffered or pecuniary benefit which they seek and state why they think they are entitled to it from the victim.

5. The MCA can therefore be used as one of a plethora of “litigation weapons” and indeed as a litigation weapon of last resort to achieve money benefits purportedly from the victim, the securing of which involves driving them into bankruptcy, thereby actually excluding them from access.

6. There appears a well oiled engine between the courts, the Official Solicitor, the police, social services, doctors and psychoanalysts that once triggered by any mechanism, operates in a manner that is unstoppable, to the exclusion of the victim.

7. These activities could not take place unless there is underlying identity theft, and theft, misuse and trading in personal data secured from private investigators and hacked from banking, solicitor, accountant records, amongst those concerned, lubricated by UNLESS orders from the courts.

8. Similarly they could not take place if the Official Solicitor did not refuse to deliver up personal data, refuse to account, and DACU (data access and compliance) omit to refer such abuse to the police.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1. The MCA has not achieved its aims. The evidence in this paper refers to cases of abuse only.

2. Which areas of the Act, if any, require amendment; and how?

2. A grass roots re-think is required of the fundamental principle of replacing a person with another; the impossibility of safeguards; and the need to be seen to speedily prosecute abuse, with the prosecution route well oiled.

3. It is extraordinary the MCA can be used for pecuniary gain as ruthlessly as it is so used, and that there are no consumer safeguards in place: for a person first hearing the word “capacity” by itself, the natural understanding is of resource capacity, eg “can you take on a piece of work, do you have time, resources, budget?” not “does your brain work?”

4. Empirical data and specific cases require public examination and offenders must be prosecuted.

5. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

5. No. The reasons are set out below for each principle.

**Principle 1:** ‘A person must be assumed to have capacity unless it is established that he lacks capacity.’ (section 1(2))

6. The principle should read “A person is presumed to have capacity” and stop.

7. This per se is sufficient together with human rights to record the correct position in law and to protect everyone.

8. The UNLESS qualification is extremely dangerous. This is because it says that a person will be treated “AS THOUGH” they did not have (mental) capacity (implicitly: even if they do have), as far as the courts are concerned, so long as “it is established” they do not.

9. Importantly “it is established” does not require the involvement of the person, their knowledge, their agreement.

10. The consequence is that, so long as there is an indicator of “it is established” by any person, in particular to the exclusion of the person involved, that person may, with purported impunity, have their identity used and their judicial standing usurped and know nothing about it.

11. The consequence is obvious: civil rights of the victim are given up, asset and contingent asset stripping, laundered and layered through the courts, all unbeknown to the victim and their dependants, who are voiceless throughout.

**Principle 2:** ‘A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.’ (section 1(3))

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
12. “all practicable steps to help him to do so without success” is an aspiration which is doomed to failure because the person (victim) is excluded.

13. Implicitly the principle says “all practicable steps….. have been taken…… by another person or persons”. This exclusion is totally in opposition to principles of human rights and natural justice.

14. Similarly “all practicable steps to help him to do so have been taken without success”. The exclusion of the person from establishing what is and what is not success and whether the steps taken are the right ones to establish success or failure fails because the person is excluded.

**Principle 3:** ‘A person is not to be treated as unable to make a decision merely because he makes an unwise decision.’ (section 1(4))

15. There are at least two persons involved in this principle. The first is the person themselves (nr 1). The second is the person who is passing judgment (nr 2) on a purported decision made by the first.

16. The person, their choice and the decision they make are all the property of the person, including their rights to unfettered enjoyment, privacy, confidentiality, a fair trial, family life. This bundle of rights, it would appear, is thrown out of the window, when there is a second person, and doubt is thrown up by person 2 as to whether a decision of the first is “unwise” or not (lack of wisdom is an allegation which is disparaging of the person and will blacken their name in any event).

If not “merely unwise” it may also suggest “lacking capacity”, with the extra task of a determination of the difference between “merely unwise” and “lacking capacity”, person 2 being in the driving seat and person 1 excluded.

**Principle 4:** ‘An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.’ (section 1(5))

17. There is a fatal fudge in this principle. Implicitly it says “An act may be done, or decision may be made, under this Act for or on behalf of a person…..” This should be made explicit so that MPs voting truly understand what is being said.

18. The principle is: “one person (nr 1) may be the surrogate of another (nr 2) in law and therefore the judicial system”. In other words the INDENTITY and RIGHTS of person 1 can be assumed by person 2, and person 2 will be treated in law “as though” they were person 1.

19. The fundamental question for MPs is; “Can a system of safeguards ever be robust enough that Parliament can be satisfied that the outcome would exactly mirror the outcome had the decision been that of person 1 plus the full consequences of further decisions and consequential decisions?” Plainly the answer must be “no”.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Principle 5: ‘Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.’ (section 1(6))

20. Principle 5 is also a fudge: either a surrogate (person 2) assumes the identity and rights of person 1 in law and the judicial system, or they do not. A decision on the way in which person 1’s “rights and freedom of action” are curtailed, to a greater or lesser extent, is made by person 2 and not person 1, and cannot be separated from the decision itself.

21. Recent rulings by the Family Court and the Court of Appeal on Family matters illustrate explosively that the judiciary have simply had enough, and do not except simply being the stooges of local authority workers: this is no more than the anonymous reports by Family court judges in the Guardian in December 2012 and February 2013, that Family court judges needed protection to carry out what they were being asked and expected to do, and that those objecting could be doing so with justification. In particular the police “hotline” gave no response.

22. Those circumstances are no different to those of persons making use of the Mental Capacity Act 2005, as yet another financial product for layering and laundering in the courts. This is a forum where there is no proceeds of crime vetting on case take on ie a free-for-all.

23. By this mechanism it is possible to steal the identity of another person and trade in their personal data, secured by infiltrating personal records including banking records, the perpetrators blagging their way including to securing access to confidential court records.

They use private investigators to establish points of weakness and therefore leverage, in particular over financial businesses with control over victims’ assets and finally they secure the services of the Official Solicitor, a mental health “expert”, high court judges, pre-retirement or deputizing post retirement under the Mental Capacity Act 2005, freeze out the victim, obtain money benefit from a court of competent authority against the victim, and use statutory demands and the Companies and Bankruptcy Courts to bankrupt and asset strip the victims. In this court there is no public inspection of records available i.e. a secret court run essentially on behalf of the Insolvency Service.

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

24. The MCA has been used (in abusive cases, the subject of this evidence) to achieve the opposite of the purpose behind the MCA, to give voice to those who are voiceless when decision making capability stops them being able to do it for themselves.

25. The MCA has become yet another litigation weapon to steal from those who are not heard but whose identity has been used, financed by their property in order to secure.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

26. Hopeless. No warning was given to the public that this new litigation tool existed and was going to be used by the state against the electorate, with state officials purporting empowerment in secret trading of personal data and refusing all contact with witnesses/victims. The techniques used are what one imagines Stalin’s Russia must have been like.

27. The Information Commissioner has not made his presence felt in this area at all, issued no warnings: the **two months** delay recently negotiated by him from the Home Office Committee in regard revelations on the clients of rogue private investigators, is piling pressure on exposing the trade in personal data, and the MCA and abuse in this area is fertile territory for investigation.

28. Similarly the investigations in regard WHISTLEBLOWING (now BIS, FCA re encouraging, and the Parliamentary Commission on Banking Standards), have not, it seems, properly reached the investigations into abuse of the MCA.

   This is now a tool for silencing whistle blowers (eg case of airline pilot who blew the whistle on the toxic air that is breathed in aircrafts), usually associated with asset stripping them, putting burden on them, and racking up legal expenses that cannot be paid and which are used to take the person’s home.

29. The use of the Official Solicitor in bankruptcy cases for vulnerable people is also open to question: with the staff of the Official Solicitor publicly evidencing they want to come in at the start and take over.

   There is absolutely no protection for victims of the Official Solicitor and his staff. It is a mystery that either BIS or the courts put up with this disorderliness.

   The administration staff make statements that they know are not true (on existence of records and who did what) and when the finally decide to come clean, exclude their victims, and never remotely consider apologising.

30. The Official Solicitor operates in contravention of the Data Protection Act, does not provide personal data within 40 days and ought to be at least suspended for investigation and possibly closed down for trading illegally, for the protection of the public.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
31. The paths of abuse are well trodden and well known. Victims facing the abuse for the first time suffer from the hurdle of disbelief. It beggars belief that state bodies and officials can act in co-operation in such flagrant abuse of the law. That they can stoop to procuring “court orders” that are sent late to the wrong address so they do not arrive, so they can railroad through what they want and get paid is shocking.

32. The mere fact that any person can trigger such a process against another, **without proving either who they are or what prejudice they have suffered**, speaks volumes for how the MCA is merely regarded as yet another “tool”. This is just the same as getting a “Civil Restraint Order” against someone in order to stop access to civil relief, or compelling someone who is a witness/victim to file under PIDA (public interest disclosure act). In such a case they have to survive the opponents publicly destroying their character (the underlying wrongdoing does not get aired), rather like the ducking stool in the middle ages where you were declared innocent if you drowned. A person who dies loses their human rights; those left behind are not regarded as having lost anything.

| 7. | Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity? |

33. No. In particular there are no public reports on evidence and those that have begun to collect evidence explicitly are not collecting case specific evidence. However without case specific evidence, trends cannot be properly established.

34. MoJ/HMCTS do not run MIS (management information systems) to provide the required data on abuse.

35. The use of “PRIVATE” hearings has become a device to purportedly legitimise bring in the perpetrators and excluding the public.

   Police say that there is no indictable offence in the uncertainty and terror including mental anguish this causes to victims and their families and dependants; it would have to be indicted as GBH (grievous bodily harm, offences against the person), as mental damage is an offence against a person as much as a physical attack is.

36. The MCA does not explicitly provide for offences under the Act, and a cause of action to the victims against the perpetrators and those who authorise or wilfully permit their action, including the right to have their identity revealed and a prosecution path without burden.

| 8. | Has the Act ushered in the expected, or any, change in the culture of care? |

37. Yes. Made it a “financial product” as many others, requiring explicit consumer and public protection.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
9. **Is there any evidence that the provisions of the MCA affect some groups disproportionately?**

   If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

38. Yes. Those whose identity is being stolen: their families and dependant families; executors of the estates of the dead; anyone who gets caught up in a dispute/standoff not directly involving them, but in which the disputing parties decide the victim will pay (“close the file in this case, but retain the relationship between us”); cases where the prosecuting bodies decide to prosecute according to who the villain is rather that what the crime is (fraudulent misrepresentation, identity theft, trade in personal data, conspiracy, acts of perverting the course of justice, blackmail, bribery, money laundering, false accounting etc), thereby leaving them at large and no protection for the victims.

### Decision making

10. **Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?**

39. The MCA is used against those with no decision making difficulties and no evidence to achieve financial gain for others.

40. The principle of “surrogacy” is the one that is open to challenge, not the detailed form.

11. **What evidence is there that advance decisions to refuse treatment are being made and followed?**

41. By excluding a person, with a label “mentally incapacitated”, the question of mental capacity is not considered, evidence is not required, and

12. **Has the MCA fostered appropriate involvement of carers and families in decision-making?**

42. These are excluded and not informed. Where the person labeled “mentally incapacitated” has dependants, family, staff, all are excluded, leading to ending of careers, closing of businesses, inability to look after older folk at home in families where the main bread winner is made redundant, and death in cases where the care home falls short of standards.

43. There is no organized way to collect data on damage, consequential damage and loss to the economy.

13. **Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?**

44. No. The Official Solicitor (Alistair Pitblado) and his staff (XXXX) step in, refuse to communicate, refuse to meet or take calls.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

45. No first hand experience

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

46. No first hand experience

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

47. No first hand experience

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

48. No first hand experience

The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

49. No first hand experience

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

50. No first hand experience

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

51. No first hand experience

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

52. No first hand experience

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
and appropriate? Is there a case for additional powers?

53. The Care Quality Commission has been publicly discredited. I have nothing to add to the public evidence that has already come out. There is a vacuum in regard what it ought to be doing.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
23. *Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?*

54. Social services are used by police to turn financial crimes reported into an issue with the person who is the witness/victim. However where the perpetrators who abuse MCA are not stopped by police/others, the witnesses/victims do not get protection under the witness and victim protection schemes.

55. Social services co-operate with police to gain unlawful access to victims medical records and details of registration, secretly communicate with doctors and use the doctors to gain inspection of the victims/witnesses, as a back door method of securing evidence that can then be used under the MCA.

56. Social services are offensive about personal faith, exclude spiritual healing from their tool kit, and therefore support from clergy. They assert they prefer “something more practical” in reference to forced attendance at a doctor to secure the record that would support incapacity and exclusion etc.

57. The courts co operate in this process by UNLESS Orders and “embargo’ed” decisions that it would be an offence to reveal including to citizens advice and an MP or family.

58. Reports to MoJ (Petty France) and to Ministers Grayling and Grant do not reach them: MoJ say they can only refer them to a “complaints” team who then say they have no experience and do not know what to do. The honesty is refreshing.

59. Those local authorities with control over the homes of the victims/witnesses are able to exercise leverage by ending leases and offering the opportunity of co-operation to the perpetrators such that the witnesses/victims may be evicted, the properties sold and the proceeds shared.

60. MoJ (and HMCTS) are signed up to the Domestic Violence, Crime and Victims Act and Code, but in practice do not treat the witnesses/victims as such, but rather as the wrong doers themselves, and enter into arrangements with the wrong doers to go down the MCA route.

61. Trading in personal data is endemic, in particular including between the perpetrators, the courts, the Official Solicitor and counsel. Judiciary refer these matters to DACU (data access and compliance) who elicit “there is nothing wrong” from one or two sources and write a letter saying to go away, without any contact details.

62. The MoJ has not carried out any investigations into the Senior Court Costs Office, a division of the High Court that operates without Notice of Issue, identification of claimant benefiting, and responds to a dispute on its jurisdiction by excluding the complainant, using the MCA and with the agreement of the perpetrators.

**Other legislation**

24. *How well is the relationship with the mental health system and legislation understood in...*
63. Very well as a litigation tool to achieve financial gain.

64. Not at all as a means of stopping abuse. There is a disconnect between abuses in court caused by those whose activities have been referred to the SFO (Attorney General’s Office, MoJ) and doing anything about the abuse.

65. HMCTS says SECURITY is empowered (Courts Act). SECURITY say this work is not in the job spec of its staff. Both statements are accurate.

Devolved administrations and international context

25. Does the implementation of the Mental Capacity Act differ significantly in Wales?

66. No first hand experience

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

67. No first hand experience

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

68. The MCA is not compliant with the European Convention on Human Rights and has no “guardians”

Below evidence is set out as to how the MCA is abused for financial gain by those not entitled, at the expense of others, using the courts and other state registries and functions including the Official Solicitor.

In particular, its use as a “litigation weapon” of last resort is explained, in order to usurp the rights of others.

As requested the points are set out as principles and techniques of general exploitation (abuse), and not case specific, save by giving one example, to illustrate the points made.

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no prejudice no relief:
a permanent state of affairs why attempts to deploy the deputizing might of the state as a litigation weapon are doomed to failure

27 March 2013

human right to a just trial and to be heard

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
includes the right to a deputy who does not represent you, but is a surrogate to complete a judicial process (subject to safeguards), but only if there is expert evidence that long term you are incapable of making a decision

**if no prejudice, no improvement by going to court**

if a court cannot grant relief (without a surrogate), the position cannot be improved with a surrogate

**if no prejudice, expert evidence is irrelevant**

if a court cannot grant relief (without expert evidence), the position cannot be improved with that evidence

**evidence of prejudice is essential and sufficient**

must be served on notice by the person prejudiced (or their deputy) to the person from whom the relief is sought

**finding requiring expert evidence, yet made without any, is meaningless and ineffective**

anything that emanates from such has no resilience, and falls on the challenge of a puff

**the boat has been missed, if no preliminary establishing of jurisdiction or reply to proper challenge on jurisdiction**

where the boat has been missed, the position of the passenger left behind cannot be improved, regardless of whether there is prejudice or not, or whether the court can grant the relief sought or not

**what is hopeless without consent, or without ceding to the jurisdiction of the court which it does not properly have, remains hopeless, whatever the trappings**

the evidence knowledge and submissions of a person cannot be buried, retrospectively or otherwise, by their volunteering a surrogate

**the appointment of a deputy cannot operate retrospectively to eliminate the judicial status quo at the date of appointment**

what was private before, is private after what was an abuse before, is an abuse after

**if no evidence to allow**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

**appointment of a deputy for one purpose,**
**the deputy cannot act for another**

*a paid deputy can never be party to their own appointment:*
*if they are, they are no longer independent and can go no further*

---

**if the gate is shut in one accounting period for gain, it cannot be open in another, by the mere expedient of shifting or other act of arbitrage**

*parasitic and leeching activities may succeed in transient perceived gain but are otherwise futile: culpability goes with encashment*

---

**a block that is permanent can never be removed**

*exposure of fraudulent trading will not be prevented by removal of any STAY or other civil protection for the benefit of the witnesses and victims, regardless of how many levels down in the judicial heirarchy the perpetrators go or however many counsel they incentivize*

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14 September 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
MCA and MCA DoLs’ Team of Cambridgeshire County Council – Written evidence

1) To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

As we see it, the MCA is not only an empowering piece of legislation but it is “cultural changing” and by that we mean the concept of capacity is now being recognized as decision and time specific. Moreover, the assessment of capacity to make a decision is no longer the domain of psychiatrists or clinical psychologists. We are encountering more and more LPAs for both types in our provision of social care and this may mean that the ability for people to plan ahead using the MCA is working to a fashion.

From our monthly practice meetings in relation to the MCA, we are still coming across especially, primary health care staff not being aware of the provisions of the Act. For example, anecdotally that we hear of GPs signing off Do not attempt resuscitation (DNAR)’s notice without interviewing the person but simply on account of their disability such as dementia.

We are currently hoping to implement a strategy to raise awareness of the Act with assistance from our Clinical Commissioning Group (CCG).

2) Which areas of the Act, if any, require amendment; and how?

We also see in practice the following issues that may warrant attention and further guidance:-

- People who have mental capacity, but whose capacity (ability to weigh the information given in balanced way and giving due weight to their own best interests alongside the interests of others) is overborne by undue influence. (for example, a mother is stopped by her daughter from accessing the help (including medical) she needs / will not engage with services, and is psychologically and emotionally undermined by her daughter who has mental health and personality problems. The mother will not stand up against her daughter. Another example would be someone trapped in relationships involving serious domestic abuse, whereby their capacity to make decision to end the relationship is being compromised by the dominant partner

- We would like some practical guidance to deal with the issue of executive functioning with someone who is deemed to have capacity to make decision but when it comes to carryout out the decision, the person is not able to. Perhaps it may be useful to amend the 2 stage capacity assessment test to take into account this issue.

- We often come across in practice of the scenario whereby someone is deemed to lack capacity by the decision maker on account of that person not in agreement with the decision maker’s proposal in terms of care or treatment as it is “easier” to then justifying under best interests than to work round it. Currently, there is no provision within the Act for someone to challenge the assessment of their capacity other than through an IMCA (but only if the person happens to be unbefriended) or through the Court of Protection which can be expensive. Perhaps in future, the

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
IMCA service can be funded to include advocating for anyone who is deemed to be incapacitated regardless whether they are unbefriended or not.

- We are wondering whether the diagnostic criteria is too narrow such that it may need to be considered in the light of the challenge raised by Art 12 CRPD. (See 27 below.)

3) **At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?**

We see the 5 principles of the Act to be the pillars for the framework in defining capacity and best interests. Locally, in our MCA Training we would advocate that when working with someone who lacks capacity, they will have to justify their actions or decisions against the 5 principles.

We would like to see more emphasis be given to the second principle of a person is not to be treated as unable to make a decision unless all practicable steps to help that person to do so have been taken without success. In other words, we should be aiming to develop a model of practice for supported decision making. What this entails in practice is the issue of allocating time resources in addition to properly trained human resources to undertake assessments.

**Implementation**

4. **To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?**

We quite often find in practice that the third principle is being compromised when risks to self neglect are involved. For example, the threshold to determine that someone is deemed to lack capacity to make decision about their care or treatment or residency will be set higher such that the person will often be said to fail the functional test of not able to weigh up the information relevant to the decision. Therefore, it is difficult to strike a satisfactory balance between enablement and protection.

5. **How effective was the Government's implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?**

The DH was very effective in providing both leadership and guidance pre and post implementation of the Act whereby there were regional leads in each region chairing and supporting local and health authorities’ MCA leads. However, this set up was disbanded a year following the implementation of the DOLS and we think this is a bit short sighted because of the continuing evolvement of the MCA through practice and case law judgments and the demand for leadership and guidance from a central source is never more keenly felt.

6. **Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
As mentioned above, the MCA is a “living” piece of legislation and it will continue to evolve with the sharing of best practice and emerging case law judgments. From our observations locally, a great deal of whether the Act is widely known and understood by professionals is dependent on whether the organization has employed a dedicated Lead person to front the implementation and development of the Act.

In the main, it will be fair to say social care professionals are slightly more au fait with the Act than health professionals and in particular those in primary care.

Through the observations of our Best Interests Assessors when they are carrying out their duties, there is often a lack in comprehensive and accurate recordings about significant assessments of capacity and best interests’ decisions. More work is needed to remedy this shortfall all round.

Through our provision of Corporate Deputyship service, banking and insurance services can do with awareness raising of the Act. The same is also applicable to colleagues in the housing provision sector.

We hope central funding for the MCA be continued so that Local Authorities are able to continue with their provision of MCA and MCA DOLS training in their own locality.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

From our observations through practice, more work is needed to raise awareness of the MCA and MCA DOLS with informal carers. That said, we are seeing more people have taken up the provision of planning ahead with setting LPAs for both personal affairs and health/welfare types.

Our Best Interests Assessors have observed that in all the assessments that they have done, they have yet come across a carer or family member knowing anything about the DOLS.

8. Has the Act ushered in the expected, or any, change in the culture of care?

For definite, this is a yes in such much as capacity is decision and time specific and the assessment of decision making ability is not longer the domain of psychiatrists or clinical psychologists.

We feel the MCA is requiring practitioners to justify their actions or decisions against the 5 principles when working with someone who lacks decision making ability. Hence, there is still some way to go to implement the MCA across the board.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
MCA and MCA DoLs’ Team of Cambridgeshire County Council – Written evidence

Through the MCA DOLS, we are seeing disability groups being affected more rather than minority ethnic groups and in this case, people with dementia, learning disabilities and acquired brain injuries.

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

There is where the second principle of the Act comes in and we are not seeing much evidence in practice that practitioners are providing all practical support to people to make decision especially life changing type of decisions such as moving into residential care.

We do on occasions come across decisions made by LPPs to be questionable in terms of whether they are in the best interests of the person. In such situations, we may suggest involvement of an IMCA and if as a resort, to refer the case to the OPG’s office.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

We do not have first hand experience on this point as we do not work in health care setting such as a hospital.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

Yes in so much as when the best interests’ checklist is being referred to when it comes to determining best interests for the person concerned.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

Without doubt, as commissioner for the IMCA Service, we found the IMCA to be a valuable resource in championing best interests and providing a voice for clients but half the problem here is to ensure an IMCA’s referral is made. In practice, there may be a bit of post code lottery because safeguarding involvement of an IMCA is discretionary although locally, we take the view that it is best practice to do so regardless and we find it makes little or no difference to impacting on their overall ability of the IMCA provider to meet demands of their service.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

The answer to the first question is partially with accommodation, safeguarding and review but not with serious medical treatments.

We have identified two possible reasons for regional variations in the number of referrals:

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
1) How much publicity is given of the IMCA service to especially acute hospitals and care homes?
2) There seems to be a direct correlation with number of referrals with appointment of a MCA lead person, be it a hospital of a care home provider.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

With our current demand for IMCA service locally, we feel IMCAs are adequately resourced and to date, we have close monitoring of our IMCA contract and we have no reasons to query their skills to assist in supported or substituted decision making.

A great deal is dependent on the contracting arrangements between the local authority and the IMCA Provider in ensuring that all IMCAs are appropriately trained and have access to relevant resources about human rights so that they can represent their clients.

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

Despite the imperfections of DOLS, it does serve the purpose in highlighting the need to comply with people’s human rights when it comes to making decisions for people who are not able to give valid consent to their placements in hospitals or care home.

Besides, the DOLS does give a voice to self funders and especially when their care regime in a care home may amount to a DOL in terms of justifying best interests and request a review of their care.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

Now that we have over three years of working with the DOLS, it will be good to do a root and branch review of the DOLS’ Code of Practice so that clearer guidance are given for the processes for authorization, review and challenge of DOLS.

What we would most value is to be given some guidance on whether an incapacitated and informal patient (not detainable under the Mental Health Act and not able to give valid consent to be an inpatient either but compliant) in a psychiatric ward setting but not free to leave until such time a suitable placement is found, does this group of patient need to be assessed under DOLS? This issue of either the Mental Health Act or the DOLS in a psychiatric ward setting has potentially massive resource implications in terms of personnel such as Approved Mental Health Practitioners (AMHPs) and Best Interests Assessors (BIAs) and care management resources through S117 of the Mental Health Act.

The Court of Protection and the Office of the Public Guardian

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

Again the answer to this question is based on our experience in providing a Corporate Deputyship service and on this issue; we think after the initial teething problems, they now seem to be operating effectively and successfully.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

Unlike LPAs for personal affairs and finances, LPAs for personal care and welfare are only beginning to come through the system and it will take a bit more time to know the impact with regard to decision making.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

One of our Best Interests Assessors had commented that she had heard from a relative complaining that it will be too costly to apply for both types of LPA the same time. Otherwise, we do not have further experience on this issue.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

Yes as far as challenging for the DOLS and it is still early days to say what impact on the recent proposed reforms on legal aid may have.

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

As far as we understand, the CQC has no direct powers to enforce the MCA but the Health and Social Care Act and its accompanying regulations have similar relevant requirements in relation to involvement, choice, decision making and care planning. These requirements about compliance are located in the CQC’s essential standards outcomes, for example outcome 2 on consent to care and treatment.

To date, we have experience as Supervisory Body that Managing Authority such as care Home or hospital tend not to pay too much attention to their responsibilities when they are working with someone who has been granted a DOLS’ authorization in terms of monitoring visits of Relevant Person Representative, reviews or complying with conditions set by the Supervisory Body to lessen the impact of DOLS. Perhaps in time, CQC will be in a better position than they are to monitor compliance of their standards.
23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

No comment.

Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?
More guidance will be appreciated on the interface between the MHA and MCA in relation to DOLS and in particular the interactions between Schedule A1 and Schedule 1A in practice.
We believe there may be a gap in practice whereby a person may not be eligible for DOLS but not detainable under the MHA but deprivation is still occurring that cannot be met through the two Acts.-

Devolved administrations and international context

25. Does the implementation of the Mental Capacity Act differ significantly in Wales?

No comment.

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

No comment.

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

As referred in 2

2 September 2013
Dr Julie McVey (University of Liverpool) – Written evidence

This is a response to questions 4 and 6 in the call for evidence.

Summary

1. **Q4:** To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

2. The evidence suggests that the five principles of the MCA have been implemented in frontline practice to some degree. Most of the staff in the study presented here have used the MCA to safeguard the rights of service users, and were aware of the five principles. One participant lacked confidence in their knowledge and understanding.

3. At the NHS Trust that this evidence was taken from, there was no mechanism for performance management or audit of the application of the principles of the MCA for that service.

4. The evidence raises a number of concerns about the balance between enablement and protection. In particular, when presented with ‘grey areas’ (i.e. a lack of comprehensive understanding about the situation, person or decision), staff used ‘safety strategies’ to protect themselves or the service users. A paternalistic model of care often occurred where best interests decisions were favoured over that of someone having capacity and making unwise decisions. Staff could be choosy about when they implemented the MCA. It was not used for day-to-day decisions, but would often be used when triggered by the need for an intervention or for a significant decision which might result in safeguarding issues. Staff acknowledged that they did not always use the Act: if a service user implied consent by not resisting care, treatment or interventions then the MCA was not used.

5. **Q6:** Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

6. There was some variance in the knowledge and understanding of the MCA amongst the staff in this study. There was large variation in training; some had corporate training, some had training commissioned by the service and provided by solicitors, others had academic teaching, one had none. All staff had access to training materials and local policy and procedures, including copies of the Act itself made available through the NHS Trust. Staff participating in this study did not have information about how their peers had accessed training or how well their peers understood the MCA, yet they used peer support substantially for managing how they used the Act. This method possibly poses a threat to the validity of the use of the Act.

7. A number of staff reported that they had encountered senior staff (including GPs and surgeons) as not understanding the use of the MCA. They reported that they had been asked by other healthcare or social care staff to use the MCA in a way that contravened the purpose of the Act, such as wanting ‘umbrella’ assessments, looking for service users to be statemented as permanently unable to have capacity over a number of decisions.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Evidence

8. A small scale qualitative study (n=11) was conducted as part of a Clinical Doctorate in Psychology, (D.Clin.Psychol) at the University of Liverpool. Using grounded theory, the study explored the experiences of healthcare staff in using the Mental Capacity Act (MCA) when working with people with a learning disability.

9. Ethical approval was gained through Integrated Research Application System (IRAS) and Local Research Ethics Committee at the NHS Trust hosting the study.

10. Participants were recruited from a Specialist Learning Disability Service in the NHS. Service users are adults with a Learning Disability who also require additional support for physical health, or have communication, behavioural, psychological or other mental health needs.

11. Participating staff had used the MCA in the six months prior to becoming involved in the research.

12. Semi-structured interviews were conducted in a private consulting room at the service and took between 25 - 50 minutes.

13. There were 11 participants; nine were nurses, one a speech and language therapist and one a clinical psychologist. This information is not presented in the table 1 to preserve anonymity.

14. Table 1: Participant information

<table>
<thead>
<tr>
<th>Participant interview number and pseudonym</th>
<th>Length of interview (minutes and seconds)</th>
<th>Years (range) working with PWLD</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Anna</td>
<td>45.32</td>
<td>5-9 years</td>
<td>White British</td>
</tr>
<tr>
<td>2 – Ben</td>
<td>38.42</td>
<td>5-9 years</td>
<td>White British</td>
</tr>
<tr>
<td>3 – Cath</td>
<td>51.10</td>
<td>25-29 years</td>
<td>White British</td>
</tr>
<tr>
<td>4 – Debbie</td>
<td>42.46</td>
<td>5-9 years</td>
<td>White British</td>
</tr>
<tr>
<td>5 – Ella</td>
<td>33.56</td>
<td>30-34 years</td>
<td>White British</td>
</tr>
<tr>
<td>6 – Fay</td>
<td>29.29</td>
<td>25-29 years</td>
<td>White British</td>
</tr>
<tr>
<td>7 – Gina</td>
<td>22.59</td>
<td>25-29 years</td>
<td>White British</td>
</tr>
<tr>
<td>8 – Harry</td>
<td>40.32</td>
<td>20-24 years</td>
<td>White British</td>
</tr>
<tr>
<td>9 – Iris</td>
<td>28.38</td>
<td>35+ years</td>
<td>White British</td>
</tr>
<tr>
<td>10 - Joanne</td>
<td>24.22</td>
<td>1-4 years</td>
<td>White British</td>
</tr>
<tr>
<td>11 – Kerry</td>
<td>40.11</td>
<td>15-19 years</td>
<td>White British</td>
</tr>
</tbody>
</table>

15. All staff believed the MCA to be useful in supporting decision making for service users.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
16. Whilst staff largely thought that they understood the MCA, many raised concerns about other healthcare professionals not understanding or using it properly, if at all. Some staff reported that they had experienced GPs and surgeons in particular not understanding the MCA or made decisions that disregarded the service user’s rights.

17. Although the MCA can be used for every day decisions there was acknowledgement from staff that it tended only to be used when the service user was faced with a specific intervention or major decision. Sometimes the MCA was not used to assess capacity to understand decisions, particularly if the service user showed no resistance to procedure.

18. There was acknowledgement that decisions are not always straightforward, and that there are often grey areas. There were a range of factors reported that made the process difficult, such as not understanding individual’s functioning or mental mechanisms, or there being a lack of clarity about the decision or the consequences of the decision.

19. To help manage grey areas, some staff had a rubric which enabled them to choose whom to use the Act with (i.e. their selection meant that all assessments led to a ‘no capacity’ outcome thus forcing best interests decision making). Some chose to manage grey areas by using a multidisciplinary team (MDT) approach.

20. When grey areas were managed by taking a best interest approach (i.e. stating that the service user does not have capacity), this may be perceived by staff to be a safe outcome. Whom this is safe for, staff to protect from risk making a wrong decision or service users, to protect them from harm is less well understood.

21. When ‘no capacity’ decisions are preferred by staff, there is the potential that this could compromise the human rights of the service user. In particular, Articles 8 (right to private and family life) and 14 (no discrimination) of the Human Rights Act (1998) are most likely to be affected.

22. The findings suggest that there are a number of personal and professional risks involved in using the MCA.

23. Personal risks involved staff experiencing difficult emotional or moral feelings around the service user and the impact of the decision to be made. In particular, service user’s right to make unwise decisions were emotionally difficult for staff to manage. When staff choose to manage grey areas through best interest decisions, staff felt safe and their self esteem was preserved. Some staff expressed that they feared doing wrong by the service users. Given that staff are involved in health and wellbeing, and have a strong moral endeavour to support the service user there is a tendency to favour best interests decision making because it is less emotionally risky to staff than watching someone they care for make an unwise (and possibly risky) decision. Some staff described this as a paternalistic model of care.

24. With respect to professional risks, staff were concerned that professionally they do right by people. Some decisions presented life changing or life threatening risks. The staff may also feel an added sense of needing to do right because the people that they work with have often suffered abuse or experienced negligent practice or prejudice.
25. Another part to the professional risk is the effect on staff. All participants were aware of the potential professional consequences (e.g. being sacked or ‘struck off’) or legal consequences (challenges though court) of decision making. As the decision is based on ‘reasonable belief’ there are no absolutes, so the staff need to justify how they arrived at a decision. Even without litigation, a poor assessment could be challenged by colleagues or other professionals. This could expose the staff to being viewed as incompetent or negligent, and have an impact on their own feelings about their professional standing.

26. Both ‘personal risk’ and ‘professional risk’ brings about ‘strategies’ which mediate the risk; allowing staff to justify their position, creating what feels like safe practice for both the staff and service user.

27. A common strategy used to mediate the risks was peer support. It helped staff manage the professional risks by getting a clear sense of the process they need to use for assessment or decision making.

28. Peer support also assist with managing feelings about the outcome (be it validation of the process/decision or a sharing of feelings about the case).

29. Using peer support poses a number of threats to the validity of the use of the MCA. It is unclear if there was any agreed standard amongst peers; potentially they could all be misguided. Team or consensus decision making can affect the outcome in a way that ‘blind-multiple-member’ decision making avoids.

30. Peer support was also identified as good for sharing responsibility. That, along with teamwork (working within a MDT), provided clarification and permitted everyone to ‘sing from the same hymn sheet’, justifying that what staff have done would also have been done by others on the team too. This ‘safety in numbers’ diffuses the burden of responsibility and is important for providing reassurance to staff that the sense they make of a situation is right – and furthermore that they are doing a good job.

31. There were particular factors that influenced the use of the MCA. The findings of this study show that safety plays a role. The participants acknowledge that they do not use the MCA for every decision in a service user’s life, but the significance of the decision that has to be made triggers the need to balance the potential outcome against the need to safeguard against harm and prejudice. Thus, context and significance of the decision influence the use of the MCA.

32. An important element to understanding what facilitates staff in their use of the MCA was consideration of experience, confidence and competence. Whilst these issues did not map onto the theoretical model in any clear way, they were a continued focus of the context to the study and provided some insights to what may be important to staff.

33. The analysis showed that experience improved confidence, and that this experience was not based on length of time (years) working with PWLD, but rather the number of assessments (i.e. practical use of the MCA). It was demonstrated that self-defined competency was less due to gaining experience (how many times the staff used the MCA), but more that developing a sense of security or self-assuredness was important.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
34. There was a lack of standardised training reported. Staff were able to access formal documentation and support. Training did not appear to be a factor in staffs' understanding and use of the MCA.

35. This research supports the development of specific approaches to knowledge and education about the MCA. It is perhaps not about learning the statutory principles alone. Instead what is needed to use it is more akin to clinical skill development, which may be better facilitated through peer learning rather than formal/corporate/mandatory training.

36. The findings supported a theoretical framework explaining how staff are making sense of the MCA in relation to a series of risks, both professional and emotional, pertaining to both themselves and service users. This in turn impacts on how they use the MCA; seeking strategies which feel safe or may otherwise protect them from personal or professional scrutiny. These strategies include peer support, supervision, MDT working, supplementary education, documenting the process, and using the MCA in a way that forces the determination of best interest decisions over unwise decisions in the face of uncertainty. The key issue is justifiability. Ultimate safety is achieved if the actions of the staff can be reasonably justified to others.

37. There could be implications to using these methods. Firstly, a lack of performance management could lead to ‘safe practices’ becoming the norm – eventually leading to a dominant paternalistic model of care. Secondly, this could compromise the aim of the MCA which is to help support autonomy. Bringing about best interest decisions at times of ‘grey areas’ may be justifiable (on a case by case, decision specific basis), but ultimately this strategy is a threat to autonomy in order to gain a safe clinical outcome.

31 August 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Mencap, The Down’s Syndrome Association and the National Autistic Society – Oral evidence (QQ 74 – 89)

Transcript to be found under The Down’s Syndrome Association in Volume 1.
Mencap – Written evidence

About Royal Mencap Society

We support the 1.5 million people with a learning disability in the UK and their families and carers. We fight to change laws and improve services and access to education, employment and leisure facilities, supporting thousands of people with a learning disability to live their lives the way they want. See www.mencap.org.uk for more information.

We are also one of the largest providers of services, information and advice for people with a learning disability across England, Northern Ireland and Wales.

About learning disability

A learning disability is caused by the way the brain develops before, during or shortly after birth. It is always lifelong and affects someone’s intellectual and social development. It used to be called mental handicap but this term is outdated and offensive. Learning disability is NOT a mental illness. The term learning difficulty is often incorrectly used interchangeably with learning disability.

This evidence is submitted on an organisational basis.

Summary

1. We believe that the Mental Capacity Act 2005 (MCA) is a positive piece of legislation which when followed properly safeguards individuals’ decision making. It provides an important legal framework within which professionals in health and social care can act confidently in. For example, when people lack capacity, there is a Best Interests process to follow.

2. Prior to the MCA decisions often made ‘for’ people with a learning disability. Decisions therefore were often not in the best interests of the individual.

3. Our concerns are therefore focused on the implementation of the MCA and the extent to which professionals understand and follow MCA code of practice and associated guidance. This was brought into sharp focus by the recent ‘Report by the Health Service Ombudsman for England of an investigation into a complaint made by Ms B’ which found that the Doctor in failed to act in line with the MCA.

4. In addition there are areas where clarity is needed. In particular the definition of Serious Medical Treatment’ needs to be clarified and understood by professionals as do Deprivation of Liberty Safeguards.

5. The same is true for Do Not Resuscitate Orders which must only ever be made if they are genuinely in the best interests of the individual and with the full involvement of an informed Independent Mental Capacity Advocate (IMCA), when the individual lacks capacity and is unbefriended.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
6. Also important is the fact that families and carers are often not aware of the legal protection the MCA provides and their right to be involved in best interests decision-making when their adult son or daughter lacks capacity. In many cases they become increasingly concerned about decisions that are being made and find it difficult to know how to challenge decisions. We have supported a number of families in such situations and our response is shaped by that.

7. Our response is also shaped by a series of interviews with those working within our services. These included service managers, learning and development team and practice leaders across the country. Key points are made throughout the response while a full list of their comments are included as an annex.

8. Finally we believe that the MCA Committee should request that the Joint Committee on Human Rights reviews the implementation of its report one year after publication as we understand the MCA Committee will be dissolved upon reporting in February 2014. Given that the MCA Committee was formed in response to concerns that practices under the MCA may not be respecting human rights, the JCHR would be ideally placed to perform the review task.

9. In addition, it is vital the MCA Committee recommendations feed into relevant current and planned initiatives such as reviews around Winterbourne View, the review of the Mental Health Act Code of Practice and standards on restraint, and the conclusions of the Post Legislative Committee on the Mental Health Act 2007.

**Overview and context**

Q1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

10. The Mental Capacity Act (MCA) is a positive piece of legislation which when followed properly safeguards individuals’ decision making.

11. Prior to the MCA decisions often made ‘for’ people with a learning disability, whether or not they had capacity. When decisions were made, they were not always in the ‘best interests’ of the individual.

12. For people with a learning disability the Act has led to their greater involvement in decisions about their lives and an acknowledgement of their right to make their own decisions.

13. The MCA provides a legal framework within which professionals in health and social care can act confidently in. For example, when people lack capacity, there is a Best Interests process to follow.

14. While the legal framework is there, concerns remain around implementation of the MCA by professionals.

Q2. Which areas of the Act, if any, require amendment; and how?

15. There are areas where we believe clarity is needed. In particular the definition of ‘Serious Medical Treatment’ (SMT). Under the Act, people who lack capacity and are
unbefriended must have an Independent Mental Capacity Advocate (IMCA) instructed if a decision is being made about serious medical treatment. It is important everyone understands what SMT is so that IMCAs are instructed appropriately. This was a key recommendation made in the Confidential Inquiry into the premature deaths of people with a learning disability published in March 2013.

16. There is therefore a strong case here for amending the Act/clarification within the code. SMT should include non-emergency Do Not Resuscitate Orders (DNRs) as well as any decision taken NOT to treat or investigate.

17. The DH’s response to the Confidential Inquiry says they will look further at how to address this. It is crucial they do this. People with a learning disability who lack capacity often have multiple health needs and are extremely vulnerable. DNR and decisions whether or not to treat or investigate will come up all the time. It is important that decisions are made which are genuinely in the person’s best interests, and involvement of an IMCA in the decision-making process will be an important part of ensuring this happens for people who are unbefriended.

18. We would like to see a more accessible Code of Practice to support the implementation of the MCA. Practitioners applying the MCA in front-line practice cannot be expected to be legal experts on the MCA, and the Code of Practice is integral to ensuring proper implementation of the MCA across the field of health and social care. The MCA Code of Practice could be re-drafted to make it more accessible, as well as drafting tailored codes of practice for particular audiences (similar to the various Codes of Practice that accompany the Equality Act 2010) to make it relevant and accessible for practitioners in different fields.

19. In addition, the Code of Practice must be made accessible for people directly affected by the MCA to bring it in line with human rights principles, including the UK’s commitments under the UN Convention of the Rights of Persons with Disabilities.

Q3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

Yes, we believe they are.

**Implementation**

Q4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

See answer to question 6.

Q5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

See answer to question 6.
Q6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

20. We know from our experience of working directly with families through our helpline and case work but also through our relationships with professionals that there is still a lack of understanding and/or lack of adhering to the Mental Capacity Act 2005.

21. Concerns around how the MCA is understood and implemented are widely shared: ‘A number of reports, including the Confidential Inquiry into premature deaths of people with learning disabilities, the Francis Report, Transforming Care and the annual CQC report on Deprivation of Liberty Safeguards all identified problems with how the MCA is understood and applied.’ (DH Six Lives Report on Healthcare for People with Learning disabilities).

22. Our health campaigning has highlighted how serious the consequences can be when the Act isn’t followed. See Mencap’s Death by indifference and 74 deaths and counting reports. Particular concerns include discriminatory assumptions, not involving families in best interests decision-making and flawed best interest decision-making. Other concerns include: not providing the right support to enable someone to understand and make their own decisions – for example, not providing information in an accessible format or providing an advocate to support the person to understand information, if needed; not doing a full enough capacity assessment and allowing someone to consent to treatment, when they are not able to weigh up the options and understand the consequences.

23. The DH Six Lives: progress report on healthcare for people with learning disabilities found a lack of understanding about how to properly involve individuals and their families in making decisions about care and treatment: 40% of respondents with a learning disability felt that healthcare staff do not always included them in decisions 52% of respondents in the family survey felt they were not always included in decisions about the person with a learning disability’s care where this was necessary.

24. The Confidential Inquiry into the premature deaths of people with a learning disability in its final report concluded how: ‘professionals in both health and social care commonly showed a lack of adherence to and understanding of the Mental Capacity Act 2005, in particular regarding assessments of capacity, the processes of making ‘best interest’ decisions and when an Independent Mental Capacity Advocate (IMCA) should be appointed’.

25. Even very recently we have seen examples of professionals not adhering to the MCA. This was highlighted in the ‘Report by the Health Service Ombudsman for England of an investigation into a complaint made by Ms B’ which was published on 16th July 2013. The report documented an investigation into a complaint against a GP practice which let down a young man (Mr H) with severe learning disabilities.

26. Mr H, aged 23, has severe learning disabilities and behavioural problems. He also has epilepsy. He has historically been prescribed a series of medicines that he takes in liquid or dissolvable form because he becomes very distressed if he has to take tablets. One of those medicines is midazolam, which is used in emergencies if his epileptic seizures last beyond three minutes.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
27. In April 2011 his mother asked their GP for a repeat prescription of midazolam in liquid form to help her son’s epilepsy. The GP refused her request because it was too expensive. He would only prescribe her son suppositories or tablets in future. His mother, Ms B advised the GP her son had only been prescribed liquid medicine from a very young age, as his learning disabilities caused him to become very distressed if he had to swallow tablets.

28. Despite this, the GP said he would no longer prescribe any of Mr H’s other medicines in liquid form for cost reasons and that he would only prescribe tablets in future. After further questioning, the Doctor told her to find a GP ‘who has bigger budgets’ and who would ‘be happy to prescribe the medications’. Ms B was clear that the decision not to prescribe her son suitable medication put him at risk, including death.

29. After investigating the case, the Health Service Ombudsman found that the GP had not given Mr H the medication he needed on the grounds of cost and ignored disability discrimination law in the process. The Ombudsman was clear in the report that the Doctor “did not act in line with the Mental Capacity Act, GMC guidance and established good practice. Dr L did not consider his responsibilities under the Mental Capacity Act in reaching his decision about Mr H’s medication. He did not assess Mr H’s capacity to make a decision about his own treatments or medications. Nor did he take any of the required actions that could have led him to reach a ‘best interests’ decision on Mr H’s medications.”

30. The Ombudsman found serious service failure in regard to the Mental Capacity Act where the doctor had not seemed to consider any of the steps of the Mental Capacity Act and to make a best-interests decision in regard to the type of epilepsy medication he was prescribing, which he had changed based on cost.

31. The Confidential Inquiry recommended that Mental Capacity Act training and regular updates should be mandatory for staff involved in the delivery of health or social care and this is something that we support.

32. Commissioners of health and social care services are integral to ensuring the MCA is correctly implemented and applied in practice. This means Commissioners should be properly trained and equipped to ensure their commissioning decisions and practices support people who lack capacity to be engaged and involved in decision making. This also means Commissioners should be accountable for their commissioning decisions and practices, particularly in relation to commissioning local advocacy services and ensuring individuals and their families have access to accurate information about their rights and what the MCA means for them.

33. Mencap has worked with healthcare professionals and Royal Colleges to develop the Getting it right charter for Clinical Commissioning Groups. The charter spells out the nine key activities that all healthcare professionals should do to ensure that there is equal access to health for people with learning disabilities. One of the key activities focuses on ensuring staff understand and apply the principles in the MCA.

34. We believe the code and associated guidance should include practical scenarios and simple examples which will help aid professionals in understanding when to apply the MCA, conduct an assessment and so on.

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35. Although some existing research exists on the implementation of the MCA, much of the evidence of how the MCA is being applied in practice is anecdotal. Further research is needed to bring together and build on recent studies to help create a more informed picture of the challenges faced in implementing the MCA, and help inform the solutions for addressing these problems.

Q7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

36. Families and carers are often not aware of their right to be involved in best interests decision-making when their adult son or daughter lacks capacity. In many cases they become increasingly concerned about decisions that are being made and find it difficult to know how to challenge decisions. We have supported a number of families in such situations.

37. There are many families who think that the only way that they can assist in the decision-making of an adult with a learning disability is by becoming a welfare deputy. They are not being consulted in best interests decisions as they should be, and believe this is the only way to ensure they are involved.

38. Even when they are involved in decision-making, families have reported to us how they can feel disempowered during the process and find themselves on the back foot in best interest meetings. In some cases family members have not received the appropriate paper work prior to the meeting and in others families talked about how they felt that the decision had already been made before they walked in the room.

39. Mencap has produced resource packs for families and carers on the MCA, explaining their right to be involved in best interests decision-making, when their family member lacks capacity to make a decision, and how they can challenge if they are not being involved. These guides are often sent out when people contact the helpline and have been well received. However it would be good if the guides had as wide a circulation as possible.

Q8. Has the Act ushered in the expected, or any, change in the culture of care?

40. To some extent, however, whilst awareness of and implementation remain a concern, there is still some way to go.

Q9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

Decision making

Q10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

See answer to question 6.

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Q11. What evidence is there that advance decisions to refuse treatment are being made and followed?

41. People with a learning disability often struggle to get the support they need to make decisions around everyday decisions, so the potential provided by advance decisions is often not even considered. This would take dedicated training and support for the individuals, families and staff involved.

Q12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

See answers to questions 6 & 7.

Q13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

42. The role of IMCAs is crucial and they have supported people to have a real voice. However not all have access to an IMCA and there is significant variation across the country, as highlighted by the DH’s most recent IMCA report.

43. We would like more accessible information to be made available about Independent Mental Capacity Advocacy (IMCA) services and to encourage the use of IMCAs.

44. We believe there should be automatic referrals to IMCA services where safeguarding issues have been raised.

45. We believe there is a need for greater/more extensive involvement in advocacy support for decisions that are outside the scope of the current IMCA offer. Support for the everyday decisions where most breaches in rights are likely to occur.

Q14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

46. From our experience not enough people are being referred and we know from the DH IMCA report that there is significant variation across the country.

47. This is of significant concern. IMCAs are there to represent the most vulnerable people in relation to important decisions about their lives. The right IMCA involved in a timely fashion, who has the facts and can see the whole picture can make a valuable contribution to the decision.

48. It does however take an IMCA time to understand the complexity of the issues facing those with very challenging behaviour and or complex health needs. We have heard that sometimes they have not been as helpful as they could be because it can take quite a lot of time to get up to speed in a challenging situation. However in other situations we have heard they have been fantastic and critical in the decision making.

Q15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

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49. In order for an IMCA to advocate effectively on behalf of someone with complex health needs and or challenging behaviour in what is likely to be a complex and challenging situation, a significant amount of training is needed. With this in mind, greater investment in order to boost the number of appropriately skilled IMCAs would undoubtedly be welcomed.

Deprivation of Liberty Safeguards

Q16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

50. We welcome that safeguards were introduced to protect very vulnerable people who are being cared for in a restrictive way (which amounts to a deprivation of liberty), and who do not come under other legislation which provides safeguards for example the MHA.

51. However we are concerned that DoLS are still not properly understood and implemented. Wide variation exists around the country meaning that not all people are protected.

52. The Care Quality Commission (CQC), in its annual report on monitoring and the use of DoLS (2011/2012), highlights how important understanding of the wider MCA is in ensuring DoLS are understood. It calls on providers and commissioners of services for vulnerable adults to improve their understanding of the MCA and the DoLS.

53. The report says that CQC’s inspectors saw examples of friends and relatives being excluded from best interests decision-making, contrary to the requirements of the law.

54. The CQC report highlighted how restraint should always be a ‘last option.’ It went on to highlight how a greater understanding of the best interests and least restriction principles in the MCA is needed. Staff need to be aware of when lawful restraint might be moving into a DoL that requires specific authorisation.

55. Families have also contacted us, questioning why they have not been made representative of their son or daughter; often they have not been given a proper explanation. In this situation, families have said they suspect it is so that they are unable to effectively challenge the decision by the local authority.

56. This concern has been raised by the Mental Health Alliance, along with others such as families who are appointed as representatives. They are not always being made fully aware of their right to an IMCA for themselves and the person they are representing.

57. They have also raised concerns about the low number of appeals, particularly by family representatives; that the route for appeals is via the Court of protection and can be cumbersome; that there is not a quicker appeals process.

58. We support the findings and recommendations from the reports the Mental Health Alliance have produced on DoLS.

59. The parliamentary committee responsible for reviewing the implementation of the Mental Health Act 2007 made the following recommendation: “There is extreme variation in their (DOLS) use and we are concerned that some of the most vulnerable members of society may be exposed to abuse because the legislation has failed to implement controls to
properly protect them. An urgent review of the implementation of DOLS should be undertaken by the Department of Health and presented to Parliament, together with an action plan for improvement, within 12 months." We believe the MCA Committee should support this recommendation and reiterate the need to conduct an urgent and thorough review of DOLS.

Q17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

See answer to question 16.

**The Court of Protection and the Office of the Public Guardian**

Q18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

60. There is significant bureaucracy surrounding applications to the Court of Protection. The calls we have had from families asking questions about the process indicate it is not always easy to understand.

61. Families are told they can fill in the forms themselves but often they need help to do this and contact organisations such as Mencap as they can not afford legal support with form filling.

62. We welcome the thoughtful and helpful judgements coming out of the Court of Protection particularly around capacity and consent to treatment, sexual relationships including DoLS and the Neary case (below).

63. We think many families seem frightened of the Court of Protection – and can see it as being in cahoots with the Local Authority. They don’t realise it is about genuinely looking at the best interests of the individual. Although many find the judgments welcome.

64. Not all families are aware that in addition to being the body to which applications for Deputyship are made, the Court is there as a last resort if a dispute around best interests can not be settled.

65. The Neary case made clear that the onus should be on the LA to refer cases to the Court of Protection when there was disagreement about best interests. We have highlighted this case to families, to make them aware that they can ask for a case to be referred and that the onus should not be on them to actually refer it.

66. We believe steps should be taken to increase the accessibility of the Court of Protection, such as ensuring access to legal aid, reducing the cost, and introducing measures to ensure the meaningful participation of the person affected.

Q19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

Q20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

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67. There is some confusion from families around when they need to apply to become a financial deputy or a welfare deputy, including what the costs are/ whether they costs can be claimed back for the application and the supervision.

68. We have highlighted the Neary case to families, which makes clear the onus should be on the LA to refer a case to the Court of Protection when a dispute over best interests can not be resolved. If the LA refers the case it will also pay the application fee.

69. We would like to see costs reduced.

Q21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

70. Access to legal aid is critical for the protection of the rights of individuals and should be focused on the everyday decisions as well as those which are significant or have public interest considerations.

Regulation

Q22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

71. The Serious Case Review into Winterbourne highlighted real concerns about implementation of the MCA, including DoLS, and monitoring of this by CQC. It included a recommendation that 'the Department of Health should assure itself that CQC’s current legal responsibility to monitor and report on the use of Deprivation of Liberty Safeguards provides sufficient scrutiny of the use of DoLS'. We welcome that the Care Quality Commission (CQC) is responding to these concerns and focusing more closely on how it monitors the DoLS – this is critical and must continue.

72. Although the Care Quality Commission (CQC) already monitors and reviews the use of the Deprivation of Liberty Safeguards (part of the MCA) and the Mental Health Act, it does not have the same remit in relation to monitoring and reviewing the wider MCA. We believe that ensuring parity of powers so that the CQC monitors the use of the MCA (including the power to investigate service user complaints and a duty to visit hospitals and care homes) would be an important step towards ensuring the MCA is correctly implemented and applied in practice.

Q23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

73. While we welcome that CQC is focusing on how to better monitor MCA and DoLS other regulatory bodies and agencies need to undertake work in this area.

74. Specifically the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have a role in order to raise awareness of the MCA among their members and issue/promote guidance accordingly.

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75. We are concerned they professional regulators are not taking failures to adhere to the MCA seriously enough. No single health care professional has been struck off for not adhering to the MCA – even though the consequences can, and have, been very serious.

76. We also believe that human rights and equality bodies which should be protecting rights in other spheres of life eg. opening a bank account, should be acting in this area.

Other legislation

Q24. How well is the relationship with the mental health system and legislation understood in practice?

77. Findings from the University of Cambridge’s report, ‘Understanding the Interface between the Mental Capacity Act’s Deprivation of Liberty Safeguards (MCA-DoLS) and the Mental Health Act (MHA)’, suggest that the interface is not well understood. The report has four recommendations and suggestions for further research. The recommendations are:
   1. Strengthen attention to decision-making capacity in psychiatric as well as general hospitals.
   2. Revise the standard Forms,
   3. Revise and update the MCA-DoLS Code of Practice and clarify the status of guidance issued by the Department of Health,
   4. Review and improve the data collection and monitoring procedures.

Devolved administrations and international context

Q25. Does the implementation of the Mental Capacity Act differ significantly in Wales?

Q26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

78. Northern Ireland is currently planning to introduce a single law on mental capacity which would replace mental health law and should be the first to be introduced in the UK since the introduction of the UNCRPD. The key driver for modernising the law on capacity was the Bamford Review (2002-2007) which looked at law, policy and services affecting people with mental health difficulties or learning disability in Northern Ireland. The vision of the Bamford review was valuing “those with mental health needs or a learning disability, including their rights to full citizenship, equality of opportunity and self-determination”.

79. The proposals for legislative change are being taken forward by the Department of Health, Social Services and Public Safety and the Department of Justice. Both Departments have set up reference groups involving a range of stakeholders, including Mencap. Consultation on early proposals took place in 2010 but plans to consult on the main proposals over the summer of 2013 have been delayed.

80. It is anticipated that the proposed reform will introduce a statutory presumption of capacity. It will put in place a statutory framework which supports decisions making, regulates situations where there are concerns about an individual’s capacity to make decisions or where they have been deemed to lack capacity, enables arrangements to be put in place on future decision making, and provides safeguards. It is also anticipated that the new law will be principles based and ensure that all practicable steps are taken to assist a person to make their own decisions. It will apply to various areas of life including: healthcare, welfare and financial decisions and across all settings including hospital and community.

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Mencap – Written evidence

81. Mencap believes that the new legislation should introduce a framework which results in respect for the autonomy of individuals, recognises that some people may need extra support to make decisions and provides support arrangements, or enables such arrangements to be put in place. Mencap believes, too, that it is vital that the new legislation reinforces the shift towards viewing people with a learning disability as individuals with rights, who may need extra support to exercise their rights. It is important that the new legislation considers what needs to be put in place prior to, and at the point of, a decision being made where a person’s ability to make a decision is being called into question.

Q27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

82. See para 19

Annex

A summary of the interviews that took place with Mencap service managers, learning and development team and practice leaders in Nottinghamshire, Devon, Northamptonshire, Bucks, Derbyshire, Essex, Yorkshire, Cornwall, Wiltshire, Staffordshire, Hampshire, Oxfordshire and Birmingham

Question Answers/Comments

To what extent have the five principles of the MCA been implemented in the practice of our staff? (Principle 1: A presumption of capacity Principle 2: Individuals being supported to make their own decisions Principle 3: Unwise decisions Principle 4: Best interests Principle 5: Less restrictive option)

Is there any example/ evidence available to show this?

The 5 Principles are being used across the country and from the interviews we undertook these show there are varying degrees of knowledge and understanding about these principles.

People when asked to describe what the act means described the key components of the act, however they did not always use the language of the act to do this. The teams are sometimes confronted with other people and systems (outside Mencap) that do not seem to have an understanding of the MCA and this can lead to additional confusion, This seems to particularly relate to principles 3 and 4.

Many of the decisions that people are supporting individuals with are the day to day decisions such as what people want to do and the food they want to eat. The way that teams support people with this implicitly includes the first two of the five principles and here are many examples of how people are supported with Principle 4.

People were being supported to actively make decisions and of the sample polled there were less people who were involved in decisions where restrictive practice were employed, a

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further description of the way that questions about restriction are dealt with is found throughout the questionnaire, but has been more specifically targeted in the Questions on DoLS.

**Key Comment:**

The most quoted/best understood part of the act was about the idea of best interests. This seems to have had significant impact on the way that people work and record the work they do.

**Example of best interests**

- MCA assessments completed around money where the person we support does not have capacity to manage all their finances. A best interest meetings was arranged to discuss the amount of money we can support people to spend. This has been developed again with another best interest meeting and agreed with family that any expenditure over £100 will be discussed with them first.

**Example of poor external guidance**

- Late 2011, a new person was moving into a service and the manager asked if capacity form filled in about their understanding tenancy agreement. Mencap manager was informed by social worker that to do so was discriminating against the person. Mencap team challenged and Social worker changed their approach.

- An issue was highlighted regarding a person we support benefits and the need for these to be reviewed with the DWP. DWP felt that the person we support should have an appointee. Manager tried to get some guidance from Social Services regarding a best interest meeting. Was told by Social services that it was not necessary and it would be normal practice for the provider to support people with their money, person’s sister has now taken this on.

**Use of least restrictive practice**

- One woman being support enjoys going food shopping, but there is an issue related to safety for young children who she has attacked in the past. She is now supported by staff to ensure she goes later when there is less chance of young children being present) and with an extra staff member.

Are you aware of the Government’s original implementation plan?

What measures were taken (By Local Authorities, and by us) to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? (for example what training, or communication was used)

Has this led to sustainable change?

The government implementation plan for the MCA does not appear to be well known or understood. People recognise that it came into place a number of years ago and that there was a code of practice to support this.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Mencap – Written evidence

The training and support they received to understand what this meant was very varied across the county.

• In some areas there appears to have been no LA training provided, in some it was just for managers (who were expected to cascade this to their staff), and in others there was a lot of training offered and this extended over a period of time.

• The training in some areas was specific to Learning disabilities and in other areas was generic training.

• In most areas it was recognised that there had been support by Mencap to train the teams, and in a number of areas the LA had also done this, or linked it to other training that they delivered.

• It was not felt that families were as aware of the act and there was only one place where it was stated that families had been part of the training that was delivered.

Although a number of people were not sure about the sustainability of the changes where they were able to comment the teams felt that sustainable change had happened the key was that people were being supported more often and better to make their own decisions.

Some of this change was attributed to the support the organisation had put to this, and some to the LA.

How do you feel that the Act is understood by any professionals required to implement it?

Does this differ across different sectors, such as health, social care, banking and others?

This area received a considerable variety of opinion, and while there are some examples of good practice and support by other professionals there has been considerable difficulties at times, particularly with health professionals.

Many of the examples here were about GPs/ nurses and hospital staff, and where there are positive examples they are often about learning disability nurses or mental health team).

There were some generally positive comments about community learning disability teams and the improved multidisciplinary working. However The specific examples of poor support that people were able to re-call outweigh the examples of good Multidisciplinary working. (it is possible that teams are more aware of/remember when things do not seem to work as well, and do not recall where things are working well/as expected).

Examples of poor health support:

• GP’s lack understanding especially around medication. They ask the staff their “opinion” without attempting to speak to the person.

• Consultants at the hospital just make decisions and when teams mention best interests they look at them and think that they are questioning their judgment.

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• One person who died in hospital last year had a best interest meeting and it was agreed that a do not resuscitate would not be put in place but GP reversed it without discussion. This was completed by GP alone as compared to the original Multi disciplinary decision had been made by about 15 people.

• A person with a hernia who the doctor wanted to consent to an operation. Support team were unclear whether the person had capacity to consent and understand the potential for impact on his life from the aftercare. Community Nurse did capacity assessment and said the person did not have capacity to make the decision. The person moved home and changed Doctor, attended the new Doctors without Community nurse and again a consultant asked staff to sign consent form

Examples of good health support:

• One person supported was spoken to by the consultant at the hospital and the consultant was clearly going through the principles checking out his language, making it simpler and he did not assume the person did or did not have capacity. He really took his time to make sure he got it right for the person.

Examples of poor financial supports:

• One person who has a financial deputy who will not pass money over for some costs for example holidays. The Manager feels that they are a bit over cautious – social services have been not been helpful in trying to resolve this case

• Some concern that Social Workers understand this with the example of One lady (with dementia) being assessed for a Court of Protection assessment where the Social Worker waved a £10 note and a pound coin in front of her to see if she understood what each was.

• One lady who has Down’s and Dementia her signature is changing. One bank refused to let her access her money due to this change. The team tried to open an account for her where a passbook could be used but this was refused as she would not understand the account. This lady’s finances have now been transferred to the Court of Protection this change took about 6 months.

Examples of poor other supports:

• One of the people we support was really poorly and his mum wanted him to make a will. It was difficult to know what the person we support understand about this will was. His mum arranged for a solicitor to come who said he did not need to follow the MCA as using an ‘old law’. The manager advised that a capacity assessment was needed and the Solicitor was adamant that this was not the case. The Solicitor eventually stopped his visit when person we support got distressed

• Discussions with social workers when moving people out of registered service, and having to explain that the people we support would find it hard to make decisions about future living choices e.g. living on their own in a flat or house.

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Mencap – Written evidence

Is the Act widely known and understood by those people we are supporting and any non-professional carers?

Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

It was felt that a lot of the people that we support would find it hard to understand the act specifically, and that this was particularly the case for people with more severe disabilities.

However throughout the responses that people gave they talked about the fact that one result of the act is that people were now more actively involved in the choices about their lives.

Some of the greater difficulties have been in ensuring that the families of people we support are aware of the act and what this means. There was little evidence of the Local authorities supporting people who have relatives where the MCA might apply, and only one authority included them in any of the initial training.

Has the Act brought about in any change in the culture of care?

Were these the changes that were expected?

There was a great deal of positivity about the act and what it seeks to achieve and there have been a number of outcomes of the MCA that people were able to identify:

• A more person centred culture, for the people we support this is more prominent now the Act is in place.

• It has emphasized the need to think about individual’s rights.

• It has made staff more aware of capacity. Support staff understand more now about capacity.

• It has altered the law about the protection of people who are vulnerable and lack capacity. It has meant that people need to know that neglecting people who lack capacity is now a criminal offence.

• It has led to much more collaborative working with professionals as the MCA best interests process gives a clear framework for joint and equal decision making.

• It means that People we support are better protected in a positive way and finances more protected.

However our teams are aware that this is not the case everywhere and highlighted some of their concerns, such as when things like Winterbourne view happens.

They saw this as highlighting that the act has not impacted upon everyone’s life yet and it’s not preventing things like that happening.

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Mangers felt that the implementation of the act has a lot to do with the quality of people managing services and the quality of support workers.

Our teams also recognised as in the examples above there is still work to do with other parts of health and social care, but they are confident that their teams are more skilled at challenging problems when they encounter them.

Do you have any experience that the provisions of the MCA affect some groups disproportionately?

If so, what evidence are you basing this on?

There was no experience of the MCA affecting any particular demographic differently, and examples were given of where the same decision was approached differently for two people in similar circumstances, with no apparent reason, for example;

- One man to move back into the area who was supported to make his own decisions. We have another man who was moved to us who was not consulted. So for one person the Act was used really well for the other person it did not feel like it was used at all.

However there were some comments about the potential of how the MCA is shared with and affects those people with PMLD, where in many areas of their life there will be a limited capacity.

A similar concern was raised about people with dementia, and people who had spent many years living in institutions who find making decisions more difficult.

There was no reference to how people with MH and under section are not included in the provisions of the act, however the reference to vulnerability of people at winterbourne view highlighted that the teams were aware that act was not positively affecting everyone’s lives.

Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past?

Is there any difference in the way that decisions are made (e.g.: through ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection) and the quality of the decision making?

This was a very strong positive response and managers felt that people were being supported to make a lot more of their own decisions, or take control of the decision-making.

They were clear that a lot of the decision making is about the day to lives of people and that staff support people with this, they also described how teams had changes their ways of working to support this;

Examples:

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Mencap – Written evidence

- One lady we support with dementia needs support to make decisions and finds it easier to have her limited choices e.g. now between 2 things. When she finds this hard the team work to makes sure that they act on what they know about she has liked and enjoyed previously. This is all recorded in her support plan and has been agreed with other professionals.

- Where people do not use words to communicate, more effort has gone into using the Act, rather than just using MDT – e.g. if somebody has been on holiday before, much more is included now about that person’s experience rather than just information from carers.

- A lot more effort has been made to pull so many people together, family and professionals – It has made utems think a lot more about decisions and who needs to be involved.

Teams noted that there was some difference in the ways that decisions are being made and there was a use of some of the ‘tools’ and resources of the MCA with varying ease, For example;

- For one person we support we are looking to get appointeeship for them and this still seemed to involve a lot of work, a lot is taken into account when making such changes and decisions are not being taken lightly.

- One teams experience of the court of Protection have been fine except when trying to arrange a funeral plan for someone. The family agreed but the Court of Protection challenged the decision. They agreed at the end with the support of the lady’s family.

- For a mixed group of people who are all under court of protection and appointee.. It has been a brilliant system and has worked really well. Not directly involved with all their money, but now can break down how much they want/need per week and the CoP deposit this onto cards. if person wants to go on holiday, do BI process, speak to CoP and with detailed planning the funds that are needed are made available to person. This team have Never had a problem with CoP not releasing funds.

- One team supports people with counter signatories and LA is taking over deputyship this has not been a quick process

- At another service LA did not have capacity to take on the role of supporting with deputyship so put team in touch with DOSH. 5 / 6 months later when lady had to move due to health issues she still did not have any of her finances sorted out.

Has the MCA improved the appropriate involvement of carers and families in decision-making?

The answers to this referred back to the best interests decisions that were clearly being used (see first question), and described how the best interests have brought in the views of families, however this has not always been easy; examples include,

Positive

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1096
Mencap – Written evidence

- In regards to best interest meetings it becomes more of a shared decision making process. The team includes the families and important people in all decision-making processes.

- In experiences that team have had with families they are a lot more involved and very supportive of the team. The teams keep families up to date and have an ‘open door’. People who we support have lived at this service for a long time and the team recognise they are lucky as they have a good relationship with family members.

- For one person with a healthcare decision involving PEG tubes, one family member said they were was greatly supported by the best interests decision making process as this meant that they were involved in putting forward their views. They recognised that the decision did not lay directly with them, or with only one healthcare professional who maybe did not know their relative well. This appears to have worked well.

**Negative**

- It has not always been helpful some families who are involved do not want to allow people choice but certainly best way is to involve as many people as possible to get a balanced view.

- There have been cases where families are in strong disagreement with Local Authority and the Local Authority decisions on how to deal with this may not always be in the best interests of the person, this can create further conflict.

- There is some lack of understanding from families – but the MCA has probably improved their involvement. Families tend to be very reliant on people who have understanding of the MCA to lead them.

Have you had any experience of working with IMCAs.

Has the role of the Independent Mental Capacity Advocate (IMCA) provided a voice for clients, and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf? The people polled had very little experience of working with IMCA’s, where they had been involved they felt that their involvement was mainly positive, and from well skilled individuals. Negative comments identified more on the lack of availability and lack of organisation of the service

**Positives included:**

- It’s a really good independent source for the people we support If and when needed to those most vulnerable. They are knowledgeable and not afraid to challenge or ask difficult questions.

- The IMCA lead is fantastic supportive and understanding and they have a really can do attitude especially re ‘un wise’ decisions.

**Negatives Included:**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Mencap – Written evidence

- When supporting a service change manager only ever managed to get one IMCA involved and they seemed really reluctant to work with people who have limited communication – meetings were so delayed that IMCA went to work with someone else.

- Where supporting someone with a DoLS and this was removed the IMCA did not seem to have been informed and continued to visit to support.

Has the level of referrals to IMCAs met expectations? If no why?

This was a very mixed opinion with one area being very positive about their access,

‘A good system where urgent or standard referrals are easily made. Its is easy to get in contact with the team by email, fax, phone and they get back quickly they have really got this right and there are posters in all services about the IMCA service.’

Other areas had less experience or needed to request through a care manager and there may be some delay in getting the service.

Are IMCAs adequately resourced and skilled to help with supported or substituted decision making for people lacking capacity?

Almost all of the IMCAs were seen to be knowledgeable and informed, and they had been trained in a way that supported them to do their jobs well.

There was only one comment that suggested that the IMCA struggled when working with people with more profound disabilities.

Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

There was little experience of this in the sample taken. However a number of the services that were contacted were supported living.

Many of the managers were aware of the process but had not needed to instigate this with the people they work with. There was some concern that some of the things that people may do everyday may result in a deprivation of liberty. People were keen to minimize any restrictions in peoples lives

The impression that was given from the responses received is that DoLS are seen as something that is inherently ‘bad’. That if you require a DoLS then there is something that you are doing wrong in your service. Not that this is a restriction that is necessary to keep the person safe and free from harm, that is agreed by a DoLS assessor as the appropriate measure to take at this time, or that there are recommendations about how this could be reduced.

People in some cases described a single restriction as a DoL and where it had been instigated the range of things that people were requested to refer to the DoLS team was varied, including the use of restraint, double staff supporting to go out to do banking, use of cot sides, lap belts, removing property from someone’s room and the use of child locks in cars.

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Mencap – Written evidence

There was no reference to the use of sedative medication but there was a reference to the use of both restraint and breakaway.

Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely

The numbers of people who have applied is very small (in sample) however the experience is that once started the process is manageable, though bureaucratic, and for a small number of people confusing.

The issue seems to remain with how to understand whether/ when individual restrictions amount to a DoL, and how to get reassurance from MDT teams that they are in agreement with the team on this.

There was one service that talked about how they had the opportunity to discuss this with the DoLS team in their area but this was not common.

9 September 2013
Mental Disability Advocacy Center (MDAC) – Written evidence

Interest and expertise of MDAC

1. The Mental Disability Advocacy Center (MDAC) is an international human rights organisation which advances the rights of children and adults with intellectual (learning) disabilities and psycho-social (mental health) disabilities. MDAC uses law to promote equality and social inclusion through strategic litigation, advocacy, research and monitoring and capacity-building. MDAC operates at the global level as well as regional and domestic levels in Europe and Africa. MDAC is headquartered in Budapest, Hungary and was founded in 2002. MDAC has participatory status with the Council of Europe and enjoys special consultative status with the United Nations Economic and Social Council. It is a member of the Fundamental Rights Platform of the EU Agency for Fundamental Rights.

2. MDAC contributed to the drafting of the UN Convention on the Rights of Persons with Disabilities and has for several years taken cases, with local lawyers, to national courts and the European Court of Human Rights, on cases involving legal capacity. These involve Shtukaturov v. Russia (2008), Stanev v. Bulgaria (2012), Kedzior v. Poland (2012) and Sykora v. Czech Republic (2012). In the last two years MDAC has organised training events on legal capacity and the CRPD in Bulgaria, Czech Republic, Hungary, Latvia, Lithuania, Moldova, Portugal and the UK, and in addition, MDAC trains judges from around Europe by acting as an expert for the Academy of European Law in Trier. It assists NGOs to carry out law reform advocacy in several European jurisdictions, and in 2012 this work resulted in legal capacity law reform in the Czech Republic, Hungary, Latvia and Russian Federation.

UN Convention on the Rights of Persons with Disabilities (CRPD)

3. These submissions address matters relevant to questions 3, 18 and 27 contained in the call for evidence:

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disabilities (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

4. The CRPD recognises the autonomy, dignity and freedom of people with disabilities. Its general principles are set out in Article 3 and include “respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons” and “full and effective participation and inclusion in society”. The general principles reject a paternalistic approach to decision-making of people with disabilities, and the only time the phrase “best interests” is used is in relation to
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

5. In essence these are the two foundations of the whole Convention. First, that people have legal capacity (which, clearly, does not mean mental ability) at all times and in all life domains. And secondly, that some people will, for some decisions, require support which is phrased as a state obligation. The Convention both promotes a classic liberty model based on freedoms, and makes the point that formulative equality is not enough for people with disabilities: some people need support to elevate them to an “equal basis with others”, a level of substantive equality to which all human beings are entitled.

6. Legal capacity includes both the ability to hold rights and to be an actor under the law (e.g. enter into contracts, vote, marry, etc.). It is the law’s recognition and validation of an individual’s will and preference and is the key to accessing meaningful participation in society. Mental capacity is distinct from legal capacity – it is the decision-making skills of an individual, which naturally vary among individuals and may be different for a given individual depending on environmental factors.

7. In order to secure equal recognition before the law for people with disabilities, laws must recognise that persons with disabilities “enjoy legal capacity on an equal basis with others in all aspects of life” (CRPD Article 12(2)). This requires a system of ‘universal legal capacity’ – where all individuals inherently possess legal capacity, and restrictions on legal capacity can only occur on the same basis for people with and without disability. To accomplish this, states must abolish denials of legal capacity that are discriminatory on the basis of disability in their purpose or effect (CRPD Article 2). Status based legal capacity systems violate Article 12 because they are facially discriminatory – for example, a law that allows for the imposition of a substituted decision-maker solely on the basis of the individual having a particular diagnosis (e.g. dementia). Similarly, functional tests of mental capacity that lead to denials of legal capacity violate Article 12 if they are either facially discriminatory or are disproportionately applied to people with disabilities.

8. In creating supported decision-making systems, states must address situations where, after all efforts are made, an individual’s will or preference cannot be ascertained. In these limited cases of last resort, there must an option for facilitated decision-making. This structure must only apply when:

a) Supports have been exhausted (including creative communication techniques, building relationships, accessible information, etc.) and they have not led to a decision; and

b) the individual’s will and preferences cannot be ascertained; and

c) the individual has no previously-expressed will and preferences (planning documents).
9. Facilitated decision-making is different to forms of substituted decision-making because:
   a) decisions must be made giving primacy to the person’s life narrative – including any evidence of will and preferences; and
   b) efforts must continue to be made to augment a person’s residual decision-making abilities; and
   c) the facilitator should build up a support network around the person with the view to developing communication with the person.

10. The UN Committee on the Rights of Persons with Disabilities is the treaty body which is set up under the CRPD to interpret the treaty and to monitor state compliance. The Committee has clearly stated on repeated occasions that systems of substituted decision-making are not compatible with Article 12 CRPD and should be “replaced” with systems of supported decision-making. Substituted decision-making denies individuals the right to operate autonomously and places their decision-making rights in the hands of others. Substituted decision-making runs the risk that decision-makers are influenced (whether consciously or not) by their own personal interests, values, beliefs or goals. At worst this can lead to exploitation, abuse or neglect of the person with disabilities. Supported decision-making, by contrast, involves supporting the individuals to give legal effect to their “will and preferences” (Article 12(4)) with the support of trusted others.

11. The shift from one regime to the other is one which legislatures are grappling with across Europe. MDAC is involved in law reform advocacy in eleven countries. There is no doubt that the MCA 2005 is superior to the legal regime in most (if not all) European states. That said, the CRPD imposes an obligation on all states to continuously review their laws, however advanced they may be in comparison to other state parties to the CRPD.

**Does the MCA 2005 comply with the CRPD?**

12. The MCA 2005 is an example of a substituted decision-making regime, and is therefore _prima facie_ incompatible with the CRPD.

13. The MCA 2005 _could_ be applied in such a way as to reduce the extent of non-compliance with the CRPD:
   a. Restricting findings of incapacity to those who genuinely cannot communicate their views and who are therefore unlikely to be able to take part in supported decision-making, and/or making findings of incapacity a last resort option only to be used for specific decisions and limited time frames when supported decision-making-options have been properly tried and exhausted.
   b. Setting at a very low level the ‘relevant information’ which must be understood in order for a person to be judged to have capacity.
   c. Avoiding findings of incapacity that are based upon a suggested inability to “use or weigh [relevant] information as part of the process of making the decision”. Different individuals may give different weight to different factors, and there is

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a real danger that this component of the capacity test allows issues of outcome and judgments as to the appropriate weight to be attached to different factors to influence the finding on capacity. Alternatively, the MCA 2005 could be amended so as to remove an inability to weigh information from the statutory test in s.3(1)(c), leaving only an inability to use information under that part of the test.

d. Placing considerably greater emphasis on the following provisions of the MCA 2005 than appears to be the case at present (judging in particular by the reported decisions of the Court of Protection):

i. Section 1(3): A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. All practicable steps should be construed so to require proper opportunities for supported decision-making to be given, and so as to preclude a finding of incapacity where this has not taken place.

ii. Section 3(3): A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

It is notable in this respect that whereas cases in the Court of Protection have from time to time been adjourned where capacity to consent to sexual relations is at issue, so that further work can be done to improve P’s ability to make decisions, there are few if any examples of the Court taking this approach in relation to other decisions.

14. Further steps that could enhance the use of supported decision-making include extending the statutory requirement for the appointment of an Independent Mental Capacity Advocate (IMCA) to cover all individuals in respect of whom it is proposed to take best interests decisions regarding their health, welfare or finances, and requiring IMCAs to have some training in speech and non-verbal communication techniques, to increase the prospects of their being able to develop strategies to communicate effectively with the individual.

15. The adoption of a model based on supports would avoid the need for the best interests formula. MDAC draws attention to the following observations of Prof Sir Ian Kennedy in 1991, which remain pertinent in the context of the MCA 2005:

“To decide any case by reference to the formula of [best interests] must be suspect... The best interests test may be beloved of family lawyers but a moment’s reflection will indicate that although it is said to be a test...it is not really a test at all. Instead, it is a somewhat crude conclusion of social policy. It allows lawyers and the courts to persuade themselves and others that theirs is a principled approach to law. Meanwhile, they engage in what to other clearly a form of ‘ad hocery’. The best interests approach of family law allows the courts to atomise the law, to claim that each case depends on its own facts. The court can then respond intuitively to each case while seeking to legitimate its conclusion by asserting that it is derived from the general principle contained in the best interests formula. In fact, of course, there is no general principle other than the empty rhetoric of best interests; or rather, there is some principle, but the court is not telling. Obviously the court must be following some principles, otherwise a toss of a coin could decide cases. But these
principles, which serve as pointers to what amounts to best interests, are not articulated by the court. Only the conclusion is set out. The opportunity for reasoned analysis and scrutiny is lost."^190

16. MDAC further notes the relatively limited role that the MCA 2005 accords to the individual’s expressed wishes and feelings, or “will and preferences” as the CRPD puts it (in Article 12(4)). Section 4 of the MCA merely identifies the individual’s past and present wishes and feelings as a relevant circumstance, along with a number of other relevant circumstances. It lays down no hierarchy or ranking as between the various factors. This has led to differing approaches in the Court of Protection, with some judges attributing considerable weight to the individual’s wishes and feelings and others suggesting that the decision maker must form a value judgment of his own when determining best interests, with the individual’s own wishes and feelings being merely one factor to be taken into account.\(^191\)

17. The courts have expressly eschewed the concept of a starting point in best interests decision-making (see K v LBX and Others [2012] EWCA Civ 79 [2012] COPLR 411) as none is provided for in s.4 MCA 2005. MDAC suggests that the best interests formula should be allied to the principles contained in the CRPD and the ECHR, and that consideration should be given to elevating P’s wishes and feelings (or will and preferences, in the words of the CRPD) above other considerations in the s.4 MCA checklist, such that any decision-maker proposing that it is in P’s best interests to do something to which P objects, should have the burden of proving his case, and should be required to seek the court’s approval in advance.

18. MDAC raises four further concerns:

a. The present safeguards concerning the assessment of capacity appear, from the reported cases, to be inadequate. There is a number of reported cases in which purportedly expert evidence on capacity has been criticized and rejected by the court, whether in respect of the conclusion reached, the method of assessment used, or the identification of information relevant to the particular decision at issue\(^192\). There is no guidance in the Code of Practice that accompanies the MCA 2005 as to what the relevant information is for particular decisions, and no formal mechanism for ensuring that professionals are kept informed of the decisions of the Court of Protection.

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191 Eg Re S and S (Protected Persons) [2009] W.T.L.R. 315; Re P [2009] EWHC 163 (Ch); Re M (Statutory Will), ITW v Z and others [2009] EWHC 2525 (Fam).

192 Eg KK v STCC [2012] EWHC 2136 (COP) (unanimous expert view of psychiatrists and social worker that P lacked capacity to decide where to live rejected); PC & Anor v City of York Council [2013] EWCA Civ 478 (expert psychiatric view that P lacked capacity to decide whether to resume married life with her husband rejected); SC v BS and A Local Authority [2012] COPLR 567 (psychiatric expert in autism had insufficient experience to assess capacity); D Borough Council v AB [2011] EWHC 101 (COP) [2011] COPLR Con Vol 313; [2011] COPLR Con Vol 313 (psychiatric expert view of relevant information relating to sexual relations rejected); A Local Authority v Mrs A [2010] EWHC 1549 (COP) [2010] COPLR Con Vol 138; [2010] COPLR Con Vol 138 (expert psychiatric evidence as to relevant information regarding contraception rejected); PH v A Local Authority and Others [2011] EWHC 1704 (Fam) [2012] COPLR 128 (independent psychiatric evidence that P had capacity rejected in favour of contrary views of treating professionals); Re P (forthcoming, 2013) (expert psychiatric view of relevant information relating to contact and residence rejected).
Against this background, it is of concern that in many instances of ‘best interests’ decision-making, no judicial or external scrutiny is brought to bear, and even when the Court of Protection is involved, the evidence of P’s capacity is often not tested and the parties proceed upon a consensus that P lacks capacity (because that is what the doctors have reported).

b. The safeguards that are in place are inadequate. There is no automatic entitlement to a litigation friend for an individual who is deemed to lack capacity to litigate. Where an individual is not entitled to legal aid, and does not have sufficient assets to fund legal representation, the Official Solicitor, due to lack of sufficient resources, does not agree to act as litigation friend unless the case concerns medical treatment. Often there is no one else willing or able to act. This is a breach of the state’s obligation under Articles 6 and 8 ECHR, and Article 5, 12 and 13 CRPD, to ensure that people with mental disabilities have the same opportunities to access justice as people without disabilities. The prospects of this breach being identified in litigation are slim, since ex hypothesi, the individuals it affects are those who are not entitled to legal aid and cannot afford legal representation otherwise.

c. A further problem arises in relation to the lack of clarity over whether the Official Solicitor (or any other litigation friend) is entitled to consent to court orders on P’s behalf, or to refuse to advance a case that accords with P’s wishes. If the litigation friend considers that P’s case is truly unarguable, the litigation friend may decline to present or argue it and/or enter into concessions purportedly on P’s behalf. In such cases, P not only has his wishes overridden, but is also prevented from arguing his position fully before the court, often on the basis that expert evidence is against him.

d. Article 12(4) of the CRPD provides that all measures that relate to the exercise of legal capacity shall “apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.” There is no such guarantee under the MCA 2005. The MCA Code of Practice expressly provides that disputes should only be referred to the Court of Protection as a last resort, and there is no other independent and impartial authority. There is no regular (or any) review of most decisions about incapacity and/or best interests decision-making.

4 September 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Mental Health Alliance – Written evidence

Scope of evidence

1. This evidence deals solely with the Deprivation of Liberty Safeguards (DoLS), which were added to the Mental Capacity Act by the 2007 Mental Health Act. The Alliance, which has 75 members, was formed originally to campaign for better mental health legislation, resulting in the 2007 Act, and has remained in being since in order to work for fair implementation of that Act in England and Wales.

Basis of evidence

2. This evidence is founded on two reports on the implementation of DoLS which were published by the Alliance in July 2010 and May 2012, and which are summarised below and attached in full as appendices. As the second of these reports is based on the situation as it was in the autumn of 2011, we have also noted the major developments since then, most recently the report of the House of Commons Health Committee’s Post-Legislative Scrutiny of the 2007 Act (including DoLS) published on August 14th 2013, and the publication on August 20th of the national DoLS statistics for England for 2012-13.

3. We have also included as an appendix, for information and as a contribution to debate, a working paper on a possible alternative to the DoLS scheme. This has been circulated within the Alliance, but it is not intended that it will be put forward for adoption as Alliance policy as it is based around the Care Bill and goes in some respects outside the Alliance’s strict remit.

4. Two questions about DoLS were asked in the committee’s call for evidence - are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate? and are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely? These questions were the main focus of our two reports, and our conclusion in both cases was that the answer was “no.” Subsequent developments have not caused us to alter that view.

The Alliance’s first report on DoLS

5. The first report, entitled “Deprivation of Liberty Safeguards – An Initial View of Implementation” was published in July 2010, although a draft had been sent to the Department of Health in March. It was based primarily on evidence gathered from organisations and individuals involved in implementation, and its conclusions were tentative as this evidence covered less than 12 months of operation of the scheme, which had come into force in April 2009. Nevertheless, its findings were widely accepted as presenting a realistic picture, and on 29 March 2010 the then Parliamentary Under-Secretary of State, Ministry of Justice (Lord Bach), said in a Lords debate on the Mental Capacity Act that (GC522):

“It is understood that the (Alliance) report confirms that there have been some improvements in practice and that there are major causes for concern in the low level of applications. There are significant variations in levels of activity between supervising bodies, lack of understanding of the Act,

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which was referred to by all noble Lords, and some lack of adherence to legal requirements. The Department of Health shares a number of these concerns.”

6. A Guidance Note was subsequently issued by the Department of Health (July 2010) addressing some of these concerns, and in particular the appointment of family members as Relevant Persons’ Representatives and the need to refer protracted disputes with families to the Court of Protection rather than using DoLS as a “final resolution” of them.

7. The summary and recommendations of the first Alliance report were as follows: The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were introduced in England and Wales in April 2009. They allow care homes and hospitals to obtain a power to detain residents or patients who lack capacity, if this is necessary in their best interests to protect them from harm. This is an initial review of the progress of implementation based on feedback from Alliance members and other organisations involved in the DoLS process, and which highlights some positive achievements but also a number of emerging concerns.

The aims of the safeguards were universally supported by respondents, and there was a wide consensus that many of those aims have been at least partially achieved. Training and awareness-raising prior to implementation led to reviews of care practices and to the removal of unnecessary restrictions on liberty, and subsequent applications for DoLS authorisations, whether or not they have been granted, have focussed attention on individual cases, leading to revision of care plans and in some cases to the commitment of more resources or a move to a more suitable placement.

However, these gains have been very unevenly distributed. The 9-month statistical outturn for England showed that the overall rate of applications was only one-third of the government’s prediction, and it has also acknowledged that there are huge and persistent variations in activity levels between different supervisory bodies (local authorities and PCTs) for which there are no obvious explanations.

The introduction of DoLS is also highlighting a very widespread lack of understanding of the main Mental Capacity Act, which means that care providers do not know when they are exceeding the powers it gives them and therefore cannot know when they need to apply for a DoLS authorisation. This is then compounded by the absence of a proper legal definition of “deprivation of liberty” or clear guidance about what it actually means in practical terms.

The responses also suggested that there may be widespread lack of adherence to legal requirements on the part of those operating the procedures. Some of this is probably inevitable in the very early stages of a completely new scheme, but if it continues it will be a matter of serious concern given that the courts quite rightly take a strict view about compliance with statute when powers of detention are involved. It is also more worrying given that the safeguards against unlawful or improper action are much less extensive than those provided for people detained under the Mental Health Act.

This would be so even if they were working satisfactorily, but the overwhelming evidence is that they have so far barely begun to function. They depend far too much on family representatives who may be elderly or disabled themselves, and there is far too much scope for supervisory bodies to protect their actions from scrutiny by selecting representatives who agree with them, by removing those who do not, or by failing to provide them with enough information or support and by batting away requests for review. The Court of
Protection is also inherently unsuitable as a route for appeals, and the process is heavily weighted against family members and in favour of the bodies which support the detention.

Although the flaws in the safeguards are fundamental, and raise questions at several points about compliance with Articles 5 and 6 of the European Convention on Human Rights, they could nevertheless be substantially ameliorated in practice by the greater involvement of Independent Mental Capacity Advocates (IMCAs). Their current level of participation is far below what was anticipated, and there should therefore be scope to increase it substantially.

**The Alliance makes the following recommendations:**

1. The government should undertake its own thorough analysis of the reasons for the lower-than-expected level of applications and the large disparities between supervisory bodies

2. The process of educating care professionals in the requirements of the main Mental Capacity Act is far from complete, and needs to be sustained

3. The government should issue revised guidance on the meaning of deprivation of liberty which is more comprehensible to care providers, and especially to staff of care homes

4. The term “deprivation of liberty” gives a negative impression which is creating resistance on the part of service providers. Whilst it is recognised that this term has for legal reasons to be used in the statute and guidance, the government should consider, at the first major review, whether an alternative title could be adopted for the scheme as a whole which would present it in a more positive light. The original intention was to title it “Protective Care” which had much more positive connotations

5. Refresher training for assessors should focus on improving their knowledge of the legal requirements and should emphasise the importance of full compliance with them

6. The government should clarify the ambiguous guidance in the Code of Practice on the selection of family or carer representatives, to make it clear that they should not be regarded as acting contrary to the detained person’s best interests solely because they object to the authorisation or are likely to challenge it, and that in selecting them the best-interests assessor or supervisory body must observe the requirements of Section 4 of the Act and caselaw on best-interests decisions

7. In any revision of the Code it should be made clear that the appointment of assessors “suitable to the particular case” is a statutory duty and not just good practice

8. Where a friend or family member is selected as representative, the appointment of a Section 39D IMCA should be automatic unless the representative positively declines it. It is recognised that this will have resource implications, but this is not a valid reason for failure to implement this important provision of the Act

9. Supervisory bodies should be required, by revision of the Code of Practice, to give full written reasons to representatives for declining to implement a request for a Part 8 review
10. The government should consider the implications for the DoLS review process of the High Court’s decision in the case of Salford City Council v BJ and issue guidance.

**The Alliance’s second report**

8. In 2011, as part of its wider review of the implementation of the 2007 Act, the Alliance conducted a further review of DoLS, which was informed by the much wider range of evidence by then available, including two full years’ statistics; the first reports of the regulators (CQC, CSSIW, HIW); the Department of Health reports on IMCA services; published research; and caselaw, in particular the Neary case. This report was issued in draft form in November 2011 and published as a chapter in the Alliance’s wider review of the 2007 Act in May 2012.

9. The main findings were that:

- While the introduction of DoLS was welcome in principle, its implementation has been extremely uneven, with the result that the protections the scheme is supposed to afford to vulnerable people are effectively unavailable in large parts of the country

- Its review and appeals processes do not comply with the requirements of ECHR Article 5(4), largely negating its intended purpose

- These flaws require remedy, and we need an urgent debate on whether this can be achieved through improvements to the current scheme or whether the regime needs to be radically overhauled or replaced

- The scheme is overly bureaucratic and stretches scarce professional resources

- **Nevertheless, where agencies have managed, with a great deal of effort, to make it work reasonably well, DoLS does perform a valuable protective function and has achieved at least some of the objectives set out for it, demonstrating that there is a need for a measure of this kind.**

10. It was noted that “The scheme has now been in place for more than two years. Such a radically new scheme could not have been expected to work perfectly from the start, but evidence suggests that many of the problems we identified in July 2010 remain.” The recommendations were that:

The Government should conduct a review of the DoLS scheme with the aim of preserving the essential purpose of DoLS but making its operation such that it:

- is much simpler and more straightforward

- is applied flexibly across the whole range of care provision

- is fully compatible with the Mental Health Act and the rest of the Mental Capacity Act at the points where they interact
Mental Health Alliance – Written evidence

- avoids conflicts of interest
- incorporates effective review processes, and
- does not rely on the Court of Protection as the first stage of appeal.

11. This report did little more than to confirm the findings of our original report, but on the basis of much stronger evidence, and in particular very clear evidence that the huge variations in activity rates between comparable areas, the reasons for which we had recommended in 2010 should be investigated, had become entrenched. However, the response of the government on this occasion, as contained in the Department of Health’s Post-Legislative Assessment of the 2007 Act in July 2012, was very different, and did not accept the need for an early review. It said that:

“National statistics suggest that there are geographical variations in the implementation of the safeguards, which may mean some areas are using them less than they should. Numbers overall however are increasing, suggesting that the safeguards are becoming better understood and there is increasing awareness...... the safeguards are still relatively new, potentially uneven in their use, and are still evolving. They play an important part in the range of safeguards available to protect people who need high quality “best interests” decision-making.”

12. We later gave written and verbal evidence to the House of Commons Health Select Committee’s Post-Legislative Scrutiny of the 2007 Act. Its report, published on August 14th, drew heavily in respect of DoLS on our second report, and its findings were:

“106. The Committee found the evidence it received about the effective application of deprivation of liberty safeguards (DOLS) for people suffering from mental incapacity profoundly depressing and complacent. The Department itself described the variation as “extreme”. People who suffer from lack of mental capacity are among the most vulnerable members of society and they are entitled to expect that their rights are properly and effectively protected. The fact is that despite fine words in legislation they are currently widely exposed to abuse because the controls which are supposed to protect them are woefully inadequate.

107. Against this background, the Committee recommends that the Department should initiate an urgent review of the implementation of DOLS for people suffering from mental incapacity and calls for this review to be presented to Parliament, within twelve months, together with an action plan to deliver early improvement.”

13. The Health Select Committee was therefore acknowledging one of the Alliance’s primary concerns, the huge variation in activity rates and the lack of central government action even to investigate the reasons, and was supporting our call for a full and urgent review. The government has yet to respond to this recommendation.

Other major developments since 2011

14. Since the second Alliance report was drafted in mid-2011 there have been two further full years of statistical returns for England from the Health and Social Care Information Centre. These show no major changes in trends which would call into question any of the
conclusions in the report, and in particular no more than a small diminution in the huge variations in activity rates between supervisory bodies, which have been present since the first returns in December 2009. The statistics for Wales are not dissimilar.

15. This year, for the first time, the English returns have contained an analysis of the differences between individual supervisory bodies, whereas previously these have been masked in all government statements by reference only to the much smaller regional differences, which are of no particular significance when the supervisory bodies (until April 2013 local social services authorities (LSSAs) and PCTs, now just LSSAs) are not organised on a regional basis.

16. However, the commentary to the returns does attempt to suggest that the variations may in part be due to social and demographic differences between supervisory bodies, and Anne-Marie Hamilton from the Department of Health advanced a similar explanation during her verbal evidence to this committee (see Q 15). In addition, she pointed out that “some areas have more hospitals and more care homes”, but this overlooks the fact that in most cases the supervisory body will be that for the area where the person is “ordinarily resident” rather than where they actually are, so London boroughs, for instance, with limited care home capacity within their boundaries, will assess their residents placed in care homes outside London.

17. It is undoubtedly the case that, even if the scheme were working satisfactorily, there would be some variation in activity rates caused by socio-demographic factors, but these can explain only a very small part of the current huge and persistent variations and cannot, even allowing for differences in population size, explain why, for instance, in 2012-13 Essex alone accounted for 13% of all applications from hospitals; why in East Riding and Hull only 23 applications in total were received from both care homes and hospitals, with just 3 being authorised, whereas the comparable totals for Leicestershire, Leicester and Rutland were 909 and 545; why West Berkshire LSSA had 3 applications, Buckinghamshire 365; why Coventry LSSA had twice as many applications as Birmingham, an authority with a population almost three times larger; and why Hillingdon LSSA had 4, Ealing 36.

18. There have also been two further DoLS Monitoring Reports from the Care Quality Commission (CQC), the regulator for DoLS in England. The March 2012 report noted that “there is some confusion about what constitutes a deprivation of liberty and this can cause inconsistent practice….. there continue to be concerns about the complexity of the Safeguards, in terms of content, processes and responsiveness.” The most recent report, published in March 2013, said that “there continues to be confusion around the precise definition and thresholds for deprivation (as opposed to restriction) of liberty. Recent court cases have ruled that there is no universal definition. Decisions can only be made on individual circumstances. The relationship between care, appropriate restrictions of liberty, the DoLS and the wider MCA has become complex and potentially confusing.”

19. It also noted that “analysis of CQC’s data from its monitoring activity shows that the umbrella legislation of the Mental Capacity Act (MCA) is not well understood or implemented in practice” and concluded that “the Safeguards cannot be understood without reference to the guidance on good practice that is found throughout the MCA. The highest priority, therefore, for health and social care providers in operating the Deprivation of Liberty Safeguards system is to improve understanding and practice of the MCA.” This is very much in keeping with a central conclusion of the two

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Alliance reports, that a full understanding of the main MCA and what it does and does not permit is fundamental to the proper application of DoLS.

20. An increasing concern of the CQC has been the number of situations it comes across where a care home or hospital resident who lacks capacity is subject to extensive restraint, or restrictions on liberty, but lacks protection because the situation is judged not to cross the threshold of deprivation of liberty as currently defined. This concern has increased since the decision in Cheshire West (see below) which can have the consequence that someone in a living situation judged as “normal” for someone with their degree of disability can be subject to very frequent restraints or severe restrictions on their liberty without coming within the scope of the DoLS safeguards, and it has also highlighted the lack of clarity as to what restraints can acceptably be applied under the protection of Section 6 of the MCA.

21. The Department of Health has funded research, although none of it is directed to investigating the differences in activity rates. At the outset of the scheme in 2009 it commissioned two studies, the first being by the School for Policy Studies, University of Bristol and entitled “Liberty, equality and capacity: the impact of the Deprivation of Liberty Safeguards on social care practice and human rights.” It was due to report in the summer of 2012 but we understand that completion has been delayed.

22. The second, which was also due to report in summer 2012, was carried out by the Cambridge Intellectual & Developmental Disabilities Research Group (CIDDRG) and was titled “Understanding the Interface between the Mental Capacity Act’s Deprivation of Liberty Safeguards and the Mental Health Act.” However, although the fieldwork was carried out in 2010-11, it is only in the past few weeks that the full 128-page paper has been posted, without publicity, on the CIDDRG website, so most practitioners in the field will not yet be aware of its existence. It does, however, contain a number of important findings, and in particular it contradicts the government view as expressed by Anne-Marie Hamilton (Q23) that “the relationship between the Mental Health Act and the Mental Capacity Act is clear in law” and supports Professor Richard Jones’s assertion (Q25) that “the relationship between the DoLS legislation and the Mental Health Act is not clear – people do not understand it.”

23. That assertion has now been further supported by a leading judicial authority, Mr Justice Charles, the President of the Upper Tribunal Administrative Appeals Chamber and the most senior judge in the Court of Protection. In his judgement in AM v SL&MT, [2013] UKUT 0365 (AAC) published on August 6th, he revisited and expanded on his previous judgement in GJ v The Foundation Trust (2009) which has up to now been the most thorough and authoritative case on the interface between the Mental Health Act and DoLS. He noted that “all decision makers who have to address the application of the provisions of the DOLS contained in Schedules A1 and 1A of the MCA are faced with complicated legislative provisions and their difficulties are compounded when they have to consider the relationship between the MHA and the MCA. Regular visitors to the provisions need to remember the daunting task they set for lawyers and non-lawyers who have to apply them.”

24. He then attempted to address the issues in a logical sequence in order to aid understanding, but the complexity of his arguments, set out in 88 densely-worded paragraphs, will still be way beyond the comprehension of most staff in the field who will be expected to apply them, often in circumstances of great urgency and confusion and after minimal training.
25. The appalling events at Winterbourne View have also focussed attention on the interface between the two Acts, and have demonstrated that, as Professor Jones pointed out at Q25, referring to the evidence of Claire Crawley at Q24, Department of Health officials are not always clear where it lies. The position at the hospital was stated correctly in the report of the NHS South of England review panel which, noting that most of the patients were at some point detained under the Mental Health Act, said (5.58) that “The Deprivation of Liberty Safeguards provide legal protection for those people who do not fall within the scope of the Mental Health Act. In this context, this would be patients with a learning disability who did not exhibit abnormally aggressive or seriously irresponsible conduct but who were deprived of their liberty in order to receive treatment.”

26. In practice this would have applied to a very small number of patients if any, as the presence of “abnormally aggressive or seriously irresponsible conduct” would be the sole justification for depriving them of liberty to receive treatment, and the real issue from Winterbourne View is the failure of the protections afforded by the Mental Health Act, which as Professor Jones pointed out contains greater procedural safeguards than DoLS. Winterbourne View also highlights the lack of protection from either legislation for residents who may be deprived of their liberty in “supported living” settings, to which it is intended that most patients from Winterbourne View and similar establishments will eventually be transferred.

27. There have also been a number of developments in caselaw. The appeal decision in Cheshire West and Chester v P, reported in November 2011, was widely seen as narrowing the meaning of deprivation of liberty in care settings, and it was narrowed further by two consequent decisions, in C v Blackburn (December 2011) and CC v KK (July 2012). Many commentators forecast that these decisions, plus the earlier decision in Neary (June 2011) which outlawed the use of DoLS as a means of resolving disputes with families which engaged Article 8, would have the cumulative effect of substantially reducing the number of people who could benefit from the protection of a DoLS authorisation.

28. However, this does not seem to have happened to the extent forecast, as the number of authorisations made continued to increase in 2012-13 albeit at a much slower rate than formerly, confirming a trend which had already begun in the second half of 2011-12. This tends to suggest that the decisions of assessors are not in fact very sensitive to the current judicial view of deprivation of liberty, and that the huge variations between supervisory bodies may have less to do with differing interpretations of this term than with differences in view as to the purpose of DoLS, or willingness to devote resources to it.

29. This in turn has implications for the appeal to the Supreme Court in Cheshire West and P & Q, which is due to be heard towards the end of this year, and in which a good deal of effort is being invested in the hope that it will bring an end to uncertainty about the meaning of deprivation of liberty and to what appears to be an increasing divergence between domestic judgements and those of the European Court of Human Rights. Even if the Supreme Court were to adopt a very simple definition which could easily be applied by best-interests assessors on the ground, it might have fewer implications for the scope of DoLS than is being widely assumed if this is not in fact being determined primarily by the assessors’ interpretation of the caselaw.

30. A simple unambiguous definition is, however, unlikely, as the outcome of every judicial attempt so far to clarify the meaning of the term has been to add yet another layer of In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
complexity, which has made it ever harder for the assessors, many of whom have had just a few days’ training, to understand it and to apply it to the situations in front of them. Mr Justice Charles, in the case, AM v SL&MT, referred to above, acknowledged (para 55) that “it is likely that whatever analysis is given by the Supreme Court the position will remain that two decision makers applying the correct approach could lawfully reach different answers.”

31. One remedy which has been widely suggested is that the Department of Health should revert to its practice before March 2011, when its DoLS implementation team was disbanded, of publishing regular digests of new caselaw. However, whilst a single authoritative body of guidance would undoubtedly be welcomed by assessors and care providers, the interpretations of the Department’s lawyers were sometimes controversial and could not properly be regarded as more authoritative than the welter of alternative views from other respectable sources.

32. In addition, there have been calls for an update of the guidance on deprivation of liberty in the DoLS Code of Practice. The seven-point checklist at para 2.5 of the Code is still widely quoted and used in training, and assessors are required by law to “have regard” to it, even though it is based almost entirely on the HL case from 2004 and takes no account of at least 24 relevant English and European cases reported since then. However, unless the Supreme Court does reduce the meaning to a simple formula, it will not be possible to update this checklist without dangerous oversimplification, and it will rapidly become out-of-date again with the accretion of new judgements.

33. Another alternative which has been widely canvassed is the replacement of a caselaw-based definition with a statutory one. This would undoubtedly lead to greater clarity, but it would be necessary to overcome the difficulty which led the then government to resist that course at the outset – that insofar as the purpose of DoLS was to ensure that English law was compatible with Article 5 of the ECHR, its definition of deprivation of liberty had to keep in step with the developing caselaw of the European Court of Human Rights.

34. The government has indicated that, although it does not see any need to amend the statute, it is prepared to consider revision of the DoLS Code as a whole. There are undoubtedly areas of it which could be improved to assist implementation, but it is important to realise that it is largely not a code of practice as generally understood, i.e guidance on the interpretation of the statute or on matters not addressed by it. Due to the impenetrability of the two Schedules of the Mental Capacity Act which form the statutory basis of DoLS, the Code was drafted primarily as a reduction of them into comprehensible English, and it therefore substitutes for them as a working document for assessors, many of whom will not have read them and may not even have ready access to a copy. Major revision of the Code would not therefore be possible without revision of the statute, which Professor Jones (Q 25) described as “so complex and interlinked that it is impossible to amend.”

35. By the same token, calls for simplification of the lengthy English standard forms need to be treated with caution as, although there is undoubtedly scope for improvement, they were designed to follow the requirements of the Schedules very closely and should therefore ensure that an assessor who follows them correctly will not make any serious legal errors even if they are not familiar with the Schedules. The Welsh forms are much simpler, but assume that the assessors do have a good understanding of the underlying statute.

Conclusions
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
36. Although the more recent of the two Alliance reports on DoLS is now almost two years old, it was widely accepted at the time as a fair reflection of the state of the DoLS scheme, and developments since have not invalidated any of its conclusions. In particular, huge variations persist in the extent to which the safeguards are being applied across the country, and in the absence of any clear understanding as to why this is the case there can be no immediate prospect of any improvement.

37. The report of the House of Commons Health Committee Post-Legislative Scrutiny of the 2007 Mental Health Act, published on August 14th, largely upheld the Alliance’s concerns and repeated its call for a full and urgent review of the scheme, and we would hope that this committee will endorse that recommendation. We would, however, counsel caution as to how far the scheme can be improved without a comprehensive revision of its statutory basis.

38. Until changes are made to the law, there has been general support expressed amongst Alliance members for efforts to be made to raise awareness and improve understanding of DoLS, and the MCA more widely, to address problems with their implementation in the “here and now”.

Appendices:

1. “Deprivation of Liberty Safeguards – An Initial View of Implementation” July 2010

2. Chapter on DoLS in “The Mental Health Act 2007 – A Review of its Implementation” May 2012 (pages 9-13)

3. Discussion paper “A possible replacement for the Deprivation of Liberty Safeguards (DoLS) using the proposed Care Act as a vehicle” Version 2.2 July 2013
Discussion paper for the Mental Health Alliance
A possible replacement for the Deprivation of Liberty Safeguards (DoLS) using the proposed Care Act as a vehicle

Summary

This paper sets out an outline proposal to replace DoLS entirely by incorporating its essential elements into the statutory care planning processes which will be contained in the Care Act (CA). The primary purpose of DoLS is to ensure that English and Welsh law complies with ECHR Art. 5, and as the CA processes will be a “procedure prescribed by law” any deprivation of liberty authorised through them should be Art. 5(4) compliant provided that they provide for “speedy access” to a judicial appeal body.

The proposal is that additional procedural safeguards should be provided for all those subject to the CA who fall into a defined “high vulnerability” group. One of these safeguards would be the involvement of an Independent Reviewing Officer (IRO) whose role would broadly equate to that of the Best-Interests Assessor (BIA) in the DoLS scheme. If it appeared that care arrangements which had been agreed as being in the best interests of an incapacitated person might amount to a deprivation of liberty (d-o-l), the IRO would be able to authorise this provided that all the necessary criteria had been satisfied as with DoLS at present, but for the additional safeguards to apply it would not be necessary to resolve the question of d-o-l one way or the other.

There would then be a right of appeal in the first instance to a tribunal-level body rather than to the Court of Protection (CoP) as at present. This scheme would effectively retain all the essential elements of DoLS but avoid all the rigidities, perverse incentives, duplicate processes and unnecessary bureaucracy of the present system, and would, in contrast to DoLS, make best interests rather than d-o-l the first question to be determined. In addition, it would ensure compliance with Art. 5 without the need to resolve the issue of d-o-l definitively, and compliance with the Art 5(4) requirement for speedy access to a judicial appeal body which the present remote court-based system does not. It would also ensure that, for the high-vulnerability group at least, the statutory assessment and care planning processes in the CA, and the best-interests decision-making processes in the Mental Capacity Act (MCA), were in practice legally enforceable.

Starting points:

1. The limitations of DoLS as a safeguarding mechanism
The DoLS Code explicitly assumes that effective needs assessments, plus care planning, monitoring and review processes, are already in place for everybody in hospital or residential care who lacks capacity, and that DoLS is there simply to authorise any necessary deprivation of liberty arising from the care plan arrived at through those processes. By the same token it assumes that the basic MCA best-interests processes will have been followed up to that point, i.e that decisions will have been taken in accordance with the MCA principles and that the person themselves, family and friends will have been involved and consulted in the making of the plan as required by MCA Section 4.

In practice, however, this is very often not the case, and even when decisions have been properly taken they are often not properly implemented. BIAs therefore increasingly use DoLS as a means of ensuring that these things happen, and see this as the major value of the

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scheme. Effectively, they use DoLS as a means of giving statutory teeth to the care planning processes which at present are primarily in guidance, and of enforcing the requirements of Sections 1-5 of the MCA which otherwise contain no sanctions for non-compliance.

However, DoLS is a very unsatisfactory way of achieving these aims, for six main reasons:

i) The main levers to ensure compliance (short authorisations, conditions, Part 8 reviews, Section 21A appeals) can be pulled only once there have been unambiguous findings of incapacity and d-o-l, and only whilst the person continues to lack capacity and to be deprived of their liberty. Incapacity and d-o-l, though, are at best very poor proxies for vulnerability to inadequate or abusive care due to failure of the statutory processes; many very vulnerable people will either fall along the borderlines of capacity or d-o-l or their status will fluctuate.

In addition, both incapacity and d-o-l are extremely difficult to define or to identify reliably, so professional judgements are bound to vary very widely even if the caselaw is clear (which it is not, and unlikely ever to be). The scheme’s coverage is therefore extremely arbitrary and haphazard and can impinge on only a proportion of cases where the person is very vulnerable due to the extent of control over their lives by others, and where proper care planning and monitoring and best-interests decision-making may be lacking and care may be inadequate or abusive.

Furthermore, the effect of P&Q and Cheshire West has been to remove the most vulnerable group – people with very severe and permanent disabilities who are under the total control of paid carers, have no family able or willing to provide alternative care, and who may be extremely vulnerable to infringement of their Art 2, 3, 6 or 8 rights – from the scope of the scheme; and if the DoLS-specific decisions in C v Blackburn and CC v KK are also allowed to stand this will further reduce the number of very vulnerable people who could benefit from the safeguards.

ii) The Part 8 review process was not designed to ensure reviews in the care planning sense, i.e regular meetings involving all parties at which all aspects of the care plan, including continued justification for any d-o-l, will be reviewed, but only to provide a statutory mechanism for revising or terminating an authorisation once grounds for doing this have become apparent. A Part 8 review should therefore follow a routine care plan review, but there is no requirement for these to take place.

iii) Conditions can impinge only on the Managing Authority (MA), whereas it is the care commissioning body (usually the Supervisory Body -SB) which is responsible for the care planning and review process (and in most cases for the decisions which lead to d-o-l) with the MA often being little more than a bystander.

iv) Although an authorisation can result in fewer restrictions than hitherto, it can have the opposite effect – it does not automatically require the MA to adhere to the care plan and unless hedged around with conditions, monitoring and regular reviews it effectively gives the MA carte blanche to impose whatever restrictions it thinks fit, which may go beyond those envisaged by the BIA at the outset. A supposed safeguard can therefore lead to greater restriction (as in the Neary case).

v) It relies too heavily on the Relevant Person’s Representative (RPR) to monitor the implementation of the authorisation and to trigger reviews or appeals – there is no provision in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
for continued formal oversight by the BIA or the SB other than by making very short authorisations. In practice RPRs, even with IMCA support, rarely pull the compliance levers.

vi) It does not apply at all to supported living, even though there is no evidence that people without capacity, in high-support settings at least, are any less vulnerable to inadequate or abusive care, or to being deprived of their liberty, than are people in registered care homes. Indeed, they may be more vulnerable, since the actual living arrangements are not currently inspectable by the CQC and are therefore effectively unregulated.

2. The approach of the Court of Protection, and the lessons from that

The judges have made it clear that they see Art. 5 and d-o-l as a secondary issue, to be addressed only when Art. 8 issues and disputes about residence have been resolved, and that DoLS cannot be used as a final resolution of the latter but that they must be referred to court. This severely limits the scope of DoLS (it would, for instance, have excluded the HL case around which the whole scheme was based) and conversely threatens to put an excessive load on the Court of Protection, which is an inherently unsuitable route for resolving the majority of Art. 8 issues, which in practice arise very frequently and could not possibly all be resolved through a higher-court-based process.

When it considers DoLS appeals, or cases which might otherwise have been resolved through DoLS, the basic approach of the CoP is to therefore give priority to the Art 8 and best interests issues, and this is in keeping with the way that the parties see the priorities i.e their first concern is whether the care arrangements are the right ones for that person, not whether they cross the legal line into d-o-l. The court’s jurisdiction is also inherently more flexible in that it can make a variety of orders, and its exercise of its powers is not dependent on a finding of d-o-l, the minimum requirement being merely that the person lacks capacity and that welfare decisions need to be made by an impartial body. What is needed, therefore, is a means of replicating this basic approach at the initial stage.

The court’s approach is also more appropriate in another respect. The DoLS scheme is irrational in that detention is “for the purpose of giving care or treatment” but the Code then says that an authorisation does not authorise the care and treatment but that a separate “best interests” process must be gone through post-authorisation, despite the fact that the BIA must have considered the proposed care and treatment, consulted with the parties and decided that it was in the person’s best interests, otherwise it would not have been possible to give the authorisation. This is especially confusing to hospitals, as they are usually looking for authority to treat as well as, or rather than, to detain.

DoLS, in this as in other respects, puts the cart before the horse – the logical sequence is first to decide, as the court does, whether the proposed care and treatment is in the person’s best interests, and then, if they will need to be detained in order to receive it, whether the risk of harm is sufficient to justify depriving them of their liberty.

3. The need to make the system simpler and more comprehensible

DoLS has created a huge body of unique bureaucratic procedures which are extremely clumsy and quite out of scale with its limited purpose, together with its own unique language. As a consequence it is not only very difficult and costly to implement but is also incomprehensible to those not involved with it on a day-to-day basis, and especially to

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1118
service users and their families. Any replacement needs to be based as far as possible on existing, proven processes and terms and to create special ones only where absolutely necessary. There is also an urgent need to simplify the confusing mass of legislation in this area – when the Care Act comes into force, then as things stand the care arrangements of someone who lacks capacity and is at risk of being deprived of their liberty may be subject to up to four distinct statutory regimes (the CA, the main MCA, DoLS, and the Mental Health Act) each with its own particular concepts and terminology.

The proposal

To replace DoLS entirely with equivalent provisions incorporated into the Care Act (CA).

The Care Bill as it stands:

The Bill, introduced into the Lords in May 2013, includes powers to make regulations but there are as yet no draft regulations or guidance. However, the Bill is based on the Law Commission’s proposals (Report 326 on Adult Social Care), and my assumption is, therefore, that regulations and guidance will follow the general lines set out by the Commission.

The DoH has acknowledged that at least 75% of people who are subject to care plans made under the CA will lack capacity in relation to care and support decisions. This means, of course, that these decisions and their implementation will need to comply also with the requirements of Sections 1-5 of the MCA (and that other provisions of the MCA e.g in relation to the appointment of IMCAs will also apply where relevant.) Most decisions under the CA will therefore be decisions under the MCA also.

The Bill contains a duty to assess need (Clause 9) which will be amplified by regulations, and duties to draw up (Clause 24) and to keep under review (Clause 27) a “care and support plan” which will (25 (1)(a)) “specify the needs identified by the needs assessment”. The duties to assess, plan and review presently contained mainly in guidance will therefore become “procedures prescribed by law.” They will also (9(3)) apply irrespective of the adult’s means or the level of their needs, i.e they will include self-funders.

These duties will not cover hospital in-patients unless (Clause 67 and Schedule 3) they have been referred to the local authority by way of an “assessment notice” as being likely to need care and support on discharge. However, from April 2013, local authorities have taken over the SB responsibility for hospitals, and so any patient referred for a DoLS assessment, or made subject to an authorisation, will be on the authority’s database and aspects of their care will be subject to assessment, planning and monitoring by it, albeit not within these provisions.

The Law Commission’s recommendations for the contents of a care and support plan (Para 8.48 of its report), based on its understanding of the requirements of current guidance, include (16) “any restrictions or deprivations of liberty imposed by the plan” and 17, “an assessment of the person’s capacity to consent to the actions covered by the plan, and confirmation that those actions are agreed to be in the person’s best interests” If these were specified in regulations under Clause 12 as “matters to which the local authority must have regard in carrying out the assessment” the statutory assessment process would then contain the first element of
the DoLS process i.e consideration as to whether an application for an authorisation needs to be made.

The proposed changes

First of all, there should be a two-tier assessment-planning-review process, with enhanced procedural safeguards for everyone who falls within a defined high-vulnerability group. High vulnerability would arise primarily from the co-existence of two sets of factors – high care needs and dependency on paid carers, and limited or absent capacity and/or ability to direct one’s own care or to access protective mechanisms. However, it would be possible to specify additional factors as contributing to high vulnerability, for instance the need for frequent or extensive restraints or restrictions, the use of sedative medication, or the absence of family or friends able to provide effective protection.

In addition, to ensure that it covers all Article 5 situations it should be made clear that this group will include inter alia everybody who might, now or in the foreseeable future, be deprived of their liberty in whatever way the courts are defining it at the time (as per Charles J at Para 64 of A LA v PB and P).

The enhanced procedure should comprise four elements:

i) Tighter procedures, and in particular requirements for regular multidisciplinary and multi-agency meetings and involvement of relatives/carers (on the general lines of the old Enhanced Care Programme Approach (CPA))  This would already be a good practice expectation in such cases and is likely to be a requirement of the CA Code in any event.

ii) An independent element, drawing on the models of the Independent Reviewing Officer (Section 118, Adoption and Children Act 2002) and independent chairs of child protection conferences.  This would, basically, be the new role for the BIAs. As with IROs, who can refer a case to CAFCASS, this person should, as a safeguard against obstruction, have the power to refer direct to the first appeal level.

iii) Where the person is believed to lack capacity, IMCA involvement on the same basic terms as in MCA Sections 37-39, but with the person and their close relatives having a right to IMCA support as in Section 39D

iv) A formal right of appeal to a judicial body for specified parties on specified issues. Although the Law Commission was precluded from formally addressing “mechanisms for redress” (probably because a new statutory LASS/NHS complaints procedure was brought in only in 2009) it did find (Scoping Report 4.331-350, Consultation Analysis 14.20-14.31) support for a “community care tribunal” to hear appeals.  The suggestion was that this should be modelled on the SEN and Disability Tribunal, and this seems to me to be appropriate for the first stage, with either the 2nd-tier tribunal or the Court of Protection being the next stage.

In their evidence to the Joint Committee on the Draft Care and Support Bill, the Local Government Association and the Association of Directors of Adult Social Services also called for an appeals tribunal, and the Committee responded as follows (Report Para 263):

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“We believe that the significant extension of local authority responsibility for assessment, and the introduction of the wellbeing principle into decision making, warrant an urgent review of arrangements for providing redress and complaints resolution. The Government should reconsider establishing a care and support tribunal to provide independent merit reviews of decisions made by local authorities.”

A tribunal on the SEN and Disability Tribunal model, with a limited remit and limited powers, ought to be sufficient to ensure Art 5(4) compliance. However, it would hear only appeals against decisions taken under the CA care planning process and would not relieve the CoP of the burden of “welfare” cases coming to it from other directions. An alternative model would therefore be to have a tribunal with a wider remit and powers which could deal at the first stage with all or most of the welfare (and possibly the property-and-affairs) matters which currently go to the CoP, leaving the court to deal only with the most intractable disputes or those where there are no novel issues of law.

In addition, there would need to be:

1. A provision requiring care providers other than hospitals to refer for assessment or reassessment anyone in their care whose situation appeared to bring them within the high-vulnerability group and who was not already subject to the enhanced procedure

2. A provision, as at present, for self-authorisation by a care provider where there was an urgent need to deprive someone of their liberty and no authority existed, to be accompanied by a referral for assessment as above

3. A provision requiring hospitals to refer for assessment any patient who they believed was being or needed to be deprived of their liberty (i.e anyone for whom they would now be required to apply for a DoLS authorisation).

As a local authority will not be able to assess, plan for or review hospital in-patient care under the provisions in Clauses 9, 24 and 27, it would be necessary to make provision for a separate process although this could use the same personnel and mechanisms. This would effectively replicate the DoLS SB processes for hospitals as they will be after April 2013. The restriction to situations of potential d-o-l would not (at least as the caselaw stands at present) have the same implications as it does in non-hospital settings as the Cheshire West “normality” argument will not generally apply.

Taken together, the above would ensure that everybody currently within the scope of DoLS, plus those outside its scope in supported living or similar staffed care arrangements, would be within the scope of the enhanced procedure.

There would, finally, need to be provision that a care plan prepared under this procedure and which was certified by the IRO as meeting all the Article 5 requirements would be sufficient authority for the care provider named in the plan to deprive the person of liberty if necessary, in accordance with the terms of the plan.

How would it work in practice?

When either the care commissioner or provider recognised (e.g through operation of the normal assessment and planning process) that the person’s circumstances brought or were...
likely to bring them within the high-vulnerability group, this would trigger a requirement for them to be placed on the enhanced procedure. This would then trigger the appointment of an Independent Reviewing Officer.

I would then envisage the IRO basically acting as does a CoP judge when first receiving a case – i.e they would assess the situation, the first question being whether the person did actually meet the criteria for the enhanced procedure. Thereafter they would give directions if necessary as to what (if any) additional action should be taken e.g convening a meeting of all parties, and including the power to direct a capacity assessment if they thought there was not already adequate evidence on this issue. If the person did fall within the MCA their first duty would be to ensure that the decision-making processes complied with it, but if they thought the situation might amount to d-o-l and thereby engage Article 5 they would also need to be satisfied there was adequate medical evidence of mental disorder and that the relevant restrictions were necessary to prevent harm, and proportionate. Basically, they would be able to do everything a BIA and DoLS co-ordinator does now, but only so far as they thought necessary, relying on existing assessments (as per Para 49 of the present MCA Schedule A1) if they were satisfied that these were sufficient. There would be no parallel processes or documentation as everything would be contained within the overall CA care planning process.

I would not envisage the formal appointment of an RPR – the care planning process, if it followed the general lines of Enhanced CPA, would (subject to directions by the IRO if necessary, and the wishes of the person themselves) identify close family and carers who must be informed and invited to meetings, and they would then have the right of appeal. This would avoid the granting of exclusive powers to one person at the expense of others who might be more inclined to use them. I would envisage that, as per Munby in Gj, Nj and Bj (and CPA practice) each review meeting would be required to review all the major legal parameters e.g capacity and continued justification for any restrictions, and this plus the continued involvement of the IRO and maybe an IMCA would render the formal monitoring role of the RPR unnecessary.

If the resultant care plan included elements which amounted or might amount to d-o-l, the plan would then be the authority for the person to be deprived of liberty if necessary, provided that the IRO certified that it met all the necessary requirements (equivalent to the present six DoLS requirements including evidence of mental disorder and incapacity). It would be “a procedure prescribed by law”; the “best interests” requirements of the MCA would all have been met; the IRO would provide the same degree of independence as the BIA; the duration of the authority would be set by the review date (with a limit of 12 months to comply with the caselaw); and there would be a quick, cheap, accessible right of appeal to a judicial body thereby satisfying Art 5(4). None of it would, however, require the issue of d-o-l to be determined conclusively, and even uncertainty about capacity would not deny a person the basic safeguards – provided that they fell within the high-vulnerability definition they would still get the benefit of the enhanced planning process, including oversight by the IRO and access to the tribunal. Fluctuating capacity and need for d-o-l, or differences of view on either of these issues, could therefore be accommodated and much sterile legalistic argument avoided.

If the enhanced care plan did not specifically authorise d-o-l, and the question of d-o-l then arose whilst the person was still subject to the enhanced procedure with an IRO in place, I would envisage that the first recourse of the care provider would be to the IRO in

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preference to self-authorisation, and that the IRO would then (as with a CoP judge receiving an emergency application) be able to give temporary authority pending a full reassessment. Self-authorisation by the provider is one of the least satisfactory features of the DoLS scheme and should occur only where the situation is so urgent that it is not possible to obtain authority from any external body.

There would be a number of crucial pieces of drafting - the high-vulnerability criteria, the powers and duties of the IRO, provision to ensure the IRO’s independence (which is currently an issue for some employed IROs in children’s services, and from which lessons therefore need to be learnt), the grounds for appeal to the tribunal - and it would be necessary also to draft an equivalent to Schedule IA to regulate the relationship with the Mental Health Act. This scheme would also not be viable if the judges continued to insist that all “Article 8” issues must go straight to the CoP, so there would need to be provision that any disagreements about place of residence which were not quickly resolved through the best-interests consultation process must be referred to the tribunal. I would envisage the tribunal having the same discretion as the CoP to accept appeals from any relative or friend who could establish a sufficient interest, but that (as with the SENDT) appeals would be accepted only on specific serious issues (e.g. a disagreement about place of residence, or whether the person met the high-vulnerability criteria) with other matters having to be taken initially through the complaints procedure or to the Ombudsman.

**Cost implications**

Costs would undoubtedly be higher than the actual cost of DoLS at present, as there is still very little activity in large parts of the country, and even where activity rates are higher the rate of appeals (although rising) is still extremely low. It would be reasonable to assume that this scheme, being much more comprehensible and accessible, would generate much higher levels of activity across the board including appeals.

The valid comparison should therefore be with DoLS as it would be if fully-implemented, rather than as it actually is. The crucial comparison is then of cost per case, and the costs per case of the CA-based alternative would depend on how tightly a number of elements were defined, and in particular the criteria for entry to the high-vulnerability category and therefore the numbers falling within it, and the extent of the IRO’s role and therefore how much time they would need to spend per case. It would be possible to define both in a way which would equate fairly closely to current DoLS practice in the “high activity” areas, but the available professional time would be much more efficiently used - the unnecessary bureaucracy and duplication would be cut out and the effort would all be focussed on the essentials. One particular area of saving is that it would no longer be necessary, in order to maintain oversight of a case, to make multiple short authorisations with consequent frequent reassessments.

The cost of the appeal stage would also depend on the remit and modus operandi of the tribunal i.e what types of case it would accept and the formality or otherwise of its processes. A less formal and more accessible judicial body would, unless it had a very restricted remit, undoubtedly attract a much higher volume of applications, but on the other hand the costs of a first-tier tribunal should be very much lower than those of the CoP which have been estimated to be in the order of £30k per case in legal costs alone, not counting the time burden on the front-line local authority and NHS staff. One of the reasons for these costs, over and above the formalities which inevitably attach to higher-N mental health alliances - written evidence

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court processes, is that the judges tend to take on “case management” and to conduct successions of reviews, and the costs of this would be much less if conducted by a lower-tier more local body.

In addition, if the remit of the tribunal were extended beyond CA appeals to encompass a wider range of current CoP applications, there would be a considerable saving relative to current or likely future costs, and this would be of considerable benefit to local authorities who currently refer to the CoP only a fraction of the cases which the caselaw indicates that they should, but which are nevertheless having to meet very high and continuing legal and professional costs. This would also result in a saving to the Legal Aid budget, although this might be offset, if Legal Aid were generally available for CA appeals, by the greater number of cases a more accessible judicial body would be bound to attract.

Please see links attached.


30 August 2013
TUESDAY 2 JULY 2013

Members present

Lord Hardie (Chairman)
Lord Alderdice
Baroness Andrews
Baroness Barker
Baroness Browning
Lord Patel of Bradford
Baroness McIntosh of Hudnall
Baroness Shephard of Northwold
Lord Swinfen

Witnesses

Toby Williamson, Head of Development and Later Life, Mental Health Foundation, former Co-Chair of the Making Decisions Alliance, and Sue Brown, Head of Public Policy, Sense, former Member of the Making Decisions Alliance

Q45 The Chairman: Good morning. I would like to welcome both of you to this evidence session. I am sorry that we have kept you waiting slightly longer than we anticipated. We are anxious to have your evidence today. You will be aware that the call for evidence has been sent out; although this evidence session will be an opportunity for you to explain things in some detail, if you wish to add anything that you do not feel you have covered adequately, or even if you simply wish to respond to the call for evidence, we would be very pleased to receive that. I am sure that it would be very helpful for us. I will start by asking about your involvement with the pre-legislative scrutiny. First, what was the purpose of the Making Decisions Alliance and how was it formed? Going on from that, could you say something about your experience of contributing to the pre-legislative scrutiny and indicate whether there were any things that you feel might have been done better?

Toby Williamson: I will start. Good morning and thank you, Lord Chairman. I co-chaired the Making Decisions Alliance from 2004. The alliance had been formed in 2002 to campaign in support of the introduction of mental capacity legislation in England and Wales. It was

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formed of about 40 national and regional charities that worked with different groups of people with disabilities; the Mental Health Foundation was one of those, as was Mind, Rethink, Mencap, Sense, Age UK and the Alzheimer’s Society. When legislation was introduced by government, firstly through the pre-legislative scrutiny process and then into Parliament in 2004, we worked closely with government, both the Department of Health and the Lord Chancellor’s Department as was—obviously now the Ministry of Justice—working in collaboration with and support of government for the legislation to be passed. It felt like quite a positive process, from the Making Decisions Alliance point of view, that we both had the same objectives to ensure that good mental capacity legislation was introduced. We worked throughout the parliamentary passage of the Bill to support it. It had a bit of a rough ride at times, because at times there were accusations that it was allowing euthanasia by the back door, and various other aspects that we certainly did not agree with or support, but that required us to do quite a lot of lobbying and support work with government to ensure that it was passed. We were particularly keen that advocacy should be introduced within the legislation, that there should be principles at the beginning of the legislation, that decisions to refuse treatment should be within the legislation, and that there should be an emphasis on non-discrimination in the way capacity was assessed and best interests were determined. So there were a number of features within the Bill that was eventually passed which we were very pleased with.

Although the Making Decisions Alliance ceased to exist after the Bill was passed and the Act came into effect, our view as an organisation—and that of many organisations I still have contact with who were members of the MDA—is that it remains a very positive and progressive piece of legislation that has benefited large numbers of people who may lack capacity through both empowering them to make decisions themselves and protecting them if decisions need to be made on their behalf, and that it provides greater legal clarity for carers and practitioners working with them. Unfortunately, as you may have heard from previous witnesses, there still remains a challenge in terms of ensuring that it is properly implemented and understood across all sectors that need to apply it in practice; particularly the health and social care sector, statutory and non-statutory services, but other sectors as well. There are a number of aspects of the Act which seem to cause difficulty in some areas, particularly, for instance, care homes and general hospitals, in terms of its application. It is much better understood within specialist services for people with learning disabilities and dementia, for example. So there is still work to be done in ensuring that it is properly implemented. But our view, and the view of other organisations that were members of the Making Decisions Alliance, is that the priority is to ensure that it is properly understood and that there is proper awareness across sectors for what is still a relatively young piece of legislation, rather than place any priority on reform of the legislation at this stage. It is still too early to do that. We are currently working with a number of organisations, including government departments, to try to develop a cross-sector collaborative approach to raise awareness and improve understanding across professional disciplines and different aspects of the health and care sector, to improve that awareness and understanding as a priority rather than focusing on legal reform.

Q46 The Chairman: Thank you very much for that helpful outline. I should have said before we started that you will be aware that the evidence is being recorded by shorthand writers and is also being broadcast. You will be given an opportunity to see a transcript of the evidence and to alter or rather correct it if there are any obvious mistakes. Do you want to add anything, Ms Brown?

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Sue Brown: I should briefly explain what Sense's role in the alliance was, and briefly our experience and interest. Sense is an organisation that works with deaf-blind people—people with both a hearing and a sight loss. We have two interests in this legislation, which was extremely important to us. We support a number of people who were born deaf-blind, who can both lack capacity in a lot of areas of their life, but one of the common issues about people who are deaf-blind, whether born deaf-blind or those who have acquired deaf-blindness, is communication and the need for support with communication. We have a number of areas of interest in this. The first one is people who lack capacity to make particular decisions and how they are supported and protected through that process of someone making that decision in their best interests. The second is people who maybe are assumed to lack capacity because they struggle with communication, and without the right communication support will be thought to lack capacity when actually they do not; and thirdly, ensuring that people who need communication support are supported through the decision-making process, whether that is them making their own decision or being involved in a best-interests decision-making process. So that is our interest. I echo what Toby has said about the way in which the alliance worked and the fact that Sense certainly feels that the legislation itself is a really good framework for supporting our staff when they are working with people in those different situations. The problem is when they are working with professionals who maybe have less awareness and understanding of the Act than perhaps they should.

The Chairman: Does Sense provide interpreters, then, who assist professionals to assess capacity? Presumably there is a communication issue between the person who is deaf and blind and the doctor or whoever is trying to assess capacity.

Sue Brown: Yes. In some cases somebody might be, for instance, a sign language user, and a sign language interpreter would be able to interpret for that person. A lot of the people we represent have quite profound and complex needs; they may have very limited language or no formal language at all but are very able to communicate provided that they have the support of someone who understands how they communicate and understand things. That can be where we have the biggest problems, when professionals do not see that what the person is doing is communicating; sometimes they are communicating very clear choices, but they way in which those choices are expressed is not in formal language so it can be quite difficult to understand. We might do a range of things, from making sure that a medical professional has booked an appropriate interpreter through to assisting a professional to understand somebody's complex and informal methods of communication.

Q47 Baroness Browning: Lord Chairman, I should first remind the Committee of my interests. I am a vice-president of two of the national charities that were part of the Making Decisions Alliance. Going back to the submission you made to the Mental Capacity Bill at the time, you indicated an overall desire that people of marginal capacity should be supported to reach capable decisions—I think we sometimes referred to marginal capacity as fluctuating capacity in the passage of the Bill—and of course that people without capacity should be involved as much as possible. Could you just give us a feel for how those two separate groups have fared under this legislation? Clearly there is quite a spectrum of decision-making, from perhaps what an in-patient wears as opposed to somebody telling them what they are going to wear when they get dressed for the day, to perhaps more serious matters such as where they are going to live in future. Can you desegregate how those two groups have fared?
Toby Williamson: Perhaps I can start and then I am sure Sue can add something to this. I should have said at the beginning that the Mental Health Foundation is a social research and development charity. We undertake work on issues that affect people with learning disabilities, dementia and mental health problems. In 2012 we published a large piece of research that was funded by the Department of Health, which we carried out with the universities of Bristol and Bradford. It looked at best-interests decision-making for people in all those groups and revealed a number of findings. First, as I have already said, in some sectors—general hospitals and care homes—there was much less familiarity with the Mental Capacity Act and they struggled with people with fluctuating capacity. We were very pleased when the Bill was passed that it had a very decision-specific and time-specific emphasis around decisions, so people could not be assessed as lacking capacity to make any decisions but had that decision-specific nature to it. While the principles were the correct ones, the findings from research indicated that a number of sectors or services and professionals struggled to understand how actually to implement the Act in relation to people with fluctuating capacity. The findings from the research indicated that the process was quite effectively followed around assessing capacity and making best-interests decisions around big decisions such as consents on medical treatment or changes in accommodation, but there was very little report made on those everyday decisions that you describe. There was perhaps a sense that a similar practice that occurred before the Bill was passed is continuing, in that there may well still be assumptions of incapacity based upon diagnosis or a disability.

The research also indicated that staff—in particular health and social care staff—struggle to apply or link the principles around assumption of capacity and wise decisions to actual practice. They said, “We think that the person has capacity, therefore we will just let them make their own decisions”. There is an example of a lady in a care home who had significant dementia, who was refusing to change her clothes at all and was becoming quite soiled, and staff were not sure what to do. They had been led to believe that they must allow people to have autonomy and make decisions themselves, and did not understand that they could use the Mental Capacity Act to assess capacity and potentially intervene to improve the person’s quality of life by making decisions for the person if they lacked that capacity. So there was an issue there around the principles not being very well linked with the actual practice. When the process was being followed around involving people in best-interests decisions and in assessments of capacity, the evidence that we gathered from research anecdotally indicated that staff can follow that process quite well. In over or around 50% of the best-interests decisions that were made, it was reported that the person who lacked capacity was involved in some shape or form in helping to direct that decision, even if they could not make the decision themselves. So staff understand process better than they understand the principles or application of the principles.

The Chairman: Mr Williamson, I am sorry to interrupt. I know that there is a lot in what you are saying, but would it be possible to give the Committee a copy of this report? That might be very helpful.

Toby Williamson: Yes, of course.

Q48 Baroness Browning: Yes, that would be very helpful. Does it include how eligible both those groups were to advocacy when they needed it?

Toby Williamson: A number of independent mental capacity advocates were involved in the research, so it focused specifically on the role of the IMCAs—the independent mental
capacity advocates. It did not go beyond that and investigate whether other advocates were being involved in decisions. As I am sure you are aware, the IMCA service is limited to very specific decisions and for people who do not have friends or family with whom it is appropriate to consult. What was quite interesting and significant, and I think reflected previous research into the IMCA role, was that IMCAs were often getting drawn into situations in which there were disputes about a best-interests decision, assisting in resolving those disputes and playing a key role in supporting all parties in coming to a good best-interests decision where there might have been disagreements. However, they were also involved in cases where family and friends of the person who lacked capacity were there. Previous research had shown that IMCAs were been drawn into those situations as well. Indeed, when we were campaigning in support of advocacy to be included within the Act, our view was that IMCAs should be made available to people who had family and friends where disputes arose, because many families would be very unfamiliar with complex health and social care systems, and therefore would be at a disadvantage if there were to be a dispute with a very knowledgeable social worker or doctor. Having advocacy to support them would therefore be very helpful. The research seems to indicate that IMCAs were getting drawn into those situations, but generally in a very helpful way. So to extend advocacy in that way could potentially be very useful.

**Sue Brown**: Just to follow on from that, we tend to find that first of all, our staff say that the people with the best understanding of the Mental Capacity Act and how it should operate tend to be front-line social workers. They find many more issues within health, and particularly within primary healthcare. GPs and dentists were the two groups that were highlighted as those who our staff had the greatest issues with on whether they were actually following the Act. One of the things that they report is that it can be easier and quicker; there tends to be an immediate assumption of lack of capacity and then they go straight into saying, “We’ll make this decision in the person’s best interests”. Rather than taking the time to explain to someone what needs to be done and getting their consent, in the case of dentists it is often, “Can we sedate this person so that we can treat them without needing their consent?”, or GPs saying, “Well, it’s in their best interests to take the blood, so we’ll just take it”. They do not take the time either to check that they understand and get consent—in a lot of cases people might understand—or even to involve them in the process and explain to them what is going to happen.

We also find that the less formal communication you have, the more likely you are to be assumed to lack capacity, without a proper capacity assessment having taken place. The feeling of our staff is that some of that is to do with lack of understanding around communication issues. Some of it may be to do with time. I have had one report of a GP who attempted to charge for the additional time taken to explain to the person what was involved in a blood test and get their consent rather than simply do a best-interests decision. So there is an issue around time, which may be why things are better in in-patient general hospitals, where there is a little more time. That is certainly the experience of our staff. There is definitely a connection with communication. There is a real issue with people understanding informal and limited communication as being someone still having the capacity to understand, and that they just communicate in a different way. Our staff say that they often have to guide other professionals through the process. They find the Act a really useful framework to be able to say, “No, this is how it is supposed to work”. But often, again, medical practitioners do not want to take that role of decision-maker and make a best-interests decision; they attempt to get our staff to consent on behalf of people, which is clearly not in line with the Act at all. I would say that there is generally a lack of
understanding of the Act, but that it is a really useful framework for our staff to be able to say, “This is how it should work”; and there are the particular problems around communication.

The Chairman: We have to make progress. I wonder if it is possible in future answers to try to keep them fairly short, because we have got quite a lot of material to get through. As I said earlier, it is always possible to supplement evidence in writing.

Q49 Lord Patel of Bradford: I will focus on the deprivation of liberty safeguards. As you will be aware, the Joint Committee on the draft Incapacity Bill, as it was known then, pre-dated the deprivation of liberty safeguards. Did the Making Decisions Alliance form a view of the DOLS during the passage of the Mental Health Bill? We have had some very opposing and varied views on the best use of DOLS.

Toby Williamson: This can be a shorter answer. The Making Decisions Alliance was coming to an end when the Bournewood case was announced and thoughts and plans were being made about how to address the so-called Bournewood gap. We recognised that a legislative solution had to be found to address that. We wanted a relatively simple legislative solution that met the requirements of the European court’s findings on the case, something that reflected the elegant simplicity of the Mental Capacity Act. What has happened is rather more complex, quite bureaucratic and difficult to understand, and it is much more procedurally driven—I am describing the current deprivation of liberty safeguards. Of course, they were led by the Department of Health at the time when it was also dealing with the reform of the Mental Health Act. So they have a very strong flavour of the procedure of the Mental Health Act rather than the simplicity of the Mental Capacity Act. We recognise that there is some research going on, both at the universities of Cambridge and Bristol, which is looking at the interface between the Mental Health Act and the Mental Capacity Act, and looking in particular at DOLS. Until that research is published I would not have much to comment, other than that the research we did—the best-interests research—reported that sometimes interventions were used which might have constituted a deprivation of liberty, but that there had not been an application made for deprivation of liberty because staff did not seem to understand or were rather concerned about what that might involve. This is one bit of the Mental Capacity Act where from our point of view the jury is out in terms of whether this should be changed or allowed to bed-in further. However, it is certainly proving challenging for many people who are affected by it, whether staff, service-users or families.

Lord Patel of Bradford: Do you have a timescale on the research?

Toby Williamson: As far as I know, the Bristol research that is looking at DOLS is due to be published this calendar year. I do not know about the Cambridge research; I thought it was due to be published last year but it has not been yet, so I do not know.

Lord Patel of Bradford: It would be useful to get it.
The Chairman: I was going to ask that as well. Do you know who is doing the research?

Toby Williamson: It is led by Professor Tony Holland and Isabel Clare at Cambridge University—that is on the interface between the Mental Health Act and the Mental Capacity Act. The DOLS research at the University of Bristol is based at the Norah Fry Research Institute.
Centre. I only know the name of the research assistant involved; I am not sure who the principal investigator is. The Norah Fry Research Centre will be able to tell you.

**Q50 Baroness Andrews:** Can I ask you to go back to the implementation of the Act? In your submission on the pre-legislative scrutiny you had concerns about the scope of the general authority. You tried to address that by suggesting at the time that various conditions were attached to the way that that should operate in terms of case conferences and additional safeguards around the general presumption of capacity. Do you think you were right, and do you regret that those changes were not made? Do you think that they would have made a difference to the way the Act is operating, particularly in light of what you said about the presumption of a lack of capacity?

**Toby Williamson:** Obviously the general authority was changed and is now known as the acts in connection with care and treatment. That was a helpful change, because it emphasised the focus on decision-specific and time-specific capacity assessments and decision-making rather than the general authority, which applied a general power to act on behalf of people who lack capacity. Again, the research we carried out showed that in around 25% of cases involving a best-interests decision, the capacity assessment that lead to the best-interests decision was based on looking at the person’s disability, diagnosis, age, appearance, condition or an unwise decision, which rather leads us to believe that, certainly in a number of those cases, people were still making assumptions about a lack of capacity for reasons which the Act does not allow, i.e. a blanket assumption based upon diagnosis or an unwise decision. That gives some cause for concern that safeguards are still not properly understood and that the process is not properly understood in terms of applying the principles to the acts in connection with care and treatment. The other thing is that the findings from the research show that in many cases complex decisions involve multi-disciplinary teams, so staff were struggling to understand who a decision-maker is and what is the exact decision that was being made. In 10% of the cases that were reported, people reported the decision as being a multiple decision, so again it was not decision-specific. We suspect that perhaps that was in certain situations; there were examples of situations in which someone was being prepared or was ready for hospital discharge and the decisions about medical treatment and accommodation issues were all being piled into one meeting, and staff were struggling to know who was the decision-maker and what different decisions they had to cover. In another 10% of cases it was reported that the person had capacity, even though a best-interests decision was being made on their behalf, which indicates a worrying lack of understanding of the legislation. This risk occurs once a lack of capacity has been found—and this may apply to DOLS as well, where people have severe dementia or a very severe learning disability and a range of decisions are being made on their behalf because it has been put in their notes that they lack capacity.

**The Chairman:** For the sake of the record, Ms Brown, I see that you were nodding agreement with what Mr Williamson was saying.

**Sue Brown:** Yes, particularly on the issue of complex decisions—not being clear who the decision-maker is in the meeting. Again, our staff report that if you have multi-agency meetings, no one agency is willing to say, “In the end, having consulted everyone, this is our decision”. That can be really difficult.

**Q51 Baroness Andrews:** In your first response to the Committee you said that you did not think that the law needed changing. You said that what you thought needed to happen in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
was that practice needed to be improved, and that there was an issue about information and understanding. For example, on the absence of a key named person who should take a lead decision, is there any argument for changing definitions legally, or for changing the nature of responsibility legally? We are trying to understand how you can change the culture, and how effective any exhortation or information can be if you still have people untrained in processes—informal and so on. It is really difficult to get to that particular challenge.

Toby Williamson: My view is partly based on research in which a lot of staff reported that the Mental Capacity Act was a really positive piece of legislation that had helped to clarify decision-making processes for them in a number of situations. So where it was understood, no one was saying, “This is bad legislation”, and it was being properly implemented and applied in a whole range of situations. I suppose that I would have some concern about having named people and named roles, because that feels rather like moving into something similar to the Mental Health Act, which is an important but a very different piece of legislation, with different aims and objectives. The Mental Capacity Act makes it quite clear that there needs to be a decision-maker who makes a best-interests decision if that is required. The emphasis should be on trying to ensure that how the Mental Capacity Act is applied is properly understood as underpinning a range of health and social care procedures that already exist.

We hear a lot about safeguarding and dignity and respect, we have the Prime Minister’s Challenge on Dementia, we hear about choice and control and risk decision-making, and those are issues that are of considerable concern to people working in the health and social care sector. However, the Mental Capacity Act, when properly applied, underpins and helps decision-making in all those settings. If staff understand how the Mental Capacity Act works—and it is a simple piece of legislation, and many people are putting it into practice on a regular basis; it is not a very complex process to assess capacity or make best-interests decisions once one is familiar with the checklists and the assessment process—you can insert that and embed it within those other policies and procedures that staff have to work to. In particular, safeguarding is dominating the thoughts and practices of many staff at the moment. You can therefore ensure that the Mental Capacity Act underpins that and empowers people to make decisions wherever they can for themselves, but also provides good legal protection for themselves and for practitioners who make decisions on their behalf. So my priority at the moment would still be to try to ensure that all those affected by the Act understand how it relates to other policies and processes that they have to work to rather than saying that the Act should be changed at this stage.

Q52 The Chairman: Baroness Shephard, I think the witnesses have already referred to IMCAs; I do not know if you want to ask a further question.

Baroness Shephard of Northwold: I would like to ask Mr Williamson if he wants to add anything to the points he has already made about the effectiveness or otherwise of the IMCA service. Is the service providing a good voice for clients? Is the legal framework understood and is it properly applied? You have already referred to it—do you want to add anything?

Toby Williamson: I would say just that not only does it provides an essential service to people who lack capacity, but anecdotally, from conversations I have had with IMCAs, it can be said that it provides an essential service to service-providers and professionals, who may be unfamiliar with the Act, who can see the benefit of having an IMCA come in who can in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
spend time with a person who lacks capacity to find out more about what their wishes, feelings, beliefs and values are. So it creates a much better decision-making process when IMCAs are involved, which broadly speaking, the professionals recognise and welcome.

**Sue Brown:** Coming back to communication, we have a particular issue around the ability to find an IMCA with the relevant communication skills. We have had IMCAs arriving to work with someone, who have no sign language and no interpreter, and therefore again, our staff have to remain involved to facilitate communication, which does not allow the person to communicate anything they might want to say about our service, for instance—because we are still in the room.

**The Chairman:** What would you advocate in that regard? Should advocates be trained in sign language or in special communications skills for those who are blind and deaf?

**Sue Brown:** Yes, I think that those who are commissioning IMCA services need to make sure that communication is part of the commissioning process, so that every IMCA service can provide someone who understands people with a range of different communication needs.

**Q53 Baroness McIntosh of Hudnall:** We come to the rather uncomfortable question of the power to restrain. The MDA indicated early on that it was anxious about the abuse of that power. It is pretty clear that at least in some cases it has been abused. If we look beyond the very high-profile examples of that abuse, do you have any views about whether your general discomfiture about the possibility of abuse has been more widely vindicated, or do you think that the power to restrain is being used in a more judicious way more widely?

**Toby Williamson:** I have very limited evidence or knowledge around this. We are not a service-provider organisation. Again, from the research that we did there was some indication that restraint was being used in a way that might indicate a deprivation of liberty, and deprivation of liberty safeguards had not been applied for, but we did not come across any examples of where restraint was being used in excessive or prolonged ways that indicated abuse by professionals. I do not know if you have anything to add to that.

**Sue Brown:** Our experience links back to the earlier question about the acts in connection with care and treatment. A decision is made that something is required, and in this case it might be restraint for the person’s safety. Does that then get reviewed, or does it just become a routine part of the person’s care that is not questioned? That can range from restraint to other issues. For example, we have recently used the Mental Capacity Act as a framework for reviewing all use of restraint within all of our services to ensure that we are not assuming that people lack capacity when they do not, to make sure that the circumstances that required restraint at the time still pertain, or whether the work that we have been doing for the person has altered their behaviour so that they no longer require restraint. In the case of our services, we are talking about things like additional harnesses when travelling and bed-rails; these are things that are clearly about the person’s safety, but in our view you still need to review whether they are still appropriate, still in the person’s best interest and still needed.

We find in a lot of services that that sort of review process does not happen. Someone may be restrained in a particular way in a particular circumstance for years and years without anybody going back and saying, “Does the situation still apply?” I think that that applied to
restraint, but also generally to the way in which you support somebody. They were not able to make that decision, perhaps because of their learning disability, but if we have been working with them on their decision-making ability for a few years, maybe they are now able to make that decision for themselves, as they have developed communication and decision-making skills. So it is about that constant process of review—"Is this still appropriate?"—rather than about relying on a best-interests judgment that was made weeks, months or years previously.

Baroness McIntosh of Hudnall: Do you think that if you read carefully the Act as currently written, it tells you that you should be doing that, and that therefore this is an issue of implementation, or is the Act insufficiently clear about how that power should be used?

Sue Brown: I think that it is about implementation and about staff understanding. The Act is very clear that it is decision-specific and time-specific. That is clear; it is a matter of agencies having the review processes in place.

Q54 Baroness Barker: Hello again. Back then, when we all sat and listened to what you had to say and were duly impressed, I think it is fair to say that we all realised that lasting powers of attorney were going to be one of the key parts of this legislation as far as the general public and legal profession—as two key players in the whole process of looking after people who lack capacity in some respects—were concerned. Back then, there were concerns about people’s ability to set up powers of attorney and have them registered and activated. There was in particular a considerable concern that the cost would put people off. Now, in the wake of experience, what do you think about the provisions around LPAs?

Toby Williamson: Again, we have not got much evidence, either anecdotal or research-based, around LPAs. It is disappointing that there has been a very low uptake of health and personal welfare LPAs, because that was obviously a new part of the legislation which had not previously been available through the old EPA system. I suspect that cost and complexity—or rather perceived complexity—may have put some people off, although our understanding was always that LPA forms should be forms that could be completed by a lay person who did not require legal advice or a legal intervention. To a certain extent I think that the forms achieved that. There is some work that could be done to promote LPAs, particularly around health and personal welfare issues, although I understand that the OPG is seeing an exponential increase in LPA registration. So they are getting more into the zeitgeist, and people are more aware of them. Perhaps because we have an ageing population, and people are concerned about the growing number of people with dementia, more people are thinking about how they can plan for the future.

Baroness Barker: My last question is about the Court of Protection. A very key part of the alliance’s submission to us was that the Court of Protection should be accessible; it should be accessible to people with impaired capacity. How do you think that has worked out?

Toby Williamson: From what I recall, when we discussed with the department about the court as the Bill was going through Parliament, we were led to believe to a certain extent that the relatively informal nature of the Court of Protection which preceded the Act being passed would continue, and that things such as bedside hearings and informal communication with the court, which were seen to be a benefit, would still be available. Inevitably, as in

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many respects it acquired a different statutory status through the Act, it has become more formalised. From what we hear, people who may lack capacity, family members and people who are unused to the court system do not go to the court very frequently. They see it as something quite complex and sometimes intimidating, so there is a case to be considered for looking into whether disputes are occurring at a lower level and never actually reaching the court and being resolved through other means, whether that is through complaints procedures or mediation systems, and whether that could be more formalised and made more accessible and available to potentially divert the need for going through lengthy court cases or not getting disputes resolved in a very satisfactory way within health and social care settings. I am aware that possibly extending the IMCA service might help in that respect, and that in other jurisdictions—in the States and Australia—the role of the public guardian is to intervene and mediate in disputes, which is obviously not the role of our public guardian. I think that there is probably a need for further research to look at what kind of disputes are occurring, how they are being resolved or not, and to draw some conclusions from that before thinking about whether the court and those legal processes around resolving disagreements need to be changed.

Sue Brown: We have some concerns about the court’s ability to engage with people who have little or no formal language and instances where, as far as we are concerned, someone is communicating very clearly a decision and the court does not recognise that because they are not using formal language. There are some real issues about the court’s understanding of the inter-relationship between communication and capacity.

The Chairman: Do you have any thoughts about how that could be improved? That problem exists; how would you go about instructing or educating the court about it?

Sue Brown: I think that it is clearly an education and training issue. It is an awareness issue rather than an inherent problem with the court, but it is one that we have come across.

Q55 Baroness Barker: If there was to be research on why people are not accessing the court in the way that was anticipated, who should we go and talk to about that? Is it frontline practitioners like people in memory clinics, or IMCAs, or who?

Toby Williamson: IMCAs would be a very good starting point, because as I said earlier, they often find themselves in situations where there are disagreements. There may be some people with fluctuating capacity, who have experienced disagreements with professionals about whether or not they can make decisions, and of course family carers may often be involved in disputes around best-interests decisions. In addition, practitioners may feel that it is not a satisfactory process around a care or health issue when there is a disagreement or dispute, and would welcome some further advice and being involved in research.

If I may, Lord Chairman, I will mention one other thing that we have not mentioned, which is about the code of practice. A number of the issues that we have discussed here, and indeed the recommendation from the research that we did, was that consideration should be given to revising the code of practice. I am aware that Department of Health officials were not necessarily of that view, and I recognise that that is a complex and costly process. We think that the code of practice is a very good document. It is very clearly written and very helpful, so we would not want to lose what is already there. Of course, however, it was drafted before the Act came into effect, so in a way it is a hypothetical set of descriptions and guidance, and now we are building up case law and evidence from research. Even if there

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was not the appetite for revising the code, perhaps consideration should be given, if possible, to issuing some kind of supplement to the code as an interim measure to gather together all the evidence that has been accumulated over the last six years since the Act came into force to provide that additional central point of reference and guidance that many practitioners would find useful. Perhaps that could go some way to addressing the concerns we have raised about awareness and understanding and show that the Department of Health, in working with other government departments, recognises the importance of the Mental Capacity Act as a piece of legislation that people really need to understand and be aware of more widely than currently is the case.

**The Chairman:** It would be useful if you could identify, obviously in written submission, any particular problems that you see with the code of practice and where it might be improved. That would be very useful for us to consider. Thank you very much for your evidence, which has been very useful indeed. As I said at the beginning, although you have given evidence we would encourage you to respond to our call for evidence. Thank you very much.
Mental Health Foundation – Written evidence

Summary

The Mental Health Foundation is a UK charity that does social research, service improvement, training and evaluation, policy work, and provides public information on mental health and wellbeing, and on issues affecting people with mental health problems, dementia, and learning disabilities across all ages.

The Foundation supported the introduction of the Mental Capacity Act 2005 (MCA) and it’s then Head of Policy, Toby Williamson, co-chaired a national alliance of organisations that supported the legislation, the Making Decisions Alliance (MDA). Since the MCA came into force in 2007 the Foundation has carried out a number of research and service development projects to support its implementation and to find out how successfully it is being applied.

The Foundation continue to believe, on the basis of considerable evidence, that the MCA is a progressive piece of legislation which when used properly can both empower and protect people who may lack capacity, provides a clear legislative framework for their family and friends, and staff who provide care, support or treatment to them, as well as enabling people with capacity to plan ahead for a time when they may lack capacity to make decisions for themselves. However, there is evidence to indicate that the Act is still not always being implemented correctly. The Act is still relatively new and we do not believe that problems with implementation are due to fundamental flaws in the Act but because there is still considerable work to be done to raise awareness and improve understanding among professionals and other staff, as well as patients, service users, carers and the general public of the Act and mental capacity issues in general. The Foundation is currently working with other organisations (including Government) and seeking support to develop a co-ordinated cross-sector, multi-organisational ‘collaborative’ to achieve this aim.

Note

Toby Williamson, who is now Head of Development & Later Life at the Mental Health Foundation, was asked to provide a briefing note to the Committee when it was being set up (see Appendix A) and also gave oral evidence to the Committee on the 2 July 2013. This written response to the call for evidence therefore only provides supplementary evidence to that which has already been given to the Committee, which addressed many of these questions.

References to research particularly refer to findings from the Best Interests Decisions Study (BIDS) undertaken by the Mental Health Foundation in partnership with Bristol and Bradford Universities (se Appendix A).

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

Research and other evidence indicate that where the Act is understood and used correctly it is generally seen to be a positive and progressive piece of legislation. This is particularly the case in dementia care and support provided to people with learning disabilities. However there is considerable evidence indicating a lack of awareness and understanding of the MCA in more generic health and social care services such as general hospitals and care homes.

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2. **Which areas of the Act, if any, require amendment; and how?**

We do not believe that the Act requires amending because it is a new piece of legislation and has only been in force for six years. Research and other evidence indicates that the need is to focus resources on raising awareness and improving understanding of the Act in health and social care, and among service users and carers, not on legislative change.

We also do not believe that it would be a good use of resources to do a full revision of the Codes of Practice for the Act or the Deprivation of Liberty Safeguards (DoLS). However, because both of these codes were written before the legislation came into force we do think that it would be helpful to issue a Supplement to the Codes to bring them up to date with developments in case law and research. This would provide additional guidance on how the Act and DoLS should be used in areas of everyday practice that the original Codes had not covered in sufficient detail or been able to anticipate the challenges that have arisen e.g.

- How the first three principles relate to assessment of capacity
- Multi-disciplinary team working and decision-making in relation to assessing capacity and best interests decisions
- Ongoing developments in case law regarding DoLS
- Relational and co-decision-making (where decisions are made jointly in the context of close relationships)
- How the Act links with, and supports recent policy and practice developments in areas such as adult safeguarding, personal health and social care budgets, shared decision-making, and dementia.

If such a supplement was published and jointly promoted by the Ministry of Justice, Departments of Health, Welsh Government, and the Office of the Public Guardian, it would be a very positive statement of support for the Act and the importance of ongoing efforts to raise awareness and understanding.

So, we do not believe that any changes are necessary to the Act for the next few years. In the long term there are areas of the Act that might be reviewed but only after thorough research and consultation had been carried out. These include addressing question such as:

- Should the criteria for IMCAs be broadened out so that they could be instructed where there are disputes involving someone who lacks capacity, or where the family or close friends of someone who lacks capacity request one?
- Should there be a ‘first tier’ mediation (e.g. through giving the Public Guardian or IMCAs additional powers and responsibilities) or simple tribunal-type system to deal with simple or low level disputes and disagreements to prevent them from escalating or unnecessary and expensive applications to the Court of Protection?
- Should there be a central register of advance decisions to refuse treatment?
- Should the Public Guardian have a clear responsibility for promoting all aspects of the Act?
- Should there be a simpler way for dealing with property and financial affairs of people who lack capacity and do not have an LPA (or were unable to make one) covering these issues, similar to the intromission with funds in the Scottish capacity legislation?

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Are there ways in which DoLS can be simplified?
Should consideration be given to incorporating mental health legislation into an expanded Mental Capacity Act?

3. **At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?**

Yes, but evidence indicates that practitioners often find it difficult relating the first three principles to capacity assessments e.g. the importance in some situations of carrying out capacity assessments to confirm an assumption of capacity or an unwise decision where practitioners have uncertainty about these, or in some situations applying the second principle as part of the assessment of capacity.

**Implementation**

4. **To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?**

See responses to Q2 and Q3 above. Evidence from BIDS indicated there is a risk that in some situations the MCA, especially the ‘best interests’ principle, becomes a tool to justify decisions to safeguard people because of concerns about lack of ‘insight’ or risk, rather than using the principles and processes of the MCA in a balanced way to support people to make decisions for themselves wherever possible, or to make a comprehensive assessment of what constitutes their best interests.

5. **How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?**

The Government’s implementation plan was fairly effective given its limited resources, the wide range of stakeholders and groups affected by the Act, and responsibilities being shared between the Ministry of Justice, Department of Health, Welsh Government and the Office of the Public Guardian. However the austerity measures introduced by the Coalition Government and the lack of a single organisation to co-ordinate ongoing implementation as well as promoting awareness and understanding of the Act, has limited this. The Mental Health Foundation, together with many other organisations has done as much as it can to independently promote awareness and understanding of the Act but now believes that there must be a well co-ordinated, cross-sector, multi-organisational approach to this work, supported by Government.

6. **Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?**

See response to Q5 above.

7. **Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for**

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Mental Health Foundation – Written evidence

Informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

See response to Q5 above.

8. Has the Act ushered in the expected, or any, change in the culture of care?

See response to Q5 above.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

No additional comments to make.

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

No additional comments to make.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

No additional comments to make.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

No additional comments to make.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

We are unable to comment in detail about the IMCA service but from the evidence we have available we believe it to be a vital role in ensuring that the best interests of a person who lacks capacity (and in the case of DoLS, the needs of their representative) are taken into account by practitioners. It is the first time that there has been a statutory right to advocacy and, with the exception of the Public Guardian, IMCAs have the only role that is wholly dedicated to mental capacity issues. We have heard anecdotally that they therefore can also play a vital function in raising awareness and understanding among health and social care practitioners who may not be so familiar with the MCA.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

No additional comments to make.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

No additional comments to make.

**Deprivation of Liberty Safeguards**

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

We do not have a specific comment to make on this but we have a concern that DoLS are too frequently seen or used in isolation from the rest of the MCA. DoLS have received some criticism for being overly complex but we are concerned that this criticism can distract attention from the benefits of the MCA which in some situations, if used properly, could avoid the need for DoLS.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

See response to Q16 above.

**The Court of Protection and the Office of the Public Guardian**

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

No additional comments to make.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

No additional comments to make.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

No additional comments to make.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

No additional comments to make.

**Regulation**

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
CQC can play a vital role in raising awareness and improving understanding of the MCA in general, over and above its DOLS responsibilities, and any additional powers (with the necessary resources to support them) that can help achieve this would be welcome.

23. **Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?**

We would like to see regulatory bodies prioritising raising awareness and understanding of the MCA among the professionals they regulate.

**Other legislation**

24. **How well is the relationship with the mental health system and legislation understood in practice?**

No additional comments to make.

**Devolved administrations and international context**

25. **Does the implementation of the Mental Capacity Act differ significantly in Wales?**

No additional comments to make.

26. **What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?**

We have followed with interest Northern Ireland’s progress in attempting to have a single piece of legislation that brings together both mental health issues and mental capacity issues. We have noted the recent publication of the Assisted Decision-Making and Capacity Bill in the Republic of Ireland which aims to fully address the implications of the United Nations Convention on the Rights of Persons with Disability.

We believe that the Scottish ‘intromission with funds’ system contained in their capacity legislation appears to have some merit. In comparison, best interests property and financial affairs decisions can only be made under the MCA if someone is someone is authorised by an LPA or the Court of Protection.

27. **Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA**

We believe that the MCA is compliant with the CRPD. We are in full agreement with CRPD’s emphasis on supporting people with disabilities to make decisions for themselves but the CRPD does not make it clear how a decision should be made on behalf of someone who lacks the capacity to make the decision themselves and it is not known or it is not clear what their decision would be if they did have capacity. We believe the best interests principle and ‘checklist’ in the MCA, represents a person-centred and practical way of addressing these situations and this view is supported by the evidence from BIDS.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Appendix A

Post-legislative scrutiny of the MCA

Information from the Mental Health Foundation

April 2013

Mental Health Foundation

The Mental Health Foundation (incorporating the Foundation for People with Learning Disabilities) is a UK wide research and development charity which carries out projects, public affairs work, and provides information on mental wellbeing and issues affecting people of all ages with mental health problems, dementia, and learning disabilities.

The Foundation supported the introduction of the Mental Capacity Act 2005 (MCA) and its then Head of Policy, Toby Williamson, co-chaired a national alliance of organisations that supported the legislation, the Making Decisions Alliance (MDA). Since the MCA came into force in 2007 the Foundation has carried out a number of research and service development projects to support its implementation and to find out how successfully it is being applied. These pieces of work are summarised in Annex A.

The most recent piece of work the Foundation was involved with was the Best Interests Decisions Study (BIDS), a major research project undertaken in partnership with the Universities of Bristol and Bradford, and funded by the Department of Health (Mental Health Foundation, 2012). The research investigated best interests decisions made under the MCA involving mainly health and social care practitioners. The research included both quantitative and qualitative methodologies and involved almost 400 participants. This gave a mixed picture of implementation. The MCA was welcomed by most participants who felt it gave greater clarity to a confused area of law and practice, and provided a better emphasis on both rights and protections for people who might lack capacity. However, the research also showed significant misunderstanding and lack of awareness of the MCA among some participants. For example, 10% of survey respondents (36 cases) reported best interests decisions being made for people who had capacity – a clear contravention of the MCA which states that best interests decisions are only made for people who lack capacity. Some quotes from the report are included in Annex A.

Brief overview of other evidence from other organisations

Despite a widespread view among service providers, professionals, patients/service user and carer groups that the MCA is a positive piece of legislation recently there has been considerable evidence from elsewhere to indicate that awareness and understanding of it remains low. Reports from the Alzheimer’s Society, Confidential Inquiry into the Premature Deaths of People with Learning Disabilities, Care Quality Commission, and Department of Health have provided evidence showing significant levels of misunderstanding about mental capacity issues and incorrect use of the MCA, including fundamental processes such as assessing capacity, making best interests decisions and providing care and treatment for people who lack capacity, and the Deprivation of Liberty Safeguards (DoLS) (see Annex B).

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
We believe that research due to be published shortly by the Norah Fry Research Centre at Bristol University about DoLS and Cambridge University about the interface between the MCA and Mental Health Act will also provide important information about current implementation of the MCA.

In addition to this, there are more than 51 million adults in England and Wales but only a tiny number has registered Lasting Powers of Attorney (LPAs) made possible under the MCA for people who wish to plan for the future. Just over 604,000 Powers of Attorney are now registered despite the UK having an ageing population which means that the numbers of people with conditions that affect mental capacity such as dementia will increase steadily in the coming years.

While specialist services for people with illnesses, disabilities and conditions that affect their capacity are more aware of mental capacity issues and the MCA, levels of awareness are much lower in more generic services such as care homes and general hospitals. Evidence also indicates that there is low awareness and understanding of DoLS, an important amendment to the MCA which created additional safeguards for people who lack capacity to consent to being in hospital or a care home but need to be there in order to provide them with care and treatment – this affects some of the most vulnerable people in our society including people with severe dementia and people with profound learning disabilities.

Lack of awareness and understanding of mental capacity issues and MCA can lead to a number of serious consequences, particularly in relation to the legal rights and safeguards for people who may lack capacity, including:

- People with particular illnesses, disabilities, or injuries who may have capacity to make some important decisions about their lives, care, or treatment having their right to make decisions for themselves ignored and decisions made for them by professionals and other staff, or families and friends;
- End of life care decisions or major decisions involving serious medical treatment, where someone lives, or depriving someone of their liberty for people who lack the capacity to make it for themselves not being made correctly in line with the law;
- People not knowing about positive ways of being able to plan for the future should they lack capacity to make decisions for themselves;
- Family members or close friends not having their rights to be consulted regarding decisions about loved ones who lack capacity;
- People being assumed to have capacity to make certain decisions when in fact they may lack capacity and being allowed to make decisions which put them at risk
- Disputes and disagreements arising about mental capacity issues involving patients, service users, professionals and other staff, family members and close friends, often resulting in costly, distressing and unnecessary legal processes.

**Conclusion**

Low awareness and understanding among professionals, other staff and service providers suggests that people who may lack capacity and their families are even less familiar with the MCA as paid staff will be one of their main sources of information. However, because the MCA is such a wide ranging piece of legislation there is no single body responsible for actively promoting and explaining all aspects of the MCA and mental capacity issues more
Mental Health Foundation – Written evidence

widely. The Public Guardian Board, which oversaw the work of the Public Guardian, a national post created by the MCA with certain statutory powers, constantly called for greater ‘championing’ of the MCA in its annual reports (the Board was abolished in 2012).

Our view, reinforced by recent discussions with a number of national organisations with particular interest in mental capacity issues, is that there needs to be a renewed drive to raise awareness and improve understanding of mental capacity and the MCA across virtually all sectors and profession who are likely to encounter it in their everyday work and provision of services. There is already extensive guidance and training available about the MCA. While this can always be improved and updated as new research evidence comes to light, our view, and the view of others is that there is a need for a high profile awareness campaign to take place, involving a cross-sector collaboration and perhaps some form of mental capacity ‘declaration’ aimed at a range of audiences to explain how mental capacity issues affect them and how the MCA can help them in their everyday lives, practices, services or policies. We are in the process of exploring this approach with a number of national organisations.

Annex A – evidence and other MCA work undertaken by the Mental Health Foundation

• Making Best Interests Decisions: People and Processes (Mental Health Foundation, 2012)

Successful MCA implementation - findings from the research:

“The Mental Capacity Act was welcomed by most of our participants, who particularly felt that it had given greater clarity to a confused area of law and practice. They particularly spoke about patient rights, about the flexible approach to capacity enshrined in the Act, and about the protection given by the MCA both to clients and to staff. A learning disability psychologist spoke for many when she said: ‘I think it’s made a huge difference. It’s provided a clear structure. And it has a good balance between opposing situations. So that you get less neglect, but you also get the person’s voice heard, but you also get the system’s voice heard where there’s a difference of opinion…services are much more contained and less impulsive as a result of the Act’”.

“One palliative care nurse…summed up neatly the benefit of the Mental Capacity Act in re-shaping her practice in approaching older people who had been referred to a nursing home. Prior to the Act, she said she would have accepted that the referral decision had been made, and not questioned it. However, she said that now, the MCA gives her the ammunition to challenge others, and to see whether the patient’s views have been sought: ‘You’ve got more strength behind questioning why nobody’s listening to the lady in the bed’”.

MCA implementation; work still needing to be done - findings from the research:

“There appeared to be a general lack of awareness about DoLS”

“Participants in interviews often confused the Mental Health Act (MHA) with the Mental Capacity Act”

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
“There were additional confusions about some aspects of the MCA itself, in particular... relating to capacity assessments and roles. There was confusion amongst a minority of participants about the fundamental link between capacity and best interests... there was often also confusion in their understanding of the IMCA role”

- **Mental capacity training.** Customised practice development and training for Southampton City Council Social Services staff undertaken in 2012. Over 40 staff participated in the training and feedback was extremely positive. This was provided through the Foundation’s training and consultancy offer: [http://www.mentalhealth.org.uk/our-work/training/mental-capacity-training/?view=Standard](http://www.mentalhealth.org.uk/our-work/training/mental-capacity-training/?view=Standard)


- **Online practice development tools.** The Foundation has developed two free, confidential, online tools for staff, other individuals, and organisations involved in mental capacity assessments (AMCAT - Assessment of Mental Capacity Audit Tool: [www.amcat.org.uk](http://www.amcat.org.uk)) and best interests decisions (BRIDGET – [www.bestinterests.org.uk](http://www.bestinterests.org.uk)). We have used aggregated data from these to inform BIDS and provide ‘snapshots’ of MCA implementation e.g. [http://www.mentalhealth.org.uk/our-news/news-archive/2010/2010-06-24/](http://www.mentalhealth.org.uk/our-news/news-archive/2010/2010-06-24/)


In addition to these, the Mental Health Foundation’s current Head of Development & Later Life, Toby Williamson, has recently co-authored a handbook for psychiatric nurses on the MCA and the Mental Health Act; *Law, Values and Practice* (Open University Press, 2013) - [http://mcgraw-hill.co.uk/html/0335245013.html](http://mcgraw-hill.co.uk/html/0335245013.html).

### Annex B - recent MCA evidence from other organisations

**Dementia 2013: The hidden voice of loneliness** (Alzheimer’s Society, 2013):

“Choice and control would be improved by supporting people with dementia to make decisions, and by respecting and implementing these choices when they are made. These principles are contained within the Mental Capacity Act. Examples of good practice do exist. But the picture of whether people with dementia are able to exercise choice and control is still poor – and certainly more should be done to improve the scope for both. Dementia 2012 made recommendations regarding the implementation and monitoring of the Mental Capacity Act in England and Wales.” [Dementia 2012: “The Mental Capacity Act 2005 must be comprehensively implemented. Analysis of the emerging evidence on how the Act is being applied, and further evidence on this, is vital”].

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Recommendation:

• “The Ministry of Justice in England and the Department for Health and Social Care in Wales should improve monitoring of the Mental Capacity Act.”

Care Quality Commission (CQC) third annual report on the use of the Deprivation of Liberty Safeguards (DoLS) 2011-12 (CQC, 2013):

• “Analysis of CQC’s data from its monitoring activity shows that: The umbrella legislation of the Mental Capacity Act (MCA) is not well understood or implemented in practice” (p.6)

• “The Safeguards cannot be understood without reference to the guidance on good practice that is to be found throughout the MCA. The highest priority, therefore, for health and social care providers in operating the Deprivation of Liberty Safeguards system is to improve understanding and practice of the MCA.” (p.9)

• “CQC expects the following: Providers and commissioners of services for vulnerable adults must improve their understanding of the Mental Capacity Act and the Safeguards” (p. 9)

Confidential Inquiry intoPremature Deaths of People with Learning Disabilities (CIPOLD) (University of Bristol, 2013):

• “In addition, professionals in both health and social care commonly showed a lack of adherence to and understanding of the Mental Capacity Act 2005, in particular regarding assessments of capacity, the processes of making ‘best interest’ decisions and when an Independent Mental Capacity Advocate should be appointed.” (p.5)

Recommendations:

• “Rec 10: Mental Capacity Act advice to be easily available 24 hours a day.

• Rec. 11: The definition of Serious Medical Treatment and what this means in practice to be clarified.

• Rec. 12: Mental Capacity Act training and regular updates to be mandatory for staff involved in the delivery of health or social care.”

The Fifth Year of the Independent Mental Capacity Advocacy (IMCA) Service – 2011 /2012 (Department of Health 2013):

“However there are still wide disparities in the rate of IMCA instructions across different local areas which cannot wholly be explained by population differences. It is likely that in some areas the duties under the MCA are still not well embedded. The duty to refer people who are eligible to IMCAs is still not understood in all parts of the health and social care sector.”

30 August 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Sophy Miles and Nicola Mackintosh– Written evidence

Submission to be found under Nicola Mackintosh.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Mind, Alzheimer’s Society and Headway – Oral evidence (QQ 90 – 105)

Transcript to be found under Alzheimer’s Society in Volume 1.
Mind – Written evidence

**About Mind**

Mind is the leading mental health charity in England and Wales.

We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding.

We work in partnership with over 150 independent local Minds to provide a range of services tailored to the needs of their local community. Services on offer include supported housing, crisis help lines, drop-in centres, counselling, befriending, advocacy, and employment and training schemes. Last year our network provided direct support to over a quarter of a million people.

Mind wants to ensure that people with mental health problems have their voices heard, and are treated fairly, positively and with respect.

Our evidence draws on our own knowledge of the legislation together with the calls we receive by our legal advice line and feedback from a small number of advocates. We also work in collaboration with other organisations and support submissions by the Mental Health Alliance (of which we are a member) and the British Institute of Human Rights.

We would also refer you to our recent work on the use of physical restraint\(^{193}\), in the light of the horrific abuse of patients at Winterbourne View and the limitations on the use of restraint set by the Mental Capacity Act. We are calling for national standards for the use of physical restraint and accredited training for healthcare staff in England. The principles of this training should be respect-based and endorsed by people who have experienced physical restraint. We are calling for an end to face down physical restraint in all health care settings urgently, and for the use of face down physical restraint to be a ‘never event’.

**Summary, including key recommendations**

**Mental Capacity Act overview**

1. The Mental Capacity Act (hereafter MCA) is good legislation with helpful principles, but needs to be better understood and implemented.
2. The five core principles in the MCA are central to understanding the MCA and need to become common knowledge across the NHS, social care, other relevant sectors and wider society.
3. We therefore support the proposal for a cross sector collaborative to promote understanding and implementation of the MCA. There also needs to be investment by the Government in information and training, and more research on the use and impact of the MCA.


In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Deprivation of Liberty Safeguards

4. The purpose of the Deprivation of Liberty Safeguards (DOLS) scheme is good and necessary, but its design is flawed and the extreme variability of its implementation deeply concerning. The processes for challenging DOLS are not compliant with the requirements of Article 5 of the European Convention on Human Rights (ECHR).

5. DOLS should therefore be urgently reviewed as recommended by the House of Commons Health Committee. There needs to be clearer guidance and objective criteria for what is a deprivation of liberty, together with accessible, human rights compliant processes for reviews and appeals.

Codes of Practice

6. The codes of practice for the MCA and DOLS need to be updated and combined as the single authoritative source of guidance, and made accessible and physically available in all health and care settings where people are likely to have capacity issues.

Advocacy

7. Independent Mental Capacity Advocates (IMCAs) need to be better resourced and available as a right to all people subject to safeguarding who are assessed to lack capacity, and to people making complaints about care or detention under the MCA.

8. There should be a right to advocacy for all psychiatric inpatients and ideally there would be a single statutory advocacy scheme.

Other protections

9. We have major concerns about the use of physical restraint. The Code of Practice should prohibit the use of face down restraint and reinforce the need for staff training in preventing and managing challenging behaviour in which physical restraint is a last resort.

10. There needs to be scrutiny of best interests decision-making outside DOLS, such as through a mandatory care and support plan review.

11. Legal Aid should be reinstated for advice and assistance in making advance decisions, and non-means tested Legal Aid should be extended to anyone who is deprived of their liberty whether or not they are under DOLS or the Mental Health Act (MHA).

12. The Care Quality Commission should have increased powers and duties to protect people who are deprived of their liberty or de facto detained and effectively police the MCA and MHA.

Mental Capacity Act and Mental Health Act

13. It can be confusing to understand and apply the two regimes MCA and MHA. Furthermore the MHA is fundamentally discriminatory in providing for the compulsory detention and treatment of people with mental health problems who have capacity. However the MHA provides a more accessible appeals process.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
14. The Government should seriously explore and consult on rationalising the MCA and MHA to provide a single regime that begins with the presumption of capacity.

Overview and context

To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1. Where the MCA is being implemented well it is making a positive difference. For example, people are planning ahead and making lasting powers of attorney and advance decisions. Staff are making capacity assessments, best interests decisions, and thinking about how to provide treatment and care without depriving people of their liberty.

2. However, understanding and awareness of the Act is very variable, including among those who should be operating it. The scandal of Winterbourne View is the starkest example of the failure of safeguards in both MCA and Mental Health Act (MHA), but we are aware of less extreme failings, where capacity is treated as ‘all or nothing’ and daily decisions are made for people when they could be supported to make the decisions themselves.

3. The evidence base is still limited though, and we think that more research is needed on how decisions are being made in practice.

4. If the aim of the Deprivation of Liberty Safeguards (DOLS) is to protect vulnerable people, they are not achieving their aims. The procedures are not compliant with Article 5(4) of the European Convention on Human Rights (ECHR), and their implementation is too variable to provide confidence that everyone who should be safeguarded is.

5. We strongly support the development of a collaborative that includes Government bodies, as promoted by the Mental Health Foundation, to promote awareness of the Act and equip people to implement it.

Which areas of the Act, if any, require amendment; and how?

6. The following areas require amendment (paragraph numbers refer to sections of our evidence that contain more detail):

   - DOLS - Clearer guidance on deprivation of liberty with objective criteria is required. The criteria need to apply equally to people irrespective of the nature and degree of their disability (55-58)
   - A human rights compliant system for review and challenge of DOLS is required. It needs to be independent of the body supervising the depriving of liberty and accessible to the person or their representative with automatic referral, as is the case with tribunals for people detained under the Mental Health Act (61-66).
   - Scrutiny and monitoring – a minimal way to improve oversight of decisions that relate to Article 8 of the ECHR would be to make periodic care reviews mandatory where they relate to people who lack capacity in respect of their care (currently these are in guidance only). However we would also like to see an independent system of scrutiny.
   - The Care Quality Commission (CQC) has powers to monitor DOLS but not specific duties to visit people who are deprived of their liberty or investigate complaints. The
Government should consider increasing the CQC’s powers and duties so that it can effectively police the operation of both MCA and MHA and fulfil its OPCAT function with respect to people who lack capacity.

- Independent Mental Capacity Advocacy (IMCA) – there needs to be more robust arrangements for accessing IMCAs, especially in relation to DOLS and safeguarding concerns (44-51)
- Code of Practice – there needs to be one authoritative source of guidance on the MCA, including DOLS (currently the MCA and DOLS codes are separate documents), and it needs to be made accessible so that different audiences can understand and use it. It is very worrying that local authorities are developing their own guidance and checklists and this may be a factor in the variations in practice.
- The Code should be provided in different formats including easy read.
- The Code should be physically available in hospital and care settings where there are likely to be residents with capacity issues. It should be mandatory for copies to be made available in such settings, for use by residents, relatives, staff and visitors

At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

7. Yes, the MCA gives clear and helpful statutory principles. These include the presumption of mental capacity and the need to take all practicable steps to support capacity, and to define lack of capacity at a material time in a particular decision.

8. All relevant professional groups should have the MCA principles incorporated into their training. These would include medical and other health care professions, lawyers, social care professions and financial services. It is also important to spread understanding of the principles in wider society, for example by including the principles in schools’ teaching on citizenship, as part of understanding citizens’ rights to make decisions and duties to support others in this.

*Implementation*

To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

9. A recent study of best interests decision-making\(^{194}\) found that the principles were generally adhered to and that a variety of perceived risks led to the processes being initiated. It found that the notion of capacity was the most difficult aspect of the MCA and there were some problematic practices, especially relating to ‘insight’.

10. We are concerned that in practice professionals and other staff sometimes take a ‘binary’ approach whereby someone is treated as having capacity or not rather than the assessment being decision- and time-specific (see also 17-18). Best interests decision-making can in

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In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
practice actually be disempowering, which runs counter to supported decision-making, a model we would like to see promoted more.

11. Further research is needed to understand how best interests decisions are being made and their impact.

12. One serious gap is the lack of scrutiny of best interests decisions. While there are safeguards for a person who is deprived of his or her liberty (Article 5), there is no independent monitoring of the Article 8 (best interests decisions made on a daily basis) for people who lack capacity or indeed for people who are vulnerable and being cared for in restrictive settings, including use of powerful antipsychotic and tranquillising medication. This can include not only care homes or hospitals but supported tenancies. For social services assessment and care planning there is guidance requiring regular reviews but we know that in reality this does not happen. In such cases unless that person has an interested relative or an advocate, that person may be subject to blanket restrictions on their liberty and have no regular monitoring.

13. At a minimum it should be mandatory to hold a periodic review of care and support plans in the case of people who lack capacity to make decisions about their care; these should be multidisciplinary and include an independent advocate.

How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

14. We do not have a view on the implementation plan overall, though we are aware that the training and awareness-raising prior to implementation of DOLS resulted in reviews of care practices and the removal of unnecessary restrictions on liberty.\(^{195}\) However we think the evidence clearly demonstrates that implementation is still a work in progress and that there is still a need for a national focus on this.

15. We support the proposal for a broad cross sector collaborative to promote understanding and implementation of the MCA but also consider that there are specific responsibilities for the Department of Health, Care Quality Commission, Health Education England, and a lead body for advocates in taking forward implementation. Investment in information and training are needed.

Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

16. We have concerns both about care staff’s understanding of the MCA (in a range of settings) and clinical decision-making psychiatric hospitals as set out below.

17. Making decisions that people can make for themselves - Our legal advice staff frequently hear from relatives and carers of people in hospital or care homes who are not being involved in decisions that they could actually make – things like when they go for meals or

\(^{195}\) Hargreaves, R. (2010), Deprivation of Liberty Safeguards: an initial review of implementation. Mental Health Alliance.
whether they can smoke or go outside. An assessment of lack of capacity in relation to, say, choosing where to live, can result in best interests decisions being made across the board for that person without involving them in decisions such as what to wear, what to eat and when to go to bed. This is not supported by the MCA, but poorly trained and unsupervised care staff may be taking daily best interests decisions with no understanding of the current best interests checklist or the person’s history.

18. Failing to promote participation when a person does lack capacity - People can be excluded from decision-making for example in a busy psychiatric hospital where a person may be assessed as lacking capacity to consent to treatment. Their views and wishes should still be considered and they should be presumed able to make their own decisions about other issues unless assessed otherwise, and supported to do so as far as possible.

19. Capacity assessments in psychiatric hospitals - The CQC has criticised medical staff for failure to carry our regular assessments of capacity in psychiatric hospitals or of people subject to community treatment orders. We are also concerned about cursory capacity assessments that do not follow the principles of the MCA and do not make adequate attempts to really enable a person to participate. For example, decisions may be made by a psychiatrist that a patient lacks capacity only because the patient disagrees with a treatment plan or particular medication and without considering the full capacity tests. This is despite the fact that the MCA states that a person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision.

20. Care planning and advance statements - We know there is good practice in care planning, but research with people who use mental health services, and Mental Health Act monitoring reports by the Care Quality Commission, show that there are still significant failings in involving people in planning their own care. Please see 32-34 below for our evidence on advance statements and crisis planning.

Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

21. It is hard for people to understand their rights (especially under DOLS) because of their capacity issues, the lack of general awareness of the MCA and the complexities of DOLS. This underpins our recommendations on wider promotion and understanding of the MCA, access to advocacy, oversight of best interests decisions and the need to have a single, accessible Code of Practice.

Has the Act ushered in the expected, or any, change in the culture of care?

196 Care Quality Commission (2013), Monitoring the Mental Health Act in 2011/12. Care Quality Commission.

197 For example, Dorothy Gould (2012) Service users’ experiences of recovery under the 2008 Care Programme Approach. Mental Health Foundation and NSUN.

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22. The Act is far from being fully embedded, as shown in our evidence above. However where good practice is followed it suggests change at a cultural level, for example an initial review of DOLS for the Mental Health Alliance found that in some instances, authorisations accompanied by conditions had been effective in bringing about improvements in care arrangements which might not otherwise have been achieved. In some cases applications resulted in care homes getting input from psychiatrists and community mental health teams who had previously regarded their residents as having low priority.

23. We think there is increasing awareness of advance decisions and expectation of making and using them.

24. However, we would also refer you to our recent work on the use of physical restraint\(^{198}\), in the light of the horrific abuse of patients at Winterbourne View and the limitations on the use of restraint set by the Mental Capacity Act. We are calling for national standards for the use of physical restraint and accredited training for healthcare staff in England. The principles of this training should be respect-based and endorsed by people who have experienced physical restraint. We are calling for an end to face down physical restraint in all health care settings urgently, and for the use of face down physical restraint to be a ‘never event’.

25. In terms of the scope of this inquiry, we recommend that the Code of Practice prohibits the use of face down restraint and reinforces the need for staff training in preventing and managing challenging behaviour in which physical restraint is a last resort.

Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

26. We are not aware of evidence for the MCA overall. There is demographic data in the Health and Social Care Information Centre’s data collection on DOLS. This shows that the number of applications is roughly similar for men and women, most applications are for older age groups, and there are higher rates of applications for white groups. Differences by ethnicity may be accounted for by the different age structures of different communities. There is demographic data on the take-up of IMCA on the Department of Health’s annual report. We would like to see further research on these issues. If differences by ethnicity were not explained by age structures or other demographics, it would be important to address why there was under-representation in a protective scheme.

**Decision making**

Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

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27. In terms of health care, there is a greater drive generally towards shared decision-making which may in turn lead to a greater expectation of planning ahead and support to make decisions for those directly affected by the Act. There are serious limits to this however.

28. To assess, engage and empower a person who may lack capacity can be resource intensive. It may require help from speech therapists or occupational therapists or for more time to be devoted to that person by the care staff or clinical team supporting them. There is a risk that in a time of austerity when resources are scarce there will be a temptation to cut corners and to fail to properly give effect to the requirements of the Act. Risk averse cultures may fail to give people adequate room to make ‘unwise’ decisions, or may allow for it to be decided that someone lacks capacity when they are just choosing a more risky or difficult option or refusing a treatment.

What evidence is there that advance decisions to refuse treatment are being made and followed?

29. There seems to be increasing use of advance decisions and of systems within health care to check for and follow those decisions, but there should be more research done to establish practice and its impact.

30. However, we still have major concerns about advance decision-making and how well advance statements are being used.

31. Mental Health Act – as people with capacity may be treated with medication without their consent under the Mental Health Act, advance refusals of treatment with medication can be overridden by the MHA. The existence of such powers may deter people from making advance statements of wishes or advance refusals of treatment if they think they will not be adhered to. This also shows the fundamentally discriminatory nature of the Mental Health Act (see 79-81).

32. Joint crisis plans – many people with mental health problems experience periodic crises when they may temporarily lose capacity to make decisions about their care and treatment. Joint crisis plans are one way to enable people to make advance statements and decisions and have them followed. In this model a joint crisis plan is a voluntary, negotiated agreement between the person and their clinical team. An independent facilitator ensures the person has their full say and genuine sign-off. An initial research pilot found that the use of compulsion was halved – 13 per cent of those with a joint crisis plan were admitted under section compared with 27 per cent in the control group.

33. However, a larger randomised trial, organised by the same research team and involving more sites, found no effectiveness in reducing the use of the Mental Health Act, though service user views of therapeutic relationships improved. The study highlighted some challenges in practice: ‘Many patients in the study complained that the agreements in the

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[joint crisis plans] were not honoured in practice and only five of the 28 care coordinators reported referring to or using the [joint crisis plan] in the follow-up period’. This demonstrates serious shortcomings in the involvement of people with mental health problems in decisions about their care and treatment.

34. Legal aid for making advance decisions – we are very concerned about the removal of eligibility for Legal Aid for advice and assistance in making advance decisions. This is important because having a decision correctly drawn up ensures that it is valid, and that its meaning is clear and medical professionals will have confidence to follow it.

Has the MCA fostered appropriate involvement of carers and families in decision-making?

35. In our experience carers and families often feel overwhelmed and perplexed. Their position is very unequal in relation to professionals who know the law and how to operate it. There should be more directive guidance to professionals to involve carers and families except where there are good reasons not to, for example where it is known that the person does not want them to be involved.

Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

36. The role of an IMCA is very important both for individuals directly affected by the MCA and for carers and relatives. Mark Neary’s experience of challenging his son Steven’s deprivation of liberty demonstrates how ‘transformative’ it was having an IMCA on board.201

37. A number of local Minds run IMCA services and our response draws on their experiences. The small number of IMCAs we have spoken to all consider that they have played an important part in articulating the position of the person who lacked capacity and in assisting relatives who were the relevant person’s representative (RPR). They have also explained that their involvement may secure a change of care regime for the person and that staff will consider less restrictive practices or enable the person to go home with increased support. Some IMCAs also effectively act as brokers in some situations, helping mediate in disputes about best interests by improving communication between parties, though this is not their main role. Indeed it is not clear that this should be their role and the fact that they are fulfilling it highlights the need for better provision for mediation where there are disputes about best interests to allow swift resolution, if possible without the need to go to court.

38. There are major limitations however on the ability of IMCAs to succeed in providing people with a voice and acting as a safeguard. These are:

- problems with access to IMCAs


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• lack of continuity
• lack of eligibility for people who fall between statutory regimes.

39. We are particularly concerned that there needs to be a more robust way of ensuring people have access to IMCAs, especially in relation to DOLS. Unpaid RPRs often have difficulty identifying that they need an IMCA and the person directly affected is rarely in a position to request one. Research on the interface between DOLS and the Mental Health Act showed that ‘almost no one subject to the MCA-DOLS initiated a review him or herself, highlighting the need for support for this group of men and women’.

202 We recommend that referrals under 39D(5), ie where there is an unpaid RPR, are automatic unless the RPR specifically declines an IMCA.

40. It is also clear from Winterbourne View that it is extraordinarily difficult for the person or their relative to take forward safeguarding issues or complaints. It is cause for great concern that the number of safeguarding referrals to IMCAs has declined for the first time in the last year. We support the proposal that an IMCA should be instructed in safeguarding and complaints where the person lacks capacity.

41. IMCAs tell us that they can provide a more coherent service where there is longer engagement, for example where an IMCA who has advocated for someone in a Deprivation of Liberty is then asked to assist with a review of their care arrangements.

42. People in locked wards without DOLS or MHA safeguards - An advocate recently told us about multiple occasions when they found patients who lacked capacity to make treatment decisions held on locked wards but without safeguards under either MCA or MHA regime. Patients had been admitted under the MHA but then a decision was made that the criteria for their detention were no longer met. The patients remained on the ward without safeguards. In this situation, they would have no right to a tribunal or IMHA and no IMCA. De facto detained patients were identified in research as one group falling between the gaps between the MCA and MHA. This may require a remedy in for example the MHA Code of Practice, and the powers and duties of the CQC (see 71-72) but it certainly highlights the need for a right to advocacy for all psychiatric inpatients – as is the case in Wales - so that no one falls between two regimes in this way.

43. Discharge from hospital following detention under the Mental Health Act – similarly, there is a need for IMCAs for people who are initially admitted to hospital under the MHA when subsequently, as informal patients, there is no assessment of their capacity to consent to arrangements that are made for their community-based care.


204 Clare I.C.H, Redley M., Keeling A. et al (2013?), Understanding the interface between the Mental Capacity Act’s Deprivation of Liberty Safeguards (MCA-DOLS) and the Mental Health Act (MHA). University of Cambridge.

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Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

44. The Department of Health’s fifth annual report on IMCAs shows that referrals to IMCA services continue to increase but that there is a concerning disparity between local areas which cannot be wholly explained by population differences. This suggests that the level of referrals should be higher. We are not in a position to explain these differences. IMCAs do tell us that there is a variable referral rate depending on the professionals involved, but this does not explain geographical variation. Commissioning may play a part as may the local authorities producing their own MCA guidance.

Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

45. We consider that IMCAs are often adequately skilled but that there are problems with resourcing IMCA services, in terms of both numbers and the training and support provided.

46. The IMCAs we have spoken to in two areas of high referral say that it can be a challenge to deal with urgent authorisations in time, particularly if there was a delay in referral, and to meet all their obligations. If the difficulties in accessing IMCAs are addressed this will further increase referrals. This is a commissioning issue, and as the Department of Health fifth annual report into IMCA points out, commissioners need to factor in increasing referrals. Commissioners of IMCA and other advocacy services need to be held to account for their commissioning decisions.

47. An additional demand on IMCA services is where IMCAs are asked to act as litigation friends. This poses demands of both time and expense and raises questions as to these two quite different roles and whether they are compatible. In any case we are aware of solicitors having difficulty finding litigation friends for some of their clients who lack capacity and this is an issue that needs to be resolved (see 63 below).

48. Training and its resourcing are also issues. In one area of the country we were told that there was no longer any funding for the area meetings and training of IMCAs that had provided a useful exchange of practice.

49. In particular, it requires confidence and adequate training and resources for an IMCA to sustain a challenge and if necessary take a case to the Court of Protection. It can be a ‘big leap’ from a review to the Court of Protection. For IMCAs to fulfil their role it is essential that they have all the support they need to take forward a challenge when necessary. This also points to the need for IMCA services to be genuinely independent.

50. Training needs to encompass the MCA of course, but also the values and requirements of the Equality Act 2010, Human Rights Act 1998 and the UN Convention on the Rights of Persons with Disabilities, in order to put the MCA provisions in context.

51. It is a serious gap that there is no national body for IMCAs or IMHAs to ensure that quality standards and training are in place. There should be a national lead body for all advocates.

Deprivation of Liberty Safeguards
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

52. No. It is important to have a protective scheme, but the extreme variation in the implementation of DOLS between different authorities suggests that there is confusion about identifying when a person is deprived of liberty and that there are significant numbers of people who are deprived of their liberty without the protection of the safeguards. In areas of high use there may also be people who are deprived of their liberty when this could be avoided.

53. The scheme is also flawed in that its review and appeals procedures are not compliant with Article 5 of the ECHR. The review of deprivation of liberty is by the same body supervising the depriving of liberty, in contrast with access to a tribunal for people detained under the Mental Health Act. The Court of Protection, which hears DOLS appeals, takes a long time, may be far away, people do not generally know about it and it often does not involve the person who lacks capacity (see also 63-66). Again this contrasts with tribunals for people detained under the Mental Health Act.

54. The House of Commons Health Committee found the controls in DOLS ‘woefully inadequate’ and recommended the Department of Health initiate an urgent review of DOLS’ implementation. We support this recommendation and set out particular concerns in more detail below.

55. Definition of deprivation of liberty - There is confusion about when there is a deprivation of liberty and this may lead to people not getting the benefit of current safeguards. We hear from professionals struggling to understand developing case law and to make sense of the facts of particular cases.

56. There needs to be clearer guidance on what a deprivation of liberty is so that frontline staff can easily identify when it is happening and apply the law consistently. There should be an objective test which relates to the reality of the arrangements for the person’s care.

57. We have heard of instances where a person has stopped objecting to arrangements for their care and so the DOL authorisation has been lifted but the arrangements for their care have not changed. A ‘DOL’ test should be able to be applied objectively, whether the person is protesting, sitting slumped in a corner as they have given up objecting, or because of their disabilities are unable to express their views.

58. There has to be recognition that all people, whether profoundly disabled or not, should have the same criteria applied to establish a DoL. It cannot be founded on personal characteristics. To adopt a test that relates to the extent to which a person is disabled is discriminatory.

59. Clarity in guidance could help address the great variation in DoLS applications between different authorities. This variation is concerning as it suggests that there are significant numbers of people who are deprived of their liberty without the protection of the safeguards, and also may be some who are subject to greater restriction than is in their best interests.
60. The DOLS scheme is also limited in that it applies in hospitals and care homes only and not supported living arrangements. A review of the scheme should address the protection of people who lack capacity and live in supported tenancies.

Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

61. No. We are particularly concerned about the arrangements for review and appeal, which we consider are not, but need to be, independent, accessible and speedy.

62. Identifying a deprivation of liberty, putting safeguards in place, making appropriate referrals to IMCAs, and carrying out reviews all ultimately rest with the supervisory body and so there is no timely and independent judicial overview or review for people who are least able to voice objections. It is vital that there should be independent and automatic reviews if no application is made within a set period of time. The Neary case (see 36) demonstrates most clearly what can happen when a local authority fails to follow the MCA requirements.

63. Access to the Court of Protection is problematic and its proceedings take a long time and are remote. The person assessed as lacking capacity has to have a ‘litigation friend’ and these are hard to find for people as the Official Solicitor is overstretched and there is a waiting list. Solicitors have recently written to Mind asking for help with identifying sources of litigation friends and local Minds have been approached to assist but do not have funds or personnel to do so.

64. The person who lacks capacity may not be closely involved in the proceedings and we question whether this is acceptable. While it will be the case that some people who lack capacity may not be able to attend or actively contribute, there needs to be a mechanism to allow people adjudged to lack capacity to have access to the court and effectively participate. For example, KK v STCC [2012] EWHC 2136 (COP) was a case where the judge listened to evidence from KK and did not consider that she had lost capacity although this was the assessment of the professionals. He cautioned against conflating a capacity assessment with a best interests assessment.

65. In contrast, under the Mental Health Act (MHA) a tribunal can be arranged swiftly (five working days for a section 2 appeal). The tribunal is held in the hospital or home where a person is detained or subject to guardianship, which makes it accessible for the person appealing and promotes their involvement. The tribunal model with three experts – legal, psychiatric/medical and a layperson with experience of community and social work – is a useful one. The distinction between legal best interests and clinical best interests in the Mental Health Tribunal guidance for representatives is helpful as it allows for a person’s participation and access to the tribunal to be supported as far as possible. These lessons need to be applied to the MCA system under the Court of Protection.

66. MHA tribunals include a system of automatic referral so that the cases of all detained people are referred to tribunal for review if they do not appeal. This is an important

http://www.bailii.org/ew/cases/EWHC/COP/2012/2136.html

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protection that is missing from the MCA DOLS regime. A system with the flexibility and accessibility of Mental Health Tribunals must be introduced for DOLS.

The Court of Protection and the Office of the Public Guardian

Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

67. No. Please see 63-66 above. It is difficult for the person concerned to be present at Court of Protection hearings in contrast with MHA tribunals. The limitations on non-means tested Legal Aid eligibility for MCA issues other than DOLS are a problem as it makes it difficult for people of modest means to appeal to the Court.

What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

68. We do not have evidence about this.

What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

69. We have heard anecdotally that there can be difficulties for people who are 'property rich but cash poor' but have very limited evidence about this.

Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

70. We are very concerned about the removal of eligibility for Legal Aid for advice and assistance in making advance decisions. This is important because having a decision correctly drawn up ensures that it is valid, and that its meaning clear and medical professionals will have confidence to follow it.

Regulation

Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

71. The Mental Health Act Commission repeatedly pressed for its jurisdiction to cover informal psychiatric patients and we have identified some of these patients as having no safeguards but being deprived of their liberty when they lack capacity. Therefore the CQC’s Mental Health Act monitoring powers and duties should be extended to cover informal patients so that they can identify and protect people who are falling between the MHA and DOL safeguards.

72. Care Quality Commission (CQC) has powers to monitor DOLS but not specific duties to visit people who are deprived of their liberty or investigate complaints. The Government should consider how to increase the CQC’s powers and duties so that it can effectively police the operation of both MCA and MHA and fulfil its OPCAT function with respect to people who lack capacity and are deprived of their liberty and/or vulnerable to abuse.

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Consideration should be given to the CQC having a role in respect of people in supported living, and in overseeing Article 8 best interests decision-making (ie beyond DOLS).

Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

73. The main role for these regulators is in ensuring that training and standards properly include the MCA.

Other legislation

How well is the relationship with the mental health system and legislation understood in practice?

74. It is confusing for care professionals who struggle to understand and to apply two different sets of criteria and it is expensive to fund two entirely separate regimes. We hear from professionals who are struggling to understand which regime a person should be subject to when they have a mental health problem and that person also appears to lack capacity to make treatment decisions. Uncertainty can lead to delays and a failure to take steps to provide safeguards at all. We also hear of people in psychiatric hospital who are in locked wards and are not given either deprivation of liberty safeguards or the safeguards of the Mental Health Act 1983 (see also 42-43 above).

75. There are some specific issues relating to the MHA and MCA. In light of Winterbourne View and from queries to our Legal Line we remain concerned about how people who lack capacity to ask for an advocate or contact a solicitor are adequately protected by MHA safeguards. We hear of situations where staff decide that a person will not benefit from these safeguards because they lack capacity and therefore they do not facilitate access for that person to an advocate or lawyer. This is another example of the failure to adopt the participatory and enabling approach that is promoted in the MCA.

76. The CQC has criticised medical staff for failure to carry out regular assessments of capacity in psychiatric hospitals or of patients subject to community treatment orders (CTOs). Only if this is done can it be ascertained whether a person is capable of consenting to take particular medication or to have a course of treatment. There is confusion over the relationship between insight and lack of capacity as opposed to disagreement with a particular treatment plan. This could sometimes be characterised as a failure to distinguish best interests and capacity.

Devolved administrations and international context

Does the implementation of the Mental Capacity Act differ significantly in Wales?

77. We shall produce supplementary information on this if we are able to do so.

What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

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78. Northern Ireland, Scotland and other jurisdictions variously are, or have been, working on merging or reconciling mental health and mental capacity legislation and it is important to learn from them.

79. It is a major concern that the Mental Health Act (MHA) is fundamentally discriminatory in providing for the compulsory detention and treatment of people with mental health problems who have capacity. Other people with capacity to make their own health care decisions are allowed to do so, including to refuse treatment (as are people with mental health problems in relation to physical health care and treatment). This issue is raised frequently with us by people who have been subject to the Mental Health Act. Any criteria for compulsory detention or treatment should include a test of impaired decision making.

80. Furthermore, providing an entire legal scheme of compulsory treatment by reference to one disability leads people with mental health problems to feel singled out and treated differently. Given 9 in 10 people already experience stigma in their daily lives, this is yet another example of discrimination which is enshrined in our legal system. It is also contrary to the requirements of the UN Convention on the rights of persons with disabilities (Articles 2, 14 and 25). Article 14 (1) states that the existence of disability shall in no case justify a deprivation of liberty.

81. The Government should seriously explore and consult on rationalising the MCA and MHA in a single piece of legislation that begins with the presumption of capacity and includes scrutiny of decision-making and quick, accessible appeals mechanisms. This would address a range of concerns described above:

- The fundamentally discriminatory nature of the Mental Health Act – we would want to see a test of impaired decision-making
- Confusion in applying two different sets of criteria - uncertainty can lead to delays and a failure to take steps to apply safeguards at all
- People who are treated under the Mental Health Act are often not enabled to participate in decision-making
- The lack of independent scrutiny under the MCA of best interests decision-making relating to people who are not detained
- Easy access to appeals
- Parity - providing supported decision-making and safeguards for everyone who does not have capacity to make decisions for themselves, on an equal footing, would be in line with the parity of esteem as between physical and mental health enshrined in the Health and Social Care Act.

Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

82. The UNCRPD challenges the notion of substituted decision-making and the alternative would be supported decision-making whereby the person receives whatever supported they need to exercise their autonomy.\textsuperscript{206} This approach should be emphasised in the


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implementation of the MCA. Specifically, this must include considering carefully how the person assessed to lack capacity can be enabled and supported to participate more actively in the decisions made about her/him including ensuring more detailed procedures and protocols to include her/him in any review processes or contested proceedings.

2 September 2013
Ministry of Justice and the Department of Health – Oral evidence (QQ 1-24)

TUESDAY 18 JUNE 2013

Members present

Lord Hardie (Chairman)
Lord Alderdice
Baroness Andrews
Baroness Barker
Baroness Browning
Lord Faulks
Baroness Hollins
Baroness McIntosh of Hudnall
Lord Patel of Bradford
Lord Swinfen
Lord Turnberg

Witnesses

John Hall, Deputy Director of Family Justice, Ministry of Justice, Nick Goodwin, Deputy Director of Court Tribunal Fees, MoJ, Anne-Marie Hamilton, Deputy Director of the Social Care Quality and Safety Branch, Department of Health, and Claire Crawley, Senior Policy Manager, Adult Safeguarding, DoH

Q1 The Chairman: Good morning. I am sorry to have kept you waiting; we had some preliminary business to attend to. Mr Goodwin, if you have any difficulty understanding or hearing what we are saying, please indicate, and we will try to accommodate you as best we can. The evidence session that we are about to begin will be webcast live as well as transcribed. The transcripts will be published on the Committee’s website and witnesses will have the opportunity to make minor corrections and clarifications to the text. I understand that there is no opening statement, but can I just have confirmation of that? In that case, we will simply go to the first question, which is to be put by Baroness Andrews.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Baroness Andrews: Thank you, Lord Chair. I am afraid that I have the blockbuster question on this hugely important Act, which is: to what extent do you think the Act has been a success? Is there a consensus about what is success? Is there a consensus, indeed, about where there has been failure? Can you say something about the nature of the evidence and the criteria that you use as departmental officials to reflect that?

Nick Goodwin: Thank you. I shall start and pass you over to colleagues at some point. Overall, our view is that the Act has been a success. When it came in, it was certainly widely welcomed as a progressive piece of legislation that balanced protections with empowerment, and that is still largely the case in terms of the core principle of the Act and so forth. We engage with stakeholders, and that is their view. That is the day-to-day dialogue that we have. We have consulted over a few minor changes to the legislation, rules, regulations and so forth to implement the Act. The sense that we have had back from those consultations is that the legislation as a whole is still highly regarded.

How one gauges its success is a bit more difficult. We do not have any hard criteria or measures at the moment, so far as I am aware. The key things you would be looking for are whether the Act is used and understood and whether the accompanying objective of securing culture change has been achieved. In terms of use, yes, the Act is being widely used. Certainly, there is enthusiastic take-up of the lasting power of attorney. There have been about three-quarters of a million since the Act came in, and there is an increase in demand year on year for Public Guardian services generally. We acknowledge that there is probably further demand out there, and at the moment we are trying to put in place measures that allow that demand to be met or captured.

Anne-Marie Hamilton: We would say broadly, yes, it has been a success, but as legislation that requires significant cultural change across the health and care sectors, it takes time to embed and to truly see that.

The criteria we use are not formal criteria as such, but we ask whether the Act is understood, whether it is being used, and whether it is having an impact on people. In terms of the hard evidence we have, from data, we can see that referrals to independent mental capacity advocates have doubled in the five years since the Act was introduced. Referrals for deprivation of liberty safeguards have also increased over that time. We would expect best interests and capacity assessments to be taken on a daily basis, but obviously we do not collect data around that.

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In terms of the informal evidence we have, we know that most hospitals and local authorities have Mental Capacity Act and deprivation of liberty safeguard leads in their organisations who are responsible for training staff, auditing practice and challenging practice. We know that local networks continue to meet to share innovative practice and discuss emerging case law. We know that the independent mental capacity advocate service is playing a valuable role in representing people’s best interests. We have significant informal evidence and some data, but broadly speaking, to echo what Nick said, we think we have made considerable progress so far but there remains a lot to be done truly to implement and embed this across the system.

**Q2 Baroness Andrews:** Thank you. What you said about that part of it is significant because when you look at the five statutory principles, they are all about culture change, essentially. The statutory principles—“A person must be assumed to have capacity unless it is established that he lacks capacity … is not to be treated as unable to make a decision … because he makes an unwise decision … best interests … Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive”—are very, very difficult. I know this is a difficult question, but do you think those statutory principles are being embedded in practice in culture?

**Claire Crawley:** I think they are in some places. Certainly we have seen evidence of individuals who previously would have had decisions made on their behalf. I shall give you an example. A woman in her very late 90s was diagnosed with vascular dementia. She was very frail and had no hearing, yet she was adamant that she wanted to live at home. Having a best interest assessment and a mental capacity assessment meant that she could make that decision and was able, with support, to go home. I think that is very different from where we were before the Act.

It is a huge culture change. Traditionally, social care and the health service have been a bit paternalistic in their attitudes towards patients and people using services. There is a huge thrust much more towards choice, control and self-determination. Front-line staff, such as care assistants and healthcare assistants, who are largely untrained and unqualified, probably need more assistance to understand the concept the Act is about. Perhaps particularly health professionals find the concept challenging. Social work traditionally has been about empowerment, change, choice and control, but clinicians sometimes find it difficult to feel that they cannot make a decision unencumbered by the patient’s view—but that is a terribly sweeping statement. We are getting there, but you are right: it is a fundamental change because it is a way of practising within human rights essentially, and it has got to be at the forefront of everything you do and all your practice. It is not an add-on.

**Q3 Lord Patel of Bradford:** I would just like to declare an interest: I am a former chairman of the Mental Health Act Commission, and I am currently a patron of a number of mental health charities. Carrying on from the question Baroness Andrews posed, you said that the Act has been used widely and it is understood fairly well in most quarters. Have you any figures about ethnic disparities in the use of the Act, lasting powers of attorney or the use of mental health advocates? Is that data monitored?

**Claire Crawley:** I am going to confess that I think it is monitored, but I am not sure. We could find out and come back to you, if that would be okay. My sense from the last IMCA In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
report is that there is perhaps, as in many things, an underrepresentation of people from black and minority ethnic groups taking up IMCA services. That would probably be because of a lack of awareness of the service being available.

The Chairman: I think it would be helpful if we had a formal note on that.

Lord Patel of Bradford: Also on what is being done about that.

Baroness McIntosh of Hudnall: Can I just pick up the point you made about things that are yet to get bedded in and matters which have not yet worked out as originally anticipated? Is there currently any plan in government to look at the Act again with a view to amending it, or is it the view that it is just keeping on going until these things get bedded in? Are there any areas where amendment is thought to be necessary?

Nick Goodwin: I think overall the view is that there is no need fundamentally to amend the Act. However, you will be aware that last year there was some consultation around the Office of the Public Guardian and its ability to move to more digital services, and there is due to be further consultation on that very shortly. Within that, depending on what the final proposals are, there may well be some proposals for change around the lasting power of attorney provisions, but they are designed to facilitate the OPG to deal with lasting power of attorney in a way that customers want, rather than fundamentally to unpick what is behind the Act in respect of LPA. “Fairly limited at the moment” would be the answer.

John Hall: The feeling is that the fundamental framework and principles are sound, and that any changes that we need to make are around ensuring that implementation continues to improve.

Baroness McIntosh of Hudnall: So can I just follow that up? As far as the code of practice is concerned, you have all indicated that you think that it is regarded highly by users, but there are some issues that have arisen intermittently—in fact, more than intermittently—over the past couple of years. Is it your view that there is anything that needs to be done to look again at the code of practice, for example, to see whether that can be amended?

Nick Goodwin: We were scheduled to look at the code of practice about now to see whether it needs updating. Jonathan Djanogly, then the Minister with responsibility for this area, wrote to Alan Beith on the Justice Select Committee and said that the intention was to defer that so that we could look at the code of practice at the same time that we look at the OPG reforms, so it can be updated all at once. There is still a plan to look at it, but it is a little way in the future. That process would obviously be fairly comprehensive and would draw in observations from around government and around society.

Anne-Marie Hamilton: Similarly, in the Department of Health there are no plans to amend the legislation. On the code of practice for the deprivation of liberty safeguards, there are two cases before the Supreme Court in the autumn. They and the report of this Committee may suggest a need to amend the code of practice, for example. We will need to consider that in due course.

The Chairman: I appreciate that you are waiting for the decision of the Supreme Court. I think one of the cases is coming up in October. Obviously you perhaps want to be informed...
by the decision of this Committee, but once that information is available, can you give us any indication of when you would come up with a revised code of practice?

Anne-Marie Hamilton: No, we would need to discuss that with our Ministers.

The Chairman: I suppose that is something we could ask the Ministers.

Anne-Marie Hamilton: Yes.

Q4 Baroness Barker: We all know about the red tape challenge and scything through unnecessary regulation. A lot of the implementation of this Act rested on not just the code of practice but on a lot of regulation. Do you see anything coming out of the red tape challenge that is going to impact on current regulations under the Act?

Anne-Marie Hamilton: The red tape challenge was very helpful, and the comments we received are publicly available. There were comments on the Mental Capacity Act and the deprivation of liberty safeguards. Some were positive, some had concerns, particularly around the process for depriving someone of their liberty; for example, the forms involved in doing that. We are considering them, and we will need to decide how we respond in the light of what this Committee finds.

Baroness Barker: But it is likely that there is going to be change, rationalisation, a general move towards making it easier for individuals to engage with the legislation and secondary legislation.

Anne-Marie Hamilton: That is certainly what people called for in the red tape challenge. That again is something that we would want our Ministers to take a view on as we go forward.

Baroness Barker: It is not actually one of our questions today, but I wonder whether I might flag up to you that those of us who were involved in the pre-legislative scrutiny of the Act found that technical issues, digital issues, and the web did not really feature at all. I think they now do, and it is perhaps something that our Committee needs to reflect on. If that is part of the work you are doing, it may perhaps be helpful for you to inform us about that.

Q5 The Chairman: The United Nations convention on the Rights of Persons with Disabilities entered into force in May 2008, subsequent to the enactment of the Mental Capacity Act, and was ratified by the United Kingdom in June 2009. Have you considered whether the Act complies with the convention? What was the outcome of that consideration?

John Hall: We took legal advice at the time that the convention was made. The legal advice was that the Act was compliant. We understand that since then some concerns have been raised among some of the senior judiciary, and we have started discussions with them. To be doubly sure, we are doing a review this year to get further advice on that, but our view is that it is compliant.

The Chairman: You are carrying that out this year.

John Hall: That is right.
The Chairman: When do you expect that to be completed?

John Hall: By the end of the year.

The Chairman: Does that include addressing the suggestions from some quarters that the substituted decision-making is not compatible with Article 12?

John Hall: That is the nub of the review.

The Chairman: What about the research provisions in Sections 30 to 34 of the Act? Are you considering whether they are compatible with the prohibition on medical or scientific experimentation on persons with disabilities without their consent under Article 15?

John Hall: We are looking across the whole gamut of issues. This Committee’s deliberations will be important to informing that.

Q6 Baroness Hollins: Before I ask my question, I should tell you that I am a retired consultant psychiatrist. I worked for 25 years as a consultant in learning disabilities services. I am also a family carer of a man with learning disabilities. I am a past president of the Royal College of Psychiatrists, and I am the current president of the British Medical Association. I want to ask you about implementation. There was initially to be a programme of work on implementation by the Department of Health, including local implementation networks. Can you describe for us the nature of your department’s work on implementation and how significant the local implementation networks were and perhaps also whether your expectation was that the department would continue to lead on implementation or whether you saw a particular end point?

Claire Crawley: We did a massive amount of implementation of this legislation, probably more than is done on most legislation, because the fundamental challenge of the change of culture was recognised. It was originally planned to have a three-year programme to support the implementation. That was, in fact, extended to five years, so a significant amount of resource went into that. You are right that that was supported by nine local area leads as well as the central policy lead and local implementation networks were enabled and supported, and most of them are still going, I think. Obviously the role of the department is one of oversight and stewardship, but because we recognise that this is such a critical piece of legislation we are still involved in supporting implementation through commissioning. For example, we have commissioned SCIE to carry out work with care homes where it is important that people understand how the Act should work and what it does. We have supported SCIE to produce popular and very successful tools, including Social Work TV on SCIE TV, and we have worked with various professional bodies on a range of other guides, so in terms of implementation we have done a lot. I do not think we see the job as done; it is just what is appropriate and what levers we now have in this new system. The new Care Bill and the NHS reforms offer us an opportunity to refresh that work because we need to talk to people in the new NHS system about what responsibilities and accountabilities they have under this legislation.

Baroness Hollins: How well do you think the Act is known and understood by relevant professionals and others required to apply it, such as carers—you mentioned carers in residential settings—as well as individuals to whom it applies?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Claire Crawley: I think it is variable. I think it is growing. My main portfolio lead is adult safeguarding. I attend a number of events to speak, and we have hosted conferences about safeguarding, and mental capacity is always raised by professionals throughout those sessions, whether they are nurses, doctors, social workers, care home owners or inspectors. It is much bigger in the profession than it was, and the Care Bill is an opportunity to refresh and remind people of it. I think it is much less known, probably, among informal carers and family and friends, although all the information and data we are getting from the Office of the Public Guardian demonstrate that that is also growing—phenomenally, actually in terms of doubling and perhaps trebling. It is less important that people, like me as a carer or a family member, know the Act and the code of practice than that I should know what my and my family’s rights are under the Act and how they can be protected and promoted. I think we are on a journey, but applications for IMCAs and LPAs show that there seems to have been a jump. There was a very slow start, as we might expect, but there has been quite a significant jump in awareness.

Baroness Hollins: I have a couple of supplementary questions. I want to pick up on something that you said about paid carers knowing more. An awful lot of carers have no or very limited training. Do you think that all carers working in services should have some training on mental capacity?

Claire Crawley: Absolutely.

Baroness Hollins: Is professional training on the Mental Capacity Act available through appropriate professional bodies? What has the department done to promote such training?

Claire Crawley: We have done work with what is now the College of Social Work and with the Social Care Institute for Excellence which is aimed at developing the training of professionals. We have commissioned a number of training programmes, tools and guides that are still out there and being used. As I said earlier, the department’s view is that this is as fundamental to health and social care practice as any other legislation. Like the Human Rights Act, it has to be absolutely embedded in everyone’s practice every day. It is not an add-on; it is not a specialist thing; it is not something you think about when suddenly you face a problem; it is there in all your work. That is a huge challenge.

Baroness Hollins: What about the royal colleges?

Claire Crawley: The royal colleges, particularly the Royal College of Psychiatrists, have all been very heavily involved in training their relevant membership groups. If you want more detail of that, I would have to go away and find out more.

The Chairman: Can we have a note on that as well?

Baroness Hollins: Just one final question: there are some dedicated roles, such as learning disability nurses. I think there were something like 30 learning disability liaison nurses working in acute hospitals. I gather the number is going down, and I think there is only one learning disability consultant nurse, but they have seen their role as working to support the application of the Mental Capacity Act within acute hospitals. Do you have a view within the department about their role in ensuring its application in hospitals and in community settings, where there are more learning disability nurses?
Claire Crawley: I think certainly they have a leadership role, but all employers and professionals have a personal, individual role as well. It would be an awful ask to ask so few people to somehow be responsible for that level of awareness. We find leaders in these posts who are absolutely committed to the principles and know how they pan out in practice.

Q7 Baroness Andrews: Can I just follow that up with two questions? The code says, “The responsible body should also have procedures, training and awareness programmes”. Are you satisfied that all local authorities have those procedures and training? How do you actually know that? My other question follows from the post-legislative assessment that was made in October 2010, and we are two and a half years away from that. It is about NHS trusts. Again, it is an evidence question, because the assessment revealed an inconsistency in assessing capacity in some trusts to ensure that the Act was fully embedded. In 2010 it said that all such trusts have met the required conditions. How do we know?

Claire Crawley: In terms of hard evidence, could I sit here and say, “I absolutely know that every local authority has appropriate plans and training processes in place”? I could not say that because I have no way of getting that evidence. The regulator of the industry, as it were, the Care Quality Commission, does not monitor local authorities or inspect them any more, so I would not know. My understanding is that they are required to do that, and if they are not, they are not meeting their statutory responsibilities. What was the second question?

Baroness Andrews: The second question was slightly different and was about NHS trusts and their capacity to ensure that the Act is fully embedded. In 2010, they were finding trusts that had not achieved that, but they said by that point that they thought all trusts had. I wonder what sort of monitoring and evaluation had gone on for the trusts for them to have that assurance.

Claire Crawley: That would probably have been the CQC’s process, as the regulator, rather than the department’s process.

Lord Turnberg: To follow on from that, how switched on do you think NHS England and the clinical commissioning groups are to the Mental Capacity Act? Are you having conversations with them?

Claire Crawley: We are having conversations. They have got a massive agenda on, so trying to get into that conversation is a challenge for all policy areas, including this. We have a dedicated lead within our team who works on the Mental Capacity Act, and she spends an extraordinary amount of time tracking down the people to talk to, so we are making progress.

Anne-Marie Hamilton: Clinical commissioning groups already have clear responsibilities around the Mental Capacity Act, so that is part of what they are expected to do. NHS England is well aware that this legislation is part of its responsibility.

Claire Crawley: As part of the authorisation process for CCGs, they had to demonstrate that they had the right processes in place.

Lord Turnberg: Did they?
Claire Crawley: Yes.

Q8 Lord Faulks: Mrs Crawley, a great deal of care is provided by people who are not professional carers, by families and even friends. Are you satisfied that in so far as it is relevant the code of practice for the MCA is sufficiently communicated and understood by most or all them?

Anne-Marie Hamilton: I think there are excellent guides. For example, organisations such as Mencap, the National Family Carer Network and the Alzheimer’s Society have a lot of materials that family carers can access to help them understand what they have access to through the Mental Capacity Act. The code of practice itself may not be in use by family carers, but there are other materials that are in use and are very helpful. For example, lasting power of attorney gets discussed on Radio 4’s “Moneybox”. It is part of the discussion for people to become aware of those rights, and it is leading people to ask for best interest assessments and to be more conscious of the framework within which the care is being provided.

Lord Swinfen: Do you have any system to identify families where informal care is being given by other members of the family so that help can be given to those informal carers, because very often they do not know what they are doing? They are just doing their best.

Anne-Marie Hamilton: No, I do not think we have a central system for identifying informal carers. There are so many people providing care of some sort or other to family or friends. I suspect that if they were looking for help or advice a lot of those people would look to organisations such as Age UK.

Lord Swinfen: General practitioners do not have any system?

Claire Crawley: No. We have been asking general practitioners for a number of years—at least 10, and probably more—to make sure they flag on patient records where carers are operating, to be able to offer them particular advice and assistance. Of course, we refreshed the carers strategy not long ago, and we do a lot of work with the various carers’ groups on how we get information like this across. You are right that GPs are often the first point of call for most family carers and the place they go, so it is really important that GPs know the circumstances. Often, if they are family doctors, they will know the family and will have known it for some time.

Lord Swinfen: They should know the family; I am not sure they all do.

Claire Crawley: No, I appreciate that.

Lord Swinfen: Not under the modern system at any rate.

Q9 Lord Patel of Bradford: On the issue of training, have you any evidence or examples of what is happening in further and higher education in respect of Mental Capacity Act training? We have concentrated on the NHS, local authorities and existing professionals, but in terms of newly qualified practitioners, whether care assistants or social workers, is any influence being exerted to say that this needs to be a core part of what they are teaching?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Claire Crawley: I would be shocked if it was not, but that is not a sufficient answer. If you want more detail, again we would have to come back to you with it.

The Chairman: Could we have a written note on that? You speak about encouraging general practitioners to flag up the records so that people with capacity problems are identified. To what extent are records readily available to other care providers? The reason I ask that question is that I was, unfortunately, admitted to a hospital in Glasgow from court one day with an MI. I had had a previous one, but my records were in Edinburgh. They had to phone the consultant in Edinburgh—this is National Health Service, not private—to get details of the previous episode. Is that a problem in England and Wales? If a GP has flagged up that someone has this problem, would that be communicated to another agency which was dealing with his or her care? Before you answer the question, I should have declared an interest—not as a patient just now—as honorary president of a charity called Capability Scotland, which campaigns for and provides services for people with mental and physical disabilities.

Anne-Marie Hamilton: There is an awful lot of work around record sharing within the NHS and across the NHS and the care system and a programme of work around electronic record sharing, but I do not think either Claire or I is familiar with the details. We would be very happy to find out more for you and to send the Committee a note if that would be helpful.

The Chairman: The reason I ask that is that it is all very well to say that GPs should flag the record, but if not followed through and the people dealing with secondary care do not know—

Claire Crawley: Particularly where people who may lack capacity are admitted to hospital in an emergency, that is a big issue.

The Chairman: They of all people might have even more problems than I did in communicating.

Claire Crawley: Absolutely.

Lord Swinfen: You say that GPs make a note on the patient's notes. That is all very well, but patient confidentiality may well mean that the GP cannot even talk to close relatives. How do you get over that if someone with a mental incapacity could be in danger of endangering themselves and possibly other people?

Claire Crawley: Well, it is very clear that the GP in that case, if you are giving it as an example, has a professional duty of care to that individual and must share the information appropriately. It is recognised that they must do that. It is a delicate balance between confidentiality and sharing, but in the example you give, it is critical that they share information.

Q10 Baroness Browning: I had better declare my interests to begin with. I am a vice-president of the National Autistic Society and also of the Alzheimer’s Society nationally. I am also the named carer of an adult relative living independently who has Asperger’s syndrome. I want to ask you about independent mental capacity advocates. We have heard that the number has doubled in the past five years, but we also know from the report by In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Lucy Bonnerjea that it is very patchy. It seems to happen in some areas, but not others. Bearing in mind that the guidance to this Act says that an IMCA must—the “must” is in italics—be instructed and then consulted for people lacking capacity who have no one else to support them, can you explain why five years on this system is so patchy?

Claire Crawley: I think it is partly because the Act is not properly embedded yet and people’s understanding is not as thorough as it needs to be. The fact that we have seen the numbers going up is positive, but they probably need to go up faster. One issue is that people often have friends or family who they prefer to use as their representatives. Our anxiety is that there may be particular cases, for example, in what is called adult safeguarding, where IMCAs should be involved and are not. Again, a lot of this is a question of awareness and time and building up the knowledge and understanding of when people need to be involved.

Baroness Browning: So when you see specific cases where this has not happened—for example, when your department received the Winterbourne View report; I have had the opportunity of speaking to the person who wrote that report and asked the question “Was the Mental Capacity Act used?”, and it was not used or mentioned at all at Winterbourne View, where you may recall that some of the staff received prison sentences—what was your department’s reaction when you identified immediately that that was where a weakness lay in terms of the implementation of this Act?

Claire Crawley: In terms of our response to Winterbourne View?

Baroness Browning: Not the response, but specifically in relation to the fact that Winterbourne View occurred without any reference to the Mental Capacity Act at all.

Claire Crawley: What happened at Winterbourne View shocked us all. In the wider context of what was going on there, in a sense one would have been surprised if they had understood and used the Act. Because of the abuse and the poor care, I do not think they had much understanding of any appropriate care or ways of working with people, if that makes sense. It was not the Mental Capacity Act alone that they had no awareness of. They did not have awareness of any proper working with those particular individuals, by the sound of it. For us, it was probably a salutary reminder that there are some people who are very vulnerable to abuse and exploitation who the Act should be protecting and is not, and we will have to do more about that more generally.

Baroness Browning: When you see something that I would describe as a trigger, who exactly in the Department of Health has responsibility for deciding that, yes, your department needs to do something about it?

Claire Crawley: I think ultimately it is probably Ministers.

Baroness Browning: Ministers? But presumably they would receive some sort of guidance from officials that it was time to act.

Claire Crawley: With Winterbourne View, they did not need any guidance from officials. The Ministers were very proactive in how concerned they were in wanting action to be taken.
Q11 Baroness Browning: Could I give you another example where the staff almost certainly would have been aware of the Mental Capacity Act? It is the reports that we have received over the years, the first from the charity Mencap, *Death by Indifference*, which involves the death of quite young learning disabled adults who are in acute hospital situations. They are not there because of their learning disability. There has been a supplementary report showing yet further deaths. In a hospital setting like that, you would expect all staff concerned to be up to speed with the Mental Capacity Act. What was your department’s response to the reports from Mencap in terms of the Mental Capacity Act?

Claire Crawley: I do not feel able to answer that because that was probably led by my colleagues. I do not know whether Anne-Marie knows.

Anne-Marie Hamilton: Are you asking who the lead official is or what the reaction was in the department?

Baroness Browning: Not specifically. We have heard the word “embedded” used a lot this morning, and of course the objective must be to embed this legislation throughout the system, but when one comes across specific examples like that, which are complex, no doubt, quite clearly the Act is not doing what it is meant to do. Clearly, it is not embedded at all. What triggers a response to try to make it more effective? Who actually takes that responsibility in government?

Claire Crawley: I think that is the Minister, and you are right, guided by officials. That is one of the reasons why we are working so hard to ensure that we have proper conversations and outcomes with NHS England and CCGs because, in a sense, that is who we have to work through. The department is in the odd position that it has parliamentary responsibility, it is the steward of the system, it exerts leadership and it dictates the direction of travel, but it has very few levers at its disposal. We have, I think, very much got to build and work through the new bodies if we are talking about hospitals.

Baroness Browning: Could I just ask one more supplementary? It is really to the Ministry of Justice. I know you are waiting for the conclusion of court cases, but you have told us this morning that from your department’s perspective, you are not of the view that this Act is in need of revision or review. When your department sees these quite high-profile cases—I have mentioned two, but they are by no means the only ones; there is unfortunately a steady progression of such cases—do you ever speak to the Department of Health about whether this legislation, on which both your departments rely, needs to be looked at seriously in terms of whether it is fit for purpose?

John Hall: We work together very closely. We have a number of forums and fora and working groups which we make sure we communicate. My team and the team that was formerly Nick’s work very closely with Anne-Marie’s team, so those conversations are happening in a joined-up fashion, if that is the question you are asking.

Baroness Browning: But the conclusion that your Minister came to based on those discussions and your advice was that there was no need to review it. Is that correct?

John Hall: Not a fundamental review at this point. That is where we are.

Baroness Browning: Does it not worry you somewhat because, although I know you are not the Department of Health, you must see these ongoing high-profile cases?

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John Hall: I am not going to comment on interdepartmental relationships. We work very closely together, and the views that we take and the advice we give to our Ministers are very much joined up.

Q12 Baroness McIntosh of Hudnall: I think Lady Browning has sort of asked the question that I wanted to ask, but I want to take you back to the answer you gave on the question about the code of practice. Although I understood that you were saying that there are some court cases that still have to be resolved, I did not get a sense—I hope you will forgive me for putting it this way; I do not mean it impolitely—that there was a great deal of urgency in your approach to the possible revision of the code of practice, and that is exactly where the issues that Lady Browning has raised are likely to be impacted upon. I wonder whether you might like to give us a slightly refined answer to the question I asked you earlier.

Claire Crawley: I hope you will not think these are weaselly words from a civil servant, but the issue is that the code of practice is very good—most people say it is—as is the legislation. It is people putting it into practice that is such a challenge. We could review the code of practice and the Act and spend a lot of resources and time doing that and not make one jot of difference to people on the ground. Our energies are focused, I think rightly, on protecting individuals rather than on revising the code. If the code was followed, those dreadful things would not happen. That is what we struggle with. What are our levers? What is our ability? How do we work with the regulator, in particular, to make sure that a good code of practice and some very good legislation actually happens?

Baroness McIntosh of Hudnall: Fair enough.

Baroness Andrews: Given that the system is changing and that the CCG is in place and so on and so forth, is there any opportunity or reason to look again at measures of evaluation and impact? That is what we are grasping at here. You have just identified it so coherently.

Anne-Marie Hamilton: I think you are right. In terms of the department’s role going forward, we want to work with our system partners, such as the Care Quality Commission, NHS England and others, in understanding what is happening out there and the levers that we have to effect change. Part of that should certainly be evaluating and understanding what is happening and what evidence, qualitative and quantitative, we have to inform that. To respond to the earlier point, we take that forward by working with those system partners. The response to Winterbourne View was led across the social care and NHS sectors and across the whole department with the different teams coming together to work on it. You are right that going forward we need to evaluate and understand.

Claire Crawley: We are working with colleagues within the department on what measures will be used to evaluate the performance of NHS England delivering on the mandate. There is some work going on on a range of issues, and we are trying to work with it on safeguarding and the MCA.

The Chairman: Can you give us a detailed note on that?

Anne-Marie Hamilton: Yes.
Q13 Baroness Hollins: I want to pick up something that you said in response to Baroness Andrews at the beginning about the principles of the Mental Capacity Act. Baroness Browning asked about Winterbourne View hospital. You said at the beginning that practice is now based on human rights, although untrained staff may not understand what that means. At Winterbourne View, they were mainly trained staff, but you said it was not an issue to do with the Mental Capacity Act. I appreciate that it was criminality really, but it was also to do with the lack of respect that those staff were showing to the patients, because it was a hospital. There is a really important issue about how far the evaluation of existing facilities looks at human rights approaches. Is there anything in the evaluations of services that are taking place that might be able to highlight a lack of a human rights approach?

Claire Crawley: Actually, that question is very timely for me, because I spent two hours yesterday with the Care Quality Commission talking about just these issues. How could Winterbourne View happen when the regulator was going in, GPs were going in and the local authority was commissioning places? You would have thought that somewhere in the system—it seems almost a complete failure, does it not? I was having exactly those discussions about how the CQC is going to train its inspectors, because perhaps the inspectors are not looking for the right things, and how they talk to people using the services, very much around the points you made. It is not just the staff delivering the service who have to have this approach, it is also the people who are monitoring and regulating them. Winterbourne View was just a dehumanising regime, was it not? It just seemed to be a catalogue of failures.

Baroness Hollins: Are you confident that the Care Quality Commission has got this kind of inspection in hand?

Claire Crawley: I am absolutely confident that it is working on getting it in hand. It sets great store by that work.

Q14 Lord Patel of Bradford: You said early on that the Mental Capacity Act is not an add-on. You are right in that. However, many practitioners have described the deprivation of liberty safeguards as an add-on to the Mental Capacity Act with a very different and less empowering ethos. Do you agree with that? If you do, what implications has it got for the Mental Capacity Act and its implementation?

Claire Crawley: I do not agree with that, and it is not the Government’s view. You are absolutely correct to say that they came later. The Act was amended through the Mental Health Act, and one of the reasons for that was that until Bournewood, which was the high-profile case that brought this all to light and to the fore, there was not really an understanding of the position that people were finding themselves in in care homes and hospitals. Certainly some Members of the Committee will remember that before the Mental Capacity Act got Royal Assent, it did not focus on it particularly. I think they are empowering. Partly it is the way they are misinterpreted or misunderstood. The language does not help. People concentrate on saying “deprivation of liberty” when what they should be concentrating on is the word “safeguards”. These are about making sure that people who in their best interest have some restrictions on their liberty—significant restrictions—to keep them safe have adequate recourse and protection within the law and within the system. I very much see them as empowering because we see a range of people whose treatment is being challenged, including through the Supreme Court and the Court of Protection work.

No, I do not accept that. I accept that the very terminology might feel confusing and

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inappropriate, but the ethos is to allow people to make as many decisions as they can and to be as free as they can.

**Lord Patel of Bradford:** Have you seen any discrepancies in terms of people understanding whether they should use the Mental Health Act or the Mental Capacity Act? Many would be almost de facto detained in these care homes.

**Claire Crawley:** Winterbourne View was an example. Nobody seemed to know about the Mental Capacity Act. I do not think there is confusion in the law, but people do not always understand which legislation they should be operating, and often it should be the Mental Capacity Act. We are working with colleagues on the mental health policy area to try to pull that apart, yet make it a coherent whole for people. We are doing some work on that.

**Lord Patel of Bradford:** Is that something that the Care Quality Commission’s mental health arm should be homing in on?

**Claire Crawley:** The person who leads on the Mental Health Act—a very senior member of staff—also leads on the Mental Capacity Act, so that is one way of bringing that together.

**The Chairman:** I think we need to move on to Question 8.

**Q15 Lord Swinfen:** You have just been talking about deprivation of liberty. Are the standards being operated the same throughout the whole country? If not, what is being done to bring the lowest standards up to the highest standards?

**Anne-Marie Hamilton:** I think everybody operating the deprivation of liberty safeguards is using the same safeguards, but there are regional variations in terms of the number of authorisations being applied for. We can see regional variations in the extent to which the safeguards are being used. The Care Quality Commission’s annual report flags that. We are discussing with the Care Quality Commission what it might do. When the original implementation programme happened, regional managers spent a lot of time going up and down the country talking to areas about how to raise awareness and how to get smaller providers familiar with this. There was an awful lot of work done. It is probably inevitable that there will be regional variations because the population make-up differs across the country. Some areas have higher populations of older people, some areas have more hospitals and more care homes and some care homes have higher populations of people with dementia. Variation is inevitable in terms of the number of safeguarding authorisations that you see, but we think that there is also something within that that means that it is not being implemented uniformly across the country and that some areas are doing this better than others.

**Lord Swinfen:** Your office could be learning lessons while looking at this. What are you doing to make certain that the lessons you learn to improve standards are promulgated throughout the country?

**Anne-Marie Hamilton:** That is something that the Care Quality Commission, as the regulator, talks about in its annual report, stating the issues it has identified and how it might build them into its processes going forward.
Lord Swinfen: Reports are very good, but they very often lie on the shelf. What are you actually doing to make certain that the recommendations are implemented?

Anne-Marie Hamilton: In terms of the Department of Health’s role? It is the role of the regulator to share that. The Department of Health continues to fund best practice guidance through the Social Care Institute for Excellence. We continue to try to raise awareness through the work that we commissioned from SCIE. We play the role that we described earlier in bringing together the different system partners, including NHS England, whose responsibility is to address this throughout the NHS. Local authorities have a statutory obligation to have this locally.

Q16 Baroness Barker: Lasting power of attorney is perhaps the part of this legislation that impacts on the general public first and most directly and is therefore very important. You said that there had been 750,000 LPAs. Can you tell us the time period for that? How does that compare to enduring power of attorney rates before the Act? Is the rate as high as we would have anticipated when the legislation went through?

Nick Goodwin: The actual figure is slightly under 750,000. LPAs have been registered since October 2007. That is about 20,000 a month at current volumes. It is very difficult to compare that with the previous system of EPAs. There is a lot of public information on the volumes, but I can give more on that.

Baroness Barker: I think we would like a lot more detail on not just when they are registered but when they are activated. We would like to know from different practitioners, such as people in memory clinics, how they are panning out with people and their families. At the time the legislation went through, there was considerable concern that the cost would be off-putting to people. We would like to have whatever data you have on that. If we can have a pretty full report on that, that would be helpful. Also, advance decisions were a very important part of this legislation. They were controversial when they came in, but I think some people have changed their mind. What data do you have on the use of advance decisions?

Claire Crawley: I think the honest answer is that we do not collect that data. I am sorry; that is not satisfactory from your point of view, but I do not think we do.

Baroness Barker: Does anybody in the course of their professional duties?

Claire Crawley: Not that I am aware of.

Lord Swinfen: What about the solicitor who draws up the lasting power of attorney? Do they have to register it anywhere?

Claire Crawley: The lasting power of attorney is registered with the Office of the Public Guardian.

Lord Swinfen: It should be able to produce the answer for you.

Claire Crawley: Advance decisions are different from LPAs.

Lord Swinfen: All right, but the modern one, does that have to be registered anywhere?

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Claire Crawley: The lasting power of attorney has to be registered with the Office of the Public Guardian, which may have data. Advance decisions can be just written by an individual on a piece of paper and signed, so they are not registered anywhere.

Lord Swinfen: They just get put in a drawer and when the time comes no one can find them.

Baroness Barker: The intention was that they would be part of a patient’s record and available to practitioners at the time of treatment. For example, if somebody had a fluctuating mental health condition, they could say, at a period when they had capacity, “I know from experience that when I lack capacity I may make certain unwise decisions. If I do that, I wish you to ignore what I say at that point.” The anecdotal feedback from a number of practitioners is that they have been helpful. It is a great shame that there has been no systematic look at their effect across the NHS.

Claire Crawley: Yes, I can see that. One of the reasons why the inquiry is going to be so helpful for us is in getting that different perspective of what is useful and what is not. Like all public bodies, we have restrictions about overwhelming the system with so much data collection that it cannot get on and do its job, but I understand the point you are making, and it is very interesting.

Q17 Baroness Andrews: May I pursue that, Lord Chair? At paragraph 9.38, the code of practice clearly analyses the complications that arise about the business of logging an advance decision and in determining whether it even exists: “It is the responsibility of the person making the advance decision to make sure their decision will be drawn to the attention of healthcare professionals”. We are dealing with people in intermittent states of confusion, very often. When you come to look at the code of practice again and the evaluation methods, it might well be worth looking to see, on the basis of what experience you can collect, whether there is something that can be done to tighten this up. This was such an important—it is increasingly important—issue for self-determination.

That was not going to be my question. This is my question. I have personally gone through the process of LPA, and it is not easy. I know that you tried to simplify it, but the terminology is still very complex and unusual, and the form is very long. Someone described it to me as being like reading a Russian novel because by the time you are halfway through, you have forgotten whether you are the donor or the attorney. Is there some way in anticipation that you can have another go at that?

Nick Goodwin: Yes.

Baroness Andrews: Good.

Nick Goodwin: It is a very common criticism. That is what the OPG is trying to simplify. We anticipate that in a short number of weeks, we will have made the first step on that. It will be a bit of a journey to get there. The first step will be a new online tool that will mean that, if you have gone through that laborious process of filling in all the information, the form is not sent back to you because you have got a few bits in the wrong box,
Baroness Andrews: That is exactly what has happened. They come back to you with another charge because you have the terminology wrong, which is causing a bit of aggro. It might be worth taking evidence from somebody who is aggrieved.

Nick Goodwin: Again, there has been consultation on this. The aim is to make it much more user-friendly and to improve the process in the Office of the Public Guardian. There have already been some improvements. We have reduced the statutory waiting time and there are some minor amendments intended to improve customer service. At the same that the online tool comes in in a few weeks’ time, there will be further detail. There were some issues that we consulted on last time that we needed to refine a bit. To get fully digital by 2015, for example, would probably require some primary. There will be more detail on that very shortly. Certainly we are with you in terms of the frustrations and improving the user experience.

The Chairman: When those details are available, can you make them available to the Committee?

John Hall: I understand that you are going to be questioning the Public Guardian. He will be able to give you a lot more of this information.

The Chairman: I think we will go to courts and regulation because Lord Faulks has to leave early. I should also say that that our adviser has to leave early to attend a funeral, so it is no disrespect if either or both of them walk out in the middle of your evidence.

Q18 Lord Faulks: Thank you, Lord Chair. I should have declared an interest earlier in that I am a practising barrister and from time to time I act on behalf of those who lack mental capacity and for doctors and healthcare professionals in cases where mental capacity is sometimes an issue. I want to ask you about the Court of Protection, which was set up, or at least expanded in its scope, by the Mental Capacity Act as a single integrated framework, as recommended by the Law Commission. In general terms, are you satisfied that it is being effective?

John Hall: The Court of Protection was bringing together those things for the first time. It was one of the big challenges of implementing the Mental Capacity Act. It has been a slow journey with some hiccups along the way, but we are very much getting there. In terms of case load, the emphasis is still on finance issues rather than health and welfare issues, which is what you would expect. We have made some changes and amendments along the way, particularly in terms of moving the administration from the Office of the Public Guardian to HMCTS to make things run a bit more smoothly from the court’s perspective. There was an anomaly in the Act which meant that no deputy judges were able to sit, and that created a bit of a backlog, but we have made some amendments to the Act to circumvent that. We think we are heading in the right direction, but there is still more work to do.

Lord Faulks: I see that actually the Act says: “The court may sit at any place in England and Wales, on any day and at any time”. In practice, are there a lot of delays? You have just described some of the improvements. Do you think it is responding quickly enough in general terms?

John Hall: There have been problems with backlog, but again that is getting better. The change around moving the administration from the Office of the Public Guardian to HMCTS in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Ministry of Justice and the Department of Health – Oral evidence (QQ 1- 24)

has improved that because of buildings. Even though the court is a separate jurisdiction, it can sit anywhere within HMCTS’s estate, so that has definitely got better. We now have regional sittings as well as sittings in London, so people do not have to travel all the way to London to have their hearings.

**Lord Faulks**: There have been some changes brought about by the LASPO Act and there is now a consultation on changes to legal aid. Have any of those changes had an impact on the availability of legal aid and therefore impeded in any way access to the Court of Protection?

**John Hall**: As far as I understand it there have been no changes in the way that legal aid is available for cases in the Court of Protection as a result of either of the two reforms.

**Lord Faulks**: You just described changes to the Office of the Public Guardian and the potential impact on the MCA. Is there anything you want to add?

**Nick Goodwin**: Sorry, could you repeat that?

**Lord Faulks**: What impact do you think that changes in the Office of the Public Guardian will have, if any, on the application of the MCA?

**John Hall**: We hope that they will improve the application of the MCA. The volumes, particularly of lasting power of attorney, have been increasing, but there is clearly a lot more to do. The Office of the Public Guardian has taken a kind of gentle approach to publicising the need for everyone to get a lasting power of attorney. Its concern—which is right—is that it did not want the office to be overwhelmed with more applications than it can handle. There is a twin-track approach of gradually raising awareness and expectations and improving the infrastructure. Digital delivery will be a key part of that. As the system becomes more robust and more able to handle the capacity, communications and awareness-raising will increase at a similar rate.

**Lord Faulks**: There was a recent, highly publicised case of someone being sent to prison by the Court of Protection. That hearing was not carried out in public in the way that you would normally expect a hearing to take place. I think there has been criticism of that. Can you reassure us that that will not happen again?

**John Hall**: You would not expect me, I am sure, to comment on individual sentencing decisions.

**Lord Faulks**: No, but as a matter of principle.

**John Hall**: As a matter of principle, the president has given guidance saying that all contempt proceedings in the Court of Protection should be heard in open court. More broadly, I know there have been concerns around transparency and openness in the Court of Protection and in the family courts. Ministers had already asked the president of the Family Division to do a review and assessment of what changes might be needed for the family courts. The Secretary of State has also written to him to ask him to look at the Court of Protection alongside that work and will be discussing the president’s proposals with him shortly.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Lord Faulks: Would it be fair to say that that was an exceptional case?

John Hall: It is the only case we are aware of at the moment where someone has been imprisoned.

Lord Faulks: Are you satisfied that the regulatory framework is robust enough? There are a number of different regulators, effectively, although, as I understand it, the CQC is responsible for the quality of care. The Care Bill currently going through Parliament proposes new powers. Are you satisfied that the regulatory framework is sufficiently robust?

John Hall: That is not my department.

Anne-Marie Hamilton: The regulatory framework has a number of parts. Obviously, the Court of Protection plays an important role in challenging decisions. Independent mental capacity advocates are also an important part of it, as is the role of the relevant person’s representative in the deprivation of liberty safeguards in being able to request a review. As you say, the Care Quality Commission as the regulator also has a key role in monitoring compliance. It takes that role very seriously and is looking at what more it can do to enhance it further. The Care Bill adds to its regulatory tools for that.

Lord Faulks: Do you think the Court of Protection needs any additional powers?

John Hall: Not at present that we are aware of, but there is a very new president of the Family Division. He is also president of the Court of Protection and he will take a view in the discussions.

Q19 Baroness McIntosh of Hudnall: Lady Browning has had to leave, unfortunately, or she would have taken you back towards the area which she raised with you earlier in the discussions: broadly what one might call the culture of care and the lessons that you might have learned from the high-profile cases. We have already touched on some of that. Can you say what the most significant findings were as far as your departments were concerned as regards the care being given to people who lack capacity? Can you reflect on a matter that probably exercises quite a lot of people, which is that at the level of implementation, which you rightly identified as being the real difficulty, we are looking at a large number of people giving care who are probably undertrained and certainly underpaid by any standards, given the sensitive nature of the care that they are delivering? Can you indicate in what way you are able from the departmental position to influence the private sector providers in getting them to think about their cost base and where they should appropriately be putting resources?

Anne-Marie Hamilton: In answer to the first part about what we can learn from Winterbourne View and other instances, there are specific issues around the management culture within those organisations focusing on, for example, financial targets rather than the care of the people they are caring for and not focusing enough on taking account of an individual’s best interest and putting the person at the heart of the decisions being made about their care. In Winterbourne View, the care planning was poor and little attention was being paid to what family and friends were saying and what the individual users wanted. Obviously there were a lot of out-of-area care placements within Winterbourne View which...
were not being reviewed and the person was not being put at the centre of the decisions being made about them.

In terms of the low-paid workforce, obviously there are legal requirements around the minimum wage. Our Minister has been calling attention to that a lot recently for private providers. They are under a duty to meet those requirements.

**Baroness McIntosh of Hudnall**: I just want to pick you up on that. The minimum wage is very low—we all have to recognise that—and the kind of care that is being delivered is of an extremely personal and sensitive nature. Is it appropriate that the standard that should be applied to care providers is that they employ people at the minimum wage?

**Clarice Crawley**: No, it is not. I wanted to come back more generally, although I will not lose sight of that problem. The issue that Baroness Hollins raised earlier was that, interestingly enough, Winterbourne View was staffed by qualified staff; it was not the lowest paid or the poorest trained, and we need to think about how that could be the case. In the statement the Government made, they said that fees for services should reflect the true costs that providers have to pay. It is a hugely challenging environment for care providers. I do not think there is any relationship between low wages and poor quality, but there are other people earning that money who are delivering brilliant care.

There is something else as well as money, and I think you would agree that lots of people do not just do it for the money. They could go elsewhere such as Sainsbury’s—poor old Sainsbury’s always gets this. It is more complicated than “Cheap, bad; expensive, good”. There is something about culture—I am sorry to keep using that word. It is that culture and attitude and whether we care for the staff in other ways as well as in monetary ways. Do we give them a career path? Do we acknowledge that it is hard work? It is really hard work. I have worked in residential care with some very challenging individuals—and that was just the staff. It is really hard work. Physically it can be quite hard, but emotionally it is incredibly draining and demanding. Do we support the person who has had a dreadful day on the ward, or who feels dreadful that they are running around and know that they should be stopping to feed someone, or know that Mrs M just wants someone to sit and talk to her and is terribly depressed and isolated? It is a huge issue. We are aware of it. We are struggling about how we respond, but one of the big things that has come out of Francis is all this talk about compassion and care, and that has to be for the workforce as well. If you have an uncared-for workforce, they cannot deliver good care.

**Q20 Baroness Barker**: In the high-profile cases we have had, what was the role of the safeguarding vulnerable adults boards? Where were they when all this was going on?

**Clarice Crawley**: Are you talking about the social workers doing safeguarding investigations or vetting and barring, or both?

**Baroness Barker**: We have had the safeguarding vulnerable adults boards for some time, and the legislation is about to change and put them on a different footing. Following your previous answer, how do we make sure that they do not just have the task but have the ability to make it happen? Secondly, most people who have a relative with a mental health condition know that there is mental health legislation. They may not know what it is, but if
something goes wrong, they know there is legislation. Is the fact that most relatives are completely unaware of the Mental Capacity Act a significant factor in bad practice not being challenged?

**Claire Crawley**: Ooh, there is a lot in there. I shall start with the boards. They are going to be made statutory and to have statutory membership and statutory functions including some more transparency about what they do and about listening to the community and what it wants them to do. Where were they in Winterbourne View? Nowhere to be seen, it seems. One of the things that struck me very forcibly on reading the serious case review that Baroness Browning referred to earlier was that a number of people turned up at the local Accident and Emergency department from Winterbourne View—all from the same place, if not the same individuals—with really quite severe injuries, such as missing front teeth, dislocated collarbones and lacerations, and the A&E staff accepted the staff's word that it was because members of staff had had to defend themselves. In a sense, the whole system has to be much more vigilant and aware because I do not imagine the board knew about that until the serious case review. There is something about being able to spot abuse. The police also took the staff's word for granted. Having the police, the NHS and local authorities as core members of these statutory boards and giving them much clearer functions and powers under the law will make a difference, but it is not a replacement for vigilance, awareness and understanding. I am sorry; I have forgotten the second part of your question.

**Baroness Barker**: It was about relatives’ and carers’ knowledge of the Act.

**Claire Crawley**: I used to be of the view that knowledge of the Act, a bit like the Mental Health Act, is not so important as long as you know your rights, but my view has changed about that because people feel much more confident in saying, “Actually, this is my entitlement; you have to do this”. This is the work we have tried to do. We are working more with partner organisations because the department has a critical view, but it is a bit like the Government's role with the Human Rights Act. It can do so much, and should support and promote it, but we need every partner in the system to do their part. We need CQC, the local authority and the NHS to play their full part. They are contributors; they are not passive recipients of what the Government do. They have a role in this system. We have a role in ensuring that they carry that role out. Your point about relatives and carers is really interesting because we keep talking about raising expectations and the rising expectations of people who want more from the system and know their rights. Maybe in this case that is not true and maybe we need to reflect on that. When you have much more evidence as a Committee, it will be interesting for us to see our way through that.

**Q21 Lord Turnberg**: You made an impassioned plea for better care for staff, quite rightly. Do you think that the Care Quality Commission has a role when it makes its inspections in ensuring that the staff are supported?

**Claire Crawley**: That was very much part of the conversation I was having with CQC yesterday, saying that care does not happen in a vacuum, we have to recognise that this is a very tough job and asking what is its role and its inspectors’ role in supporting improvement in practice and care and looking after staff as well as the people using the service, as well as telling them what they are not doing right. There is something about. Hopefully, we are all in this business for the same reason: to improve the lives of people, to make a good impact. We need to work much more collaboratively to do that and to understand each other.
Ministry of Justice and the Department of Health – Oral evidence (QQ 1-24)

think there have been too many adversarial relationships between providers and local authorities and between providers and the regulator. We need to work together positively to improve care.

**Lord Turnberg:** Are the regulators perceived as being inspectors with a severe visage or are they regarded as friends to make sure that things are happening correctly?

**Claire Crawley:** I think the former, largely.

**Lord Turnberg:** That is not very helpful for supporting the staff.

**Claire Crawley:** No. Some areas are building on that. Some CQC teams are doing some of that work, but we have really good examples of local authorities or what were PCTs having, for example, small clinical support teams who will go into a nursing home that is struggling with some of the care and help it to build up its standards. That is the approach that we want. This is not about driving people out of business but about keeping people in business and improving their services.

**Anne-Marie Hamilton:** The Care Quality Commission works alongside other bodies within the system. We mentioned the Social Care Institute for Excellence, and there are similar bodies on the NHS side that have a specific improvement function in terms of working with providers in the sector.

**Lord Patel of Bradford:** Just a quick point in respect of the inspectors: I suppose one should recognise that the mental health inspectors of the Care Quality Commission were the old commissioners, who were visitorial members and not inspectors. So one thing there is that their role was never to inspect and always to visit and interview detained patients. That is one element where all the evidence, or a majority of the evidence, was gleaned from actually talking to patients and not from other inspection tools. For me, a lot of Winterbourne View would be tackled if we honed in on that visitorial talking to patients.

**Anne-Marie Hamilton:** The Care Quality Commission piloted a study in 2011-12 around how they could try to understand more from what the users think in terms of the deprivation of liberty safeguards. I think they plan to learn from that in terms of how they can make that a bigger part of their role going forward, because I think they recognise and would agree with what you said.

**Claire Crawley:** This has obviously given the CQC quite a shake-up, all this. I know they have recognised, for example, the need to return to specialism inspection. It is a big ask of a generalist sometimes to understand all the various types of provision that are being regulated, and they are really looking at their methodology—you know, how do you get actual evidence from people and much better training for their own staff, because actually the quality of an inspection in a sense is only as good as the quality of your inspectors.

**Q22 Lord Swinfen:** Has practice under the Mental Capacity Act led to greater or less involvement of carers and families in decision-making? Have there been tensions between involvement of carers in decision-making and the aims of autonomy? If so, what have these been?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Anne-Marie Hamilton: I think we would say yes, it has led to greater involvement of families, as we understand it, in terms of the best interest assessment and the family and friends and carers of people being consulted as part of that decision-making process. I think there are bound to be tensions, and I am sure there have always been tensions between family views and the views of the person involved. The best interest assessments puts a process in place to discuss those views and reach a decision, hopefully as far as possible that the person themselves wants, respecting their capacity to make that decision. It may well be that some family members are not so happy with that outcome, but I think those tensions have probably always been there. The Mental Capacity Act puts a framework in place to enable a decision to be made in the individual’s best interests.

Q23 Lord Alderdice: The question that I would like to put to you is whether you are satisfied that the relationship between the Mental Capacity Act and mental health legislation is really fully and properly understood, and whether there are any difficulties that arise amongst practitioners, particularly where there is medical work involved. I draw attention to the fact that I am a retired consultant psychiatrist from Northern Ireland, and have involvement in a number of mental health charities.

That leads on to the second part of my question, which is of course that in Northern Ireland we have had the Bamford review some years ago, which recommended a more unified framework across mental health and mental capacity. It has not been implemented yet; the department of health took the lead on that, and I think there has been a little bit of hold-up in bringing along the Department of Justice in Northern Ireland, despite the fact that the Minister is a former social worker and very keen to see it happening. I wonder if you could perhaps help us understand if you do see any dilemma between the two, and if you think that a more unified approach would be helpful in addressing any problems that might be arising.

Anne-Marie Hamilton: The relationship between the Mental Health Act and the Mental Capacity Act is clear in law, but I think you are right that in practice it is not always understood by professionals using it. There are probably particular issues around people detained under the Mental Health Act and whether or not the Mental Capacity Act could be used in those circumstances. Professionals understand and are aware of both, but probably in reality there is confusion about how the two are used in practice. That may reflect the fact that the Mental Health Act has obviously been in existence for considerably longer than the Mental Capacity Act, so it may be a question of time and experience and practice, as people get more familiar with both pieces of legislation. In terms of whether or not it would make sense to bring them into a unifying piece of legislation, I suppose in a sense that they have a different ethos and approach and are clear in law. I am not sure whether that would add value, but it is not something we have discussed with our Ministers, for example.

Claire Crawley: We have commissioned some research about this, because we are aware that it is an issue for people, and we have only recently received that so will need to look at that research and what it says. But one of the things it does say quite clearly, I think, is that within psychiatric mental health settings there is poor understanding of the Mental Capacity Act, so we will need to look at that—and look at it jointly with our colleagues in mental health.
Lord Alderdice: You have suggested that one of the reasons might be just because the mental health legislation has been around for longer. Are there any other reasons why it might not be clear in people’s minds, as practitioners?

Anne-Marie Hamilton: I think the research that we received, which we would be happy to send to you and which reported this year, did particularly identify it as an issue within the hospital settings. Maybe that is because people are more familiar with using the Mental Health Act, which I suppose relates to what I said about use and custom. It suggested as well that there might be issues around the complexity of the process that people need to adhere to for the deprivation of liberty safeguards, and that that might also be something that people were experiencing. So it may well be not only understanding of it, but also “How do you use that piece of legislation in practice?”.

Lord Alderdice: Lord Chairman, I would certainly be interested in taking up the offer of sight of the research work. That would be very helpful. Could I just be clear whether there has been any discussion with the department of health and social services and the Department of Justice in Northern Ireland about their approach to Bamford and implementation?

Claire Crawley: I am unaware of that.

Anne-Marie Hamilton: I am, similarly.

Claire Crawley: It might be that we could go back and ask colleagues.

Lord Alderdice: I would find that very helpful.

Claire Crawley: Okay. We will do that.

The Chairman: Again, just a note confirming one way or another.

Q24 Lord Faulks: If you could help me, I wonder if you could just give us an example of where there is a potential tension between the two different Acts—a concrete example.

Claire Crawley: In law or in practice?

Lord Faulks: In practice.

Claire Crawley: It is difficult to use Winterbourne View as an example, because so much was wrong at Winterbourne View, but clearly there were people there who should have been treated under the Mental Capacity Act and were not. They were detained under the Mental Health Act—if they were detained at all, actually, because I have sense that some were probably illegally detained, because they were neither detained under the Mental Health Act or the Mental Capacity Act. So in sense, although it is an extreme example, I am sure in lesser severity that is mirrored around the country, I would have thought; it cannot be the only one.

Lord Patel of Bradford: Just on that, if any of the patients were detained under the Mental Health Act, then there is potential for a second opinion. Now, that is a big issue if people are almost de facto detained using the Mental Capacity Act, but there is nobody else coming in.

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Claire Crawley: They have to be reviewed under DOLS—

Lord Patel of Bradford: By the local authority.

Claire Crawley: Yes. They have to be reviewed, and also people can apply to the Court of Protection and challenge that detention.

Anne-Marie Hamilton: Everybody deprived of their liberty through the deprivation of liberty safeguards has a relevant person’s representative. They may also have an independent mental capacity advocate. Those people can request a review at any point in the process. So if that is working properly for someone, they can request a review of the deprivation of liberty. Then, as my colleague said, after a year it would be reviewed anyway, because the deprivation could not be for longer than a year without review.

Lord Patel of Bradford: All the more reasons the CQC mental health people need to get back to specialisms, understanding the difference between the two laws, I think.

Lord Swinfen: Are the local authorities very often not the people running the care homes or responsible for them, so in actual fact they are reviewing themselves?

Claire Crawley: No, local authorities very rarely run care homes these days. The vast majority are in the independent sector.

Lord Swinfen: Yes, but I know that some of them are still run by local authorities.

Claire Crawley: Very, very, very few.

Anne-Marie Hamilton: And I think the Mental Capacity Act and deprivation of liberty best interest assessors have to be separate from the local authority, so that there is not that conflict of interest in those cases where that is the case.

Claire Crawley: I think perhaps the biggest challenge is one professional challenging another’s judgment and decision, and I am sure that is true in most professions.

The Chairman: Lord Turnberg, a final question?
Lord Turnberg: I think my questions about the CQC have been asked; we have dealt with those.

The Chairman: Well, thank you very much to all of the witnesses for the marathon. You have lasted very well, and I hope you get a well deserved lunch or something from the departments.

Claire Crawley: I do not think so.

The Chairman: Thank you very much.

Baroness Barker: Lord Chairman, I completely forgot to declare my interests. I got stuck straight into the questions, so can I refer people to them in the list?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Ministry of Justice and Department of Health – Written evidence

Following the oral evidence given to the Committee by Nick Goodwin and I (Ministry of Justice) and Anne-Marie Hamilton and Claire Crawley (Department of Health) on 18 June 2013, the Committee requested further information and provided officials with a list of follow up questions to clarify a number of issues.

Please find attached to this letter a response to each of the questions asked by the Committee. This comprises of information from both the Department of Health and the Ministry of Justice.

If you require any further information, we would be happy to assist.

John Hall
Deputy Director, Family Justice

1. **What is the involvement of the Royal Colleges in training their members on the Mental Capacity Act? What is the Department of Health doing to monitor and promote such training?**

The Royal College of Psychiatry developed an e-learning programme for Section 12 doctors, which is available on their website. They also report that they offer one to one training. The Royal College has a useful leaflet on the Mental Capacity Act, available on their website, with links to the BMA MCA Toolkit, and to MIND and to information on how to apply to the Court of Protection.

The Royal College of Medicine organises various events, such as ‘Consent, capacity and the law in clinical psychiatric practice’ as part of the Psychiatry Section Centenary Year celebration, and ‘Patient safety and the law: capacity, liberty and coroner’s inquests’.

Most large hospitals also have a Mental Capacity Lead person, with responsibility for MCA training. We have seen a wide variety of innovative approaches to training, including full day training courses, half day training courses, training presented during ward rounds, during hand-over times, training with the aid of theatre, multi-agency training with other professionals such as social workers and police, as well as e-learning.

Deprivation of Liberty offices in local authorities have taken on a responsibility for promoting MCA and DOLS training. Many actively facilitate both basic training and refresher training; many are active in having annual training days where case law is studied, and where Court of Protection judges give talks.

It is the Department of Health’s role to steward the system, to ensure that a variety of relevant training is available, but not to monitor the training.

2. **What training is provided in further and higher education concerning the Mental Capacity Act?**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Mental Capacity Act is part of all social work training, where it is increasingly being recognised as an essential part of adult social care law. It is also part of nursing training and the training of occupational therapists and psychologists.

Several universities and higher education colleges offer Best Interest Assessor (BIA) training. This is a 5 or 6 day course for social workers, OTs, nurses and psychologists originally devised for those who want to practice as Best Interest Assessors (BIA) for the DOLS. However, some local authorities are now recognising the BIA training is of much wider relevance; it is recognised as the best way of acquiring a good understanding of the MCA and of making appropriate capacity assessments and best interests decisions making. These authorities are offering BIA training to social workers who will not necessarily be working on DOLS, but who work with people with mental impairments in their day to day work. The Department of Health supports this trend to make BIA training available to all social workers working in adult social care, as well as to many nurses and occupational therapists.

The College of Social Work developed the Professional Capabilities Framework as the basis of learning and development for social workers, in their qualifying training and in continuing professional development throughout their careers. The Department commissioned the development of Best Interest Assessor capabilities from The College of Social Work, to provide a development framework for learning and development for social workers and educators to reflect upon and improve practice.

Skills for Care have also developed a Mental Capacity Qualification, at level 3, which is available for people to take. The outline of the course, with its competencies, is on the Skills for Care website.

3. **What is the agreed protocol for record sharing within the NHS and between the NHS and the care system? Is information regarding specific needs, as well as advance directives to refuse treatment, being routinely and appropriately shared? What progress has been made towards electronic record sharing?**

The Government has an information strategy for health and care in England, *The power of information* (May 2012). It sets a ten-year framework for transforming information for health and care, using new technologies to achieve higher quality care and improve outcomes for patients, service users and family carers. Key aims include:

- Information is recorded once, at a person’s first contact with professional staff, and shared securely between those providing care supported by consistent use of information standards that allow data to flow between systems whilst keeping confidential information safe and secure; and

- Electronic care records progressively becoming the source for core information used to improve people’s care, improve services and to inform research, reducing unnecessary data collections and enabling quality to be measured.

Legal provisions in the Health and Social Care Act 2012 will ensure that information standards, to which all providers of health and social care are required to have regard, can be set once across the health and care system in England. A fundamental part of setting
those standards will be comprehensive and consistent use of the NHS number across health and social care services, at the point of care and as care is delivered.

From April 2013, the Health and Social Care Information Centre has also taken on its new status and functions, collecting, linking securely and making information readily available to those who need it in safe, anonymised formats, with safeguards in place to protect the confidential data it holds.

Taken together, these provisions will help drive the consistent recording and secure sharing of core data across health and care. It will also allow data to be collected and used at the national level, for example to determine and monitor the extent of health inequalities.

NHS England's planning guidance for the NHS for 2013/14 - 'Everyone Counts' - includes specific steps to drive forward implementation of this strategy, and the Secretary of State for Health's challenge to the NHS to become 'paperless by 2018'.

The DH, NHS England, PHE, Care Quality Commission (CQC), Monitor and the National Institute for Health and Care Excellence (NICE) have agreed collective arrangements to prioritise data collections and the information standards that will apply across the health and care system, through the Informatics Services Commissioning Group.

Advanced directives are increasingly used as part of people’s records; particularly in the area of end-of-life care, where people’s wishes are much more routinely collected and made available to all relevant staff. This focus on people’s wishes goes beyond advanced directives, which can only be used to refuse certain types of treatment.

4. **What measures will be used to evaluate the performance of NHS England delivering on the mandate with regard to safeguarding and the Mental Capacity Act?**

The NHS Mandate requires NHS England to demonstrate progress in continuing to improve safeguarding practice in the NHS. This includes improving the understanding and implementation of the Mental Capacity Act. The priority of safeguarding is stated explicitly in addition to the requirement to provide safe care. The Department is developing measurements to assure itself that NHS is delivering on all its objectives. The initial measurements suggested for safeguarding are focused on process and structure. The experience of using them will help the Department of Health refine and improve over time and move towards outcome-focused measures.

There are a number of measures that relate to other objectives in the Mandate that will contribute to our understanding of how well NHS England is performing in this area. These include measures relating to improving involvement of people with dementia and long term conditions and their carers. An important aspect of this will be enabling records to follow individuals to any part of the NHS or social care system. The assurance process will require NHS England to improve the transparency of information and the ability of patients to give feedback.

5. **What discussions have taken place with the Northern Ireland Department of Health and Social Services and the Department of Justice about their approach to the Bamford Review and its possible implementation?**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Department of Justice in Northern Ireland is developing a Mental Capacity Bill, which aims to incorporate provision for both mental health and mental capacity in relation to both civil society and the criminal justice system (CJS). Much of this work stems from the Bamford Review of Mental Health and Learning Disability, in particular the range of court disposals and the risk management arrangements in place.

Colleagues from Northern Ireland have been in contact with Department of Health officials, requesting ‘background information’ on our policy and legislation in these areas. However there have not been any substantial discussions.

Colleagues from Northern Ireland have not been in contact with Ministry of Justice officials.

6. What monitoring is undertaken regarding ethnic disparities in the use of Lasting Powers of Attorney, or Independent Mental Capacity Advocates or Independent Mental Health Advocates? What are the latest available figures? What action is taken as a result?

**Lasting Powers Of Attorney:**

The Office of the Public Guardian (OPG) has undertaken some monitoring regarding ethnic disparities in the use of Lasting Powers of Attorney (LPA). In early 2012, as part of their work to better understand their customers, the OPG conducted ‘Customer Journey’ interviews with individuals who had made LPAs. From a small sample of 55 donors and 139 attorneys, they have ascertained that the vast majority (96% of donors and 97% of attorneys) are white.

In June 2013, the OPG issued a tender for a research project to learn more about potential LPA customers, identifying the key groups/segments which can be targeted to maximise overall uptake of LPA applications and the best means to achieve this. The OPG hopes that the project will help them to understand the blockers and enablers (whether cultural, financial, social etc.) in all groups identified through this research so that in the future it can target those groups/segments depending on their individual needs. The main objectives of the project include:

- To understand OPG’s potential LPA customer base, to segment it into clearly defined groups, with an analysis of each group which allows the OPG to differentiate its offer, both in terms of services/support and awareness raising;
- To identify which segments will be most responsive to engagement, education and marketing about the value of making either a Health & Welfare or Property & Finance LPA and assess the potential uptake numbers;
- To understand the current blockers and enables across all segments identified;
- To identify potential avenues for engagement and support which may promote LPA uptake;
- To identify any specific issues in relation to uptake among Black, Asian, Minority or Ethnic (BAME) groups; and
- To identify other organisations in whom potential applicants (or groups thereof) have high levels of trust to inform the development of future partnership work to promote LPAs.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Under the draft timetable for this research, OPG envisages selecting a supplier within the next few weeks with a final report towards the end of the year.

**Independent Mental Capacity Advocates or Independent Mental Health Advocates:**

The Department of Health has data on ethnicity for people referred to the IMCA service and for people being referred for a DOL authorisation. This is monitored annually through the Annual Report on the IMCA service and through annual statistics on Deprivation of Liberty Safeguards.

We have compared the breakdown of IMCA referrals to the number of clients receiving local authority adult social care services in 2011/12. This shows that people from Asian ethnic groups are slightly underrepresented compared to those from white groups (referrals per user are about 2/3rds of those from the white group). This is an area for further exploration to understand what is causing the differences. We must be careful not to infer, on the basis of numbers, that this is a negative situation. IMCAs must be used where serious decisions such as choice of accommodation are being considered and the individual lacks the capacity to make that decision and does not have a friend or family to represent their best interests. It may be that people of Asian origin face the decision about accommodation less frequently or and that they are more likely to have, and use family or friends to represent their interests.

**Deprivation of Liberty Safeguards (DOLS):**

We have compared the breakdown of DOLS applications with the numbers of people in hospitals and care homes (from the 2001 census – we don’t have results from the 2011 census yet). We need to be cautious about drawing definitive conclusions from this census analysis as the data on which this is based is over ten years out of date. The mix in care homes in particular may have changed over that period. Again it really highlights an area for further examination. The data from the 2011 census will increase our understanding of the issue, particularly as both the Mental Capacity Act and DOLS came into force since 2001 and we know that embedding both into practice is a significant challenge.

The census data from 2001 shows that people of Indian origin, alongside white British and white Irish background, are most likely to be providing informal care that is unpaid care by relatives, friends or neighbours. Those least likely to be providing informal care were people from mixed backgrounds and those of Chinese origin. That reflects to some extent, the different age structures of the different ethnic groups as informal care is most likely to be provided by people aged 50 to 60. The white groups have older age structures and are therefore more likely to both need and provide care.

In April 2001, 0.8 per cent of the population of Great Britain were resident in hospitals or other care establishments. The percentage varied by ethnic group from 0.1 per cent among Bangladeshis and Pakistanis to 1.0 per cent among the White Irish group.

In conclusion the data show differences in use of both IMCA and DOLS, but the differences are not evidence that there are problems in accessing these safeguard
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>% of service users</th>
<th>IMCA recipient rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>91%</td>
<td>89%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Mixed/other</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Table 2: Comparison of DOLS applications in 2011 with the number of people in hospitals and care homes in 2001 (2001 are latest figures available and we would expect 2011 hospital and care homes figures to be different) by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>DOLs/care population</th>
</tr>
</thead>
<tbody>
<tr>
<td>White: Total</td>
<td>3.0%</td>
</tr>
<tr>
<td>Asian/Asian British: Total</td>
<td>3.0%</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British</td>
<td>4.3%</td>
</tr>
<tr>
<td>Mixed + other</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

What is being done?

DH has discussed the data with MCA leads and with IMCAs. DH has also discussed the data with DH statisticians and asked for this to be re-examined when the new census data are ready.

7. What are the latest available figures regarding the use of independent mental health advocates? Are there regional variations?

We have no data on Mental Health Advocates.

We do have data on Independent Mental Capacity Advocates (IMCAs). The Department of Health publishes an annual report to Parliament on the use of the Independent Mental Capacity Advocate service. A link to the latest report is attached.


This report shows that there has been a year on year increase in number of people supported and represented by the IMCA service, and that numbers have doubled over five years. During 2011/2012, there were 11,899 referrals.

The report does show that there was a regional variation, which cannot be wholly explained by population differences. We think some of the difference in referral rates is a result of different levels of awareness. Levels of awareness are in part related to the level of resources devoted to awareness raising and training in hospitals and in social care, and to the commissioning arrangements of the IMCA services. Where IMCA services are commissioned to assist in awareness-raising, the level of referrals appears to be higher.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
8. **What are the latest available figures for registered lasting powers of attorney, and activated lasting powers of attorney?**

Between 1 October 207 and 30 June 2013, 770,169 LPAs have been registered by the OPG. This can be disaggregated as follows:

- 600,383 - Property and financial affairs LPA
- 169,786 - Health and Welfare LPA

Property and Financial Affairs LPAs can be used as soon as they have been registered, while Health and Welfare LPAs can only be used when the donor has lost capacity.

A donor can specify that a property and financial affairs LPA can only be used if capacity has been lost by placing a restriction in the LPA to that effect. Of a sample of 1560 cases in 2011, 9% contained restrictions and 7% contained additional guidance to attorney(s). 33% of the restrictions related to not using the LPA until capacity was lost. In these instances, we do not know or have any figures relating to when the LPA is activated.

9. **What information is there on the routes to creating an LPA; is there sufficient sign-posting at relevant services, such as memory clinics? What evidence is there on how well this is working?**

The OPG is currently in discussion with the 3rd sector organisations to seek their help in supporting customers to make LPAs. This is particularly important as the OPG LPA digital tool was launched on 1 July ([https://lastingpowerofattorney.service.gov.uk/](https://lastingpowerofattorney.service.gov.uk/)) and there is a need to ensure that those customers less able to access the digital tool – for whatever reason – are not left behind. In addition, we will shortly be consulting on amendments to the paper forms, seeking to streamline them and make them easier to complete. Early discussions leave us optimistic that this will lead to more 3rd sector activity in LPA creation. We will continue to work with the 3rd sector to see what support they will need.

Beyond this, the OPG has generally limited proactive engagement to senior level discussions with key stakeholders, such as umbrella groups, for them to raise awareness/discuss the need for LPA planning within their member organisations. The main reason for this more cautious approach is due to the limitations with the current IT platform and being able to scale up quickly to deal with significantly higher volumes of work. Once the OPG’s transformation programme has delivered a more flexible and scalable IT solution (scheduled for early 2014), proactive work to raise greater awareness of LPAs will take place. Any such work will, however, need to be mindful of Government spending restrictions on advertising and marketing.

The OPG also continues to respond positively to workshop requests by Local Authority safeguarding teams, NHS and others, where early diagnosis may present opportunities for LPA planning.

10. **What evidence is there that costs are deterring people from making LPAs?**
The current cost of registering an LPA with the OPG is £130. The OPG have not found that this cost has deterred applications to register an LPA.

In early 2012, as part of their work to better understand their customers, the OPG conducted ‘Customer Journey’ interviews with individuals who had made LPAs. From a sample of 55 Donors, 23% of them were eligible for a fee remission on their application to register their LPA.

In addition, half of them utilised a professional to assist in making an LPA. Anecdotal and qualitative evidence obtained during the interviews also suggests that some OPG customers, once aware of the costs incurred by using a legal professional (which can range from £200 to £1,000 per application), will then continue with the application themselves. However, the OPG has also found that those who could neither afford professional assistance nor complete the application themselves, would either approach a third party (such as Citizens Advice Bureau) or if that failed, simply discontinue the process.

11. Could we have a copy of the research on the relationship between the Mental Health Act and the Mental Capacity Act, referred to by DoH officials on pp 39-40 of the transcript.

The report is attached.

DoLS FINAL REPORT COMPLETED 170413

12. What is the timetable for review of the Code of Practice?

The Ministry of Justice is responsible for the review of the MCA Code of Practice.
The Department of Health is responsible for the review of the DOLS Code of Practice.

Mental Capacity Act code of practice

As the Committee were advised during the oral fact finding session, the Ministry of Justice wrote to the Rt. Hon. Sir Alan Beith as Chair of the Justice Select Committee on 3 September 2012, advising the Justice Committee that the MoJ had deferred any review of the MCA Code of Practice whilst the OPG was undergoing its transformation programme aimed at making its services fully digital by 2015.

The Ministry of Justice’s intention is to consider reviewing the Code in 2015, by which time:

- the impact of the OPG digital transformation will be clearer
- we will have considered any recommendations made by this House of Lords Committee; and
- the effect of any judgments from the Supreme Court in relation to the Deprivation of Liberty cases, due to be heard in October 2013 and which may impact on the main code, will have been considered.

DOLS code of practice

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Department of Health’s view is that case law has been very important in assisting the understanding and use of the Deprivation of Liberty safeguards. This case law needs to be summarised and distilled into the Code of Practice; however this should only be done once case law has progressed to better agreement on issues such as a definition or threshold of deprivation of liberty.

This question will be reviewed after the two cases are concluded in the Supreme Court.

13. Could the Ministry of Justice provide a list of improvements already made to simplify the process of making an LPA, and outline the programme of work planned for further simplification (referred to on pp 27-28 of the transcript).

After LPAs were launched on 1 October 2007, we become aware that many customers found the process lengthy and wanted the process to be simplified, notwithstanding the introduction of certificate providers and upfront registration, which were brought as safeguards to improve on the previous system of Enduring Powers of Attorney (EPA). Improvements already made since then consist of:

- October 2009: New LPA forms were introduced following consultation. The forms were redesigned in length and design, guidance notes were included in the margins of the forms and simpler /clearer language used. Continuation sheets were introduced to allow donors to add additional information. The various sections of the form were colour coded to enable the various individuals required to complete the form i.e the donor, the certificate provider and the attorney to easily identify which section of the form referred to them.

- October 2009: Following a consultation, the fee to register an LPA was lowered from £150 to £120 in order to maintain cost levels due to greater than anticipated demand and a consequent rise in fee income.

- October 2011: Following a consultation, the fee to register an LPA increased from £120 to £130. The increase was required to cover the costs of delivering the OPG’s current processes (as they are a full cost recovery service) and to support the development of a new IT system.

- November 2011: OPG commenced joint work with the Government Digital Service (GDS) to develop a web based tool to allow people to enter all of the information required in an LPA in a structured way that takes people through the process step by step, thus reducing errors and repetition.

- 1 April 2013: in order to speed up the registration process, the statutory waiting times for registration of LPAs was reduced from six weeks to four weeks and the notice period to named persons was reduced from five weeks to three.

- 1 July 2013: the OPG launched a new digital tool to assist in the making of LPAs. The tool can be found at https://lastingpowerofattorney.service.gov.uk/.

Further improvements currently being considered include:

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
• Re-designing the existing forms to reduce duplication of basic information and overcome the reliance on continuation forms.
• The possible introduction of a new ‘combined’ LPA form which could be used to create either a property and financial affairs LPA or a health and welfare LPA or both LPAs together.
• Redesigning the application to register for an LPA in order to make the form shorter and reduce duplication.
• Extending the reduced application fee to those cases which can only be registered by an application to the Court of Protection because the LPA contains an unlawful clause.
• The development of proposals for a fully digital LPA, which could be submitted to the OPG via an electronic means. The intention would be to retain the paper form for those customers who were not IT literate.

14. Have there been any prosecutions under section 44 of the Mental Capacity Act 2005? Have any of these prosecutions resulted in convictions? If the answer to either question is yes, the committee would be very interested to see details of the cases.

The table below provides information on the numbers of convictions under Section 44 of the Mental Capacity Act. We do not record details of individual cases on our central databases. Providing the Committee with this information would require the manual identifying of, and checking of, the case files or court log to identify the section 44 hearings and the outcomes. This would incur disproportionate costs.

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<tr>
<td>Proceeded against</td>
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<td>-</td>
<td>5</td>
<td>36</td>
<td>47</td>
<td>68</td>
<td>81</td>
<td>85</td>
</tr>
<tr>
<td>Found Guilty</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>7</td>
<td>22</td>
<td>28</td>
<td>26</td>
<td>36</td>
</tr>
<tr>
<td>Sentenced</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>9</td>
<td>22</td>
<td>28</td>
<td>26</td>
<td>36</td>
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<tr>
<td>Absolute discharge</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>Conditional discharge</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
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<tr>
<td>Fine</td>
<td>-</td>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Community sentence</td>
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<td>-</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Suspended sentences</td>
<td>-</td>
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<td>-</td>
<td>2</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>15</td>
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<tr>
<td>Otherwise dealt with</td>
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<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Immediate custody</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>8</td>
<td>6</td>
<td>10</td>
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</tbody>
</table>

'-' = Nil

(1) An offence under S44 of the Mental Capacity Act 2005.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
(2) The figures given in the table relate to persons for whom these offences were the principal offences for which they were dealt with. When a defendant has been found guilty of two or more offences it is the offence for which the heaviest penalty is imposed. Where the same disposal is imposed for two or more offences, the offence selected is the offence for which the statutory maximum penalty is the most severe.

(3) Every effort is made to ensure that the figures presented are accurate and complete. However, it is important to note that these data have been extracted from large administrative data systems generated by the courts and police forces. As a consequence, care should be taken to ensure data collection processes and their inevitable limitations are taken into account when those data are used.

(4) The number of offenders sentenced can differ from those found guilty as it may be the case that a defendant found guilty in a particular year, and committed for sentence at the Crown Court, may be sentenced in the following year.

(5) Excludes data for Cardiff magistrates’ court for April, July and August 2008.

9 July 2013
Ministry of Justice and the Department of Health – Supplementary written evidence

Executive Summary

1. The Mental Capacity Act 2005 has been widely welcomed for providing, for the first time, a statutory framework for people who lack capacity to make decisions for themselves or who have capacity and want to make preparations for a time when they may lack capacity in the future. The statutory principles of the Mental Capacity Act set out a framework which assumes people have capacity and recognises the importance of enhancing people’s capacity so that many more people can make decisions for themselves.

2. As part of the Mental Capacity Act, the Deprivation of Liberty Safeguards were introduced to provide a statutory framework of scrutiny, checks and balances which both empower people and protect them. These procedural safeguards introduce greater scrutiny of people’s care and protect their rights.

3. The Government has invested significant effort in implementation of the Act, in recognition of the scale of cultural change and the changes in working practices which the Act required.

4. The Government considers that this implementation programme made a considerable contribution to changing the approach which many professionals take to assessing capacity and supporting people who lack capacity to make decisions, rather than making decisions on their behalf. Evidence to support this includes: most hospitals and local authorities having policies on consent and best practice, as well as Mental Capacity Act/Deprivation of Liberty leads who support staff training; Best Interests Assessors are trained to examine and scrutinise care plans; Independent Mental Capacity Advocates make a major contribution to supporting people who lack capacity; Court of Protection judgements provide a framework for debate about the Mental Capacity Act; and increasing numbers of Lasting Powers of Attorney are being made and registered.

5. The Government is committed to taking the necessary steps to make more progress to continue to embed the Mental Capacity Act further across all sectors, including the NHS, social care, housing, banking and the police. Working with national partners, the Government is, therefore, planning further work to understand the progress which has been made to date before it decides what further steps are required.

6. The Government welcomes this Committee’s Post Legislative Scrutiny of the Act to help assess progress with implementation. Alongside the recent findings of the Health Select Committee’s Post Legislative Scrutiny of the Mental Health Act 2007, it looks forward to the Committee’s findings to help inform future work.

7. The following paragraphs set out the Government’s response to the Committee’s detailed questions. We understand that the Public Guardian will be submitting evidence to you separately about his role and the work of his Office.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
**Detailed answers**

**Overview and Context**

**Question 1: To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?**

8. The Government considers the Mental Capacity Act has begun to achieve many of its aims of empowerment and protection. Evidence includes:

- most hospitals and local authorities have Mental Capacity Act/Deprivation of Liberty Safeguards leads who champion the Act, carry out training, conduct audits and provide advice, as well as having policies on consent, best interests and on when and how to involve the Independent Mental Capacity Advocate service;
- regional Mental Capacity Act/Deprivation of Liberty Safeguards networks meet to support and develop best practice, examine case law and complex cases and carry out peer reviews;
- the involvement of Best Interests Assessors in examining and scrutinising care planning;
- the contribution of the Independent Mental Capacity Advocate service, which the Government highlights in its annual national reports207;
- case law208 and Court of Protection judgements, which continue to provide an important framework for discussion and debate; and
- use of Lasting Powers of Attorney: over 700,000 have been made and registered since October 2007.

9. However, the Government recognises that the Act is not yet fully embedded in working practices across all sectors. It will require continued effort in the longer term, both nationally and locally, to ensure that all sectors - including the NHS, social care, housing, banking and the police - adopt and use the principles of the Mental Capacity Act when supporting people who may lack capacity so that the Act achieves all its aims. The Government is, therefore, planning further work to assess progress and to understand what further action is required.

**Question 2: Which areas of the Act, if any, require amendment and how?**

10. The Government does not consider that the Mental Capacity Act requires amendment at present but will keep this under review.

11. Some groups have asked for a definition of a Deprivation of Liberty, which is not tied to European Court of Human Rights or domestic case law. However, the Mental Capacity Act concept of a Deprivation of Liberty must keep in step with developments in European


208 http://www.39essex.com/resources/newsletters.php

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Court of Human Rights case law on Article 5\(^{209}\), as the Mental Capacity Act Deprivation of Liberty Safeguards were introduced to provide procedural safeguards to comply with Article 5 for people lacking capacity, who were not subject to the Mental Health Act 1983, but whose care and treatment in hospitals or care homes involve a Deprivation of Liberty. However, a statutory definition could not simply address the complex facts in individual cases. The Government will consider the decision by the Supreme Court in the appeal of *Cheshire West and Chester Council v P* (2011) EWCA Civ 1257\(^{210}\) to review whether to provide further clarity in relation to a definition of Deprivation of Liberty.

**Question 3: At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?**

12. The principles and definitions of capacity and best interests are vital parts of the Act. There is widespread support for the statutory principles and for the way in which the legislation is founded in these to provide a fundamental framework for supporting people who lack capacity to make decisions.

**Implementation**

**Question 4: To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?**

13. The Government’s assessment is that significant progress has been made implementing the principles of the Mental Capacity Act in frontline practice. Evidence taken from discussions with people working in the NHS and social care demonstrates much good practice.

14. However, implementation nationally is variable and the principles of the Mental Capacity Act are not yet fully embedded in all front line practice. The recent Public Inquiry into the Mid Staffordshire NHS Foundation Trust\(^{211}\), the Serious Care Review held about Winterbourne View\(^{212}\) and the Parliamentary and Health Service Ombudsman Report on Six Lives\(^{213}\) demonstrate that much more needs to be done.

\(^{209}\) Article 5(1) of the European Convention on Human Rights provides that “Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:… (e) the lawful detention… of persons of unsound mind.”

\(^{210}\) This case will be heard by the Supreme Court with another DOLS case Re P and Q; P and Q v Surrey County Council; sub nom Re MIG and MEG (2011) EWCA Civ 190 on 22-24 October 2013.

\(^{211}\) [http://www.midstaffspublicinquiry.com/](http://www.midstaffspublicinquiry.com/)

\(^{212}\) [http://hosted.southglos.gov.uk/wv/report.pdf](http://hosted.southglos.gov.uk/wv/report.pdf)


In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
15. The balance between protection and autonomy is at the heart of the Mental Capacity Act. However, legislation cannot balance protection and autonomy in practice. It gives policy makers and practitioners the necessary tools to find the balance for people who have very complex care needs, challenging behaviour and/or may be receiving end of life care. Disseminating good practice will help people discern this balance.

**Question 5: How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?**

16. The Mental Capacity Implementation Programme (MCIP) was a joint programme between the Ministry of Justice, the Department of Health, the Office of the Public Guardian and the Welsh Assembly Government.

17. The MCIP published a series of booklets entitled ‘Making Decisions’ aimed at family, friends and unpaid carers, professionals in health and social care and advice workers; a DVD entitled ‘Three Stories’, which depicted three real life stories about how the Mental Capacity Act empowers and protects people who lack mental capacity to make some decisions or who find it difficult to communicate some of their decisions; and a monthly Mental Capacity Act implementation update newsletter which sought the views of everyone who had an interest in the Act to ensure that it would work in practice. The newsletter was distributed to professionals in social, healthcare and legal professions and at its height had 4000 subscribers.

18. Over five years, the Department of Health also funded an implementation team with a national manager and nine regional managers to support implementation. Work included:

- commissioning a series of training materials and audit tools to support practitioners working in a number of settings, including training for care homes, hospitals and psychiatrists. Audit tools were developed for different settings. The Department also funded a support project for Independent Mental Capacity Advocates.

- writing to all local authorities to invite them to set up multi agency Local Involvement Networks to begin to address the implementation of the Mental Capacity Act. The networks were very effective, for example they reviewed policies and practices, introduced training and awareness raising events, and shared good practice.

- making additional funding available to local authorities and the NHS to support implementation from 2008 onwards. Government funding for local authorities has been increased annually and amounts to £33 million in 2013/14.

19. The Department of Health worked on implementation with many partner organisations, including: the NHS Confederation; the Association of Directors of Social

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215 Hard copies of the DVD were available until the summer of 2010

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1209 Services; the General Medical Council; the British Medical Association; and the voluntary sector. A Mental Capacity Act grant programme funded over fifty organisations to update policies, develop good practice guidance, design audit tools and carry out research in ways that other organisations could also benefit from it. Many of these guides are published on the website of the Social Care Institute of Excellence.

20. Many local authorities fund carers’ centres or carers’ development workers. The voluntary sector has also produced a large amount of relevant and useful guides, fact sheets, targeted information. This includes a guide funded by the Government and produced by MENCAP, called ‘Know Your Rights Under the MCA’216.

21. The Government therefore considers that the implementation programme made a significant contribution and led to important steps forward in changing cultures to embed the Mental Capacity Act. However, the Government would not seek to claim that practice everywhere fully meets the ambitions and expectations of the Act and is committed to taking steps to make more progress nationally and locally to embed the Act fully in working practices across all sectors. Working with national partners, it intends to assess progress implementing the Act to decide what further action is required and welcomes the Committee’s scrutiny of the Act to inform this.

**Question 6:** Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

22. The Act is now quite widely known by the relevant professionals in the health and care sectors who can describe broadly its vision and principles. However, it is to be expected that the use and application of the Act by professionals in their working practices is variable. There is no data available either to confirm this assessment or to draw comparisons across the different sectors.

**Question 7:** Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

23. Many families who have supported their relatives through the care system have learnt about the Mental Capacity Act and actively use it, whilst others will know little about the Act. However, the Government considers that it is less well understood by families and carers than it is by the professionals required to implement it, although there is little national evidence available to answer this question.

24. Both the Ministry of Justice and the Department of Health receive letters from the public on the Mental Capacity Act which suggest that some people find it difficult to understand the idea that ‘everyone’ can assess capacity and ‘everyone’ can carry out Best Interests decisions. By contrast, others say that care planning using the Act’s principles


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helped a family member move out of long stay hospitals to live a more fulfilling life in the community. The Mental Capacity Act aims to strike a balance between offering protection and supporting autonomy, which is a complex message for family carers and others.

25. The Government considers the Mental Capacity Act does strike the right balance between protecting carers and protecting the person lacking capacity.

**Question 8: Has the Act ushered in the expected, or any, change in the culture of care?**

26. The Mental Capacity Act has created a change in the culture of care although it is difficult to identify its direct impact, amongst other factors, or to judge if it has had as much impact as expected. The Government is keen to gather further evidence to understand this.

27. The Act has led to greater involvement of people who lack capacity and their families in decision making where professionals take time to make careful best interest decisions. There are many professionals who champion the Mental Capacity Act and value its framework, principles and vision, in particular recognising the importance of this in social care. Social workers who have trained as Best Interests Assessors are now proficient in understanding and using case law on the Mental Capacity Act, the Mental Health Act and the Deprivation of Liberty Safeguards to identify what is a restriction, a restraint or a Deprivation of Liberty.

28. In the NHS, most hospitals have Mental Capacity Act leads, even though this is not required by the Mental Capacity Act or the Department of Health. These leads are appointed to design the appropriate Mental Capacity Act compliant policies and procedures and to respond to the problems the hospital environment and processes can create for those who lack capacity.

**Question 9: Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?**

29. The data that exists to inform this answer relates only about referrals to an Independent Mental Capacity Advocate and for a Deprivations of Liberty Safeguards order, not on capacity assessments, best interests decisions or advanced decisions. In addition, the interpretation of this data is not straightforward. There are more referrals to Independent Mental Capacity Advocates of white people than of people from minority ethnic backgrounds. However, we know that the age profile and family structure and size for minority ethnic groups is often different. Family is relevant because Independent Mental Capacity Advocates are mainly for those who have no family or friends to speak on their behalf.

30. Similarly, referrals for Deprivation of Liberty authorisations appear to suggest that more white people may receive a Deprivation of Liberty authorisation than people from

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217 IMCA data is referenced in footnote 1. DOLS data is published at: http://www.hscic.gov.uk/dols. Both publications have tables showing the referrals by ethnic origin of the people.

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other ethnic groups. However, there is no up-to-date data on the ethnic backgrounds of the care home population or of older people in inpatient hospitals care, so it is not possible to say whether this is disproportionate or not.

31. With the forthcoming publication of data from the last census in 2014, the Government hopes that a better analysis will be possible.

**Decision making**

**Question 10: Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?**

32. There has been a large growth both in supported decision making and in people enabled to have choices and make decisions. Good practice can be seen in the work of Learning Disability services and Consultant Nurses, who have all promoted the use of the Mental Capacity Act in the NHS. There is also increasing good practice available in relation to end of life planning for people with dementia and others. Disseminating this will help ensure it becomes embedded across the NHS and social care.

**Question 11: What evidence is there that advance decisions to refuse treatment are being made and followed?**

33. Although there is no national data on numbers of people making advance decisions to refuse specific forms of treatment, the Government believes that many more people know that they can refuse treatment and make choices about their end of life.

34. Significant improvements have been made in providing better end of life care, with a much greater role for people’s wishes and feelings in choosing which interventions and what care and in what settings they might prefer. This goes beyond advance decisions to refuse specific forms of treatment. Instead, individuals may be invited to set out in an ‘advance statement’ what their wishes are. While these additional aspects of advance planning are not legally binding, they are of increasing importance and more people appear to be interested in recording their broader wishes and feelings.

35. The Department of Health’s End of Life Care Strategy introduced electronic palliative care information\(^218\), which records people’s wishes and preferences (whether or not as part of an ‘advance statement’), advance decisions to refuse specific treatment, any Lasting Power of Attorney made, as well as the contact details of any person the person wishes to be involved in decision making.

**Question 12: Has the MCA fostered appropriate involvement of carers and families in decision-making?**


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36. The Mental Capacity Act is about balancing protection with autonomy; the involvement of the person who lacks capacity with the involvement of family; and supported decision making with Best Interests decision making. This requirement to consider different perspectives makes it an important piece of human rights legislation.

37. The Government considers that this is an area of practice that is not yet well understood. Whilst families are consulted and feed into many decisions, some feel they are insufficiently involved in decision making and consider that their role is more marginal than they wish it to be. Increasing carers and families’ understanding of the Mental Capacity Act and sharing best practice amongst professionals will help.

**Question 13: Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?**

38. The role of Independent Mental Capacity Advocates has been very important in providing a voice for people. The Government considers that Independent Mental Capacity Advocates are an innovative and successful safeguard, with voluntary organisations providing a statutory, human rights based service.

39. The Department of Health publishes an annual report setting out the number of people who benefit from the Independent Mental Capacity Advocate service and including qualitative information taken from Independent Mental Capacity Advocates’ reflections on their work. In 2012/13, 11,899 people benefited from the Independent Mental Capacity Advocates service. The numbers have doubled since the Mental Capacity Act was introduced. The year on year increase in referrals suggests a corresponding increase in people’s knowledge and understanding about who qualifies for a referral to an Independent Mental Capacity Advocate, meaning more people are now benefiting from their support.

**Question 14: Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?**

40. Prior to the Mental Capacity Act, there were no statistics on people who had no family or friends who could be consulted, so there were no firm expectations on levels of referrals. The data demonstrates a year on year increase in referrals, which suggests a continual increase in knowledge and understanding of the service.

41. However, the Government is concerned that there are regional variations in the number of referrals. It appears that a key reason for this variation is the strength of local Mental Capacity Act leadership, in both local authorities and the NHS which is likely to lead to investment in Mental Capacity Act compliance and, as a result, more referrals to Independent Mental Capacity Advocate services. As part of its assessment of progress to date, the Government will consider this issue in more detail with national partners to decide what further action may be needed to address this regional variation.

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**Footnote 1**

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**Question 15: Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?**

42. The Department of Health commissioned a National Advocacy Qualification\(^{220}\) with an Independent Mental Capacity Advocate and a Deprivation of Liberty unit, to support the training of Independent Mental Capacity Advocates and other advocates. This is the first national qualification for advocates and is useful for advocates starting in their role. This qualification is not, however, enough on its own - it needs to be complemented by specialist training and by regular supervision, personal development plans and the opportunity to interact with, and learn from, other advocates.

43. The Department of Health makes resources (circa £7 million per annum) available to local authorities to commission Independent Mental Capacity Advocate services. These resources are part of the annual settlement that local authorities receive from central government and are not ring fenced.

**Deprivation of Liberty Safeguards**

**Question 16: Are the safeguards in the Deprivation of Liberty Safeguards (DOLS) adequate?**

44. The Deprivation of Liberty Safeguards were introduced to make sure that procedural safeguards were in place to comply with Article 5\(^{221}\) for people lacking capacity, who are not subject to the Mental Health Act 1983, but whose care and treatment in hospitals or care homes involves a Deprivation of Liberty. Before the introduction of the Deprivation of Liberty Safeguards, it was necessary to refer cases to the Court of Protection to deprive someone of their liberty to provide care and treatment. The local process introduced by the Safeguards is preferable and more efficient.

45. The Safeguards focus on the care of people with very complex needs. They create a statutory framework of scrutiny, checks and balances which offers both empowerment and protection. The Government is aware that there are concerns that the processes supporting Deprivation of Liberty Safeguards are complex and could be simplified but it does not believe that the statutory framework put in place by the Safeguards is not adequate.

**Question 17: Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?**

46. Prior to 2011, the use of the Deprivation of Liberty Safeguards was based on the Mental Capacity Act and the Deprivation of Liberty Safeguards Codes of Practice. In 2011, this was extended by the *Neary vs Hillingdon* case from the Court of Protection\(^{222}\). The Neary


\(^{221}\) Article 5(1) of the ECHR provides that “Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:… (e) the lawful detention… of persons of unsound mind.”

\(^{222}\) (Re Steven Neary; LB Hillingdon v Steven Neary (2011) EWHC 1377 (COP)).

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case extended the guidance in the Code and led to scrutiny of the role of the Supervisory Body. In particular the clarification that the Supervisory Body role was a more active role than previously thought, requiring scrutiny of the quality of the assessments prior to authorisation, was important.

47. The Government is aware that many people consider that the process for authorising a Deprivation of Liberty is bureaucratic and, in particular, has heard concerns from the recent Red Tape Challenge about the forms which people may use for this process. As part of wider work to review progress implementing the Mental Capacity Act and the Deprivation of Liberty Safeguards and decide what further action may be needed, the Government intends to review and simplify these forms.

48. Recognising the difficulties which some people experience in understanding how to apply the Deprivation of Liberty Safeguards, the Department of Health has already commissioned the Social Care Institute for Excellence to write further guidance on good practice on applying the DOL safeguards, which will be published later in 2013. This will include a suggested template for supervisory bodies to use as part of their authorisation.

**The Court of Protection and the Office of the Public Guardian**

**Question 18: Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?**

49. The Office of the Public Guardian is an Executive Agency of the Ministry of Justice. We are aware that the Public Guardian has submitted evidence separately to the Committee and have not, therefore, covered issues relating to the Office of the Public Guardian in this response.

50. The Government is taking action to address the remaining lack of clarity over the respective roles of the Court of Protection and the Office of the Public Guardian. Information on the Court of Protection and the Office of the Public Guardian is available on the GOV.UK website. The wider publication of judgments and the development of online forums and newsletters by legal and social care practitioners to discuss Court of Protection cases and practice are a helpful resource to all and seek to increase awareness and knowledge. In addition, the Court of Protection has recently refreshed its guidance on how to access the Court and it regularly updates a ‘frequently asked questions’ document that addresses most of the common issues experienced by users.

51. Knowledge about accessing the Court among legal practitioners and social care professionals concerned with the Court’s property and affairs jurisdiction is high. The Court of Protection has an active user group and, along with the OPG, it engages actively with local authorities who make property and affairs applications, including consulting on changes and contributing to respective guidance.

52. However, the level knowledge and awareness about accessing the Court of Protection for personal welfare and deprivation of liberty applications is not as well embedded, particularly as these applications represent only a small proportion of the Court of Protection’s total workload. The framework provided by the Mental Capacity Act means that the majority of decisions about care and personal welfare can, and indeed ought to, be...
made without accessing the Court; and because practitioners and carers involved in personal welfare decisions are usually different to those involved in property and affairs matters. The Government recognises, nonetheless, that the variations in regional practice and the fact that practices have taken longer to bed down in some areas, have resulted in similar variations in knowledge about how to access the Court of Protection.

53. The Court of Protection has over 90 nominated district and circuit judges who sit at a wide range of court all over England and Wales. This means that subject to the availability of judges, cases can always be heard close to where the parties live. Over half of all hearings take place outside London.

**Question 19: What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?**

54. Over 700,000 Lasting Powers of Attorneys have been registered since their introduction in October 2007. The vast majority of these are for property and financial affairs Lasting Powers of Attorney. The introduction of Lasting Powers of Attorney for personal health and welfare has particularly benefited those individuals who have longstanding, complex health and care needs, for example, for families who manage large personal budgets to manage the complex needs of a family member.

**Question 20: What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?**

55. It costs £400 to start proceedings in the Court of Protection. If the application concerns property and affairs, then costs, including fees, can be recovered from the assets of the person lacking capacity. The Court of Protection also has a comprehensive fee remission and exemption system where it will take into account the assets of the person lacking capacity. The person making the application will have to agree any legal costs and pay them out of the assets of the person lacking capacity. If they cannot agree the costs, the applicant can apply to the Senior Courts Costs Office, who will assess the bill, to see whether all the charges are reasonable, and if appropriate, reduce the charges.

56. If the application relates to personal welfare, then the court will usually make no order for costs, which means that the applicant will be responsible for paying the court fee and any legal costs. It could be argued that this could deter some from accessing the Court of Protection, because they would have to do it at their own expense. The Government considers, however, that this is consistent with the personal welfare decision making framework provided by the Mental Capacity Act, namely that the Court of Protection should be used as a last resort only. The costs provision help ensure that this works as it was intended. This contrasts with property and affairs matters, where only the Court or a deputy can make decisions where the person cannot decide for themselves. The Court of Protection has discretion in personal welfare matters to order that another party or the person lacking capacity should pay costs and fees.

**Question 21: Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?**
57. In the Court of Protection, non means tested legal aid is available only in those cases where there is an application under section 21A of the Mental Capacity Act 2005 as a challenge to a standard authorisation for deprivation of liberty or a condition thereof. There are many other classes of case dealt with by the Court of Protection, including others where deprivation of liberty under section 16 of the 2005 Act is at stake where, although legal aid is available, it is means tested.

58. Advice is available for any mental capacity matter and representation is available for the Court of Protection in limited circumstances where there is to be an oral hearing and the case will determine the vital interests of the individual i.e. life, liberty, physical safety, medical treatment (including psychological treatment), capacity to marry or enter into a civil partnership, capacity to enter into sexual relations, or the right to family life.

59. Following the Government’s review of legal aid, we have retained legal aid for those mental capacity cases currently funded by legal aid (at the levels of service currently funded). Paragraph 5(1)(c) of the Legal Aid Sentencing and Punishment of Offenders Act provides that civil legal services may be made available in relation to matters arising under the Mental Capacity Act 2005. Such services may relate to decisions of the Court of Protection made under that Act concerning the property, financial affairs and personal welfare of persons who lack capacity to take those decisions for themselves. Paragraph 5(3) excludes services provided in relation to the creation of lasting powers of attorney or the making of advance decisions under the Mental Capacity Act 2005, but sub-paragraph (4) states that this does not exclude services relating to the validity, meaning, effect or applicability of a lasting power of attorney that has been created, or an advance decision that has been made.

Regulation

Question 22: Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

60. The Care Quality Commission has a clear role and mandate in inspecting for Mental Capacity Act compliance within the NHS and within care homes under Chapter 11 of the Deprivation of Liberty Safeguards Code of Practice. The Care Quality Commission has powers to monitor the Deprivation of Liberty Safeguards by visits to hospitals and care homes; by interviews with people deprived of their liberty and by inspecting relevant records relating to care and treatment. The Care Quality Commission can require disclosure of information and should examine protocols and procedures. If the Care Quality Commission finds that the safeguards are not being used correctly, it can take enforcement action using its general regulatory powers under the Health and Social Care Act 2008. The Care Quality Commission also requires section 4 of the Mental Capacity Act (best interests) to be applied by service providers in obtaining service users’ consent to care and treatment. Given its existing role and powers, the Government does not consider that the Care Quality Commission requires additional powers.

61. The Government intends to work with the Care Quality Commission, and other national partners, to draw on its expertise and experience to understand the extent to which the Act has been implemented. The Government will work with the Care Quality


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Commission as it develops its new approach to regulation and inspection to consider how it can use its existing role and powers to continue to support implementation of the Act.

**Question 23: Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?**

62. Health and social care professional regulators have to have an understanding of how the MCA applies to their work and can share best practice with their members. This applies both to regulators in and outside of the care sector, including the General Medical Council, the Nursing and Midwifery Council and the Health and Care Professions Council.

**Other Legislation**

**Question 24: How well is the relationship with the mental health system and legislation understood in practice?**

63. The Government is satisfied that the relationship between the Mental Health Act and the Mental Capacity Act is clear in law.

64. However, in a recent research report from the University of Cambridge, a range of difficulties were identified in how the relationship worked in practice. The research team made recommendations to address this, which the Government is considering.

65. The Government is also currently reviewing and updating the Mental Health Act Code of Practice. The intention is to make it clearer how the two legislations work together in practice and to include reference to the Deprivation of Liberty Safeguards, which were introduced after the Code was last updated. The Department of Health will consult on the proposed changes in 2014.

**Devolved administrations and international context**

**Question 25: Does the implementation of the Mental Capacity Act differ significantly in Wales?**

66. Implementation of the Deprivation of Liberty Safeguards in Wales differs slightly. Specifically there are different timescales relating to when Deprivation of Liberty Safeguard assessments should be made and for the setting up of Independent Mental Capacity Advocate services:

**Question 26: What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?**

224 The Mental Capacity (Deprivation of Liberty :Assessments, Standard Authorisations and Disputes about Residence) (Wales) Regulations 2009

225 The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person’s Representative)(Wales) Regulations 2009

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67. The Government is keen to keep up to date with the development of legislation and its implementation in other jurisdictions. The Public Guardian is in regular contact with his fellow post holders around the world in order to exchange ideas on the operation of the legislation in their respective countries. A ‘Four Jurisdictions’ (England and Wales, Scotland, Ireland and Northern Ireland) conference is held annually, with the next conference scheduled for October at the Royal Courts of Justice.

68. Currently, the Government is also reviewing the Draft Assisted-Decision Making (Capacity) Bill 2013 published recently in the Republic of Ireland, to consider what might be learnt from the approach taken there.

**Question 27: Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?**

69. The Mental Capacity Act 2005 pre-dates the United Nations Convention of the Rights of Persons with Disabilities. The Mental Capacity Act enables autonomy and self-determination for an individual, with adequate proportionate safeguards. This is entirely in line with the ethos and values implicit in the UN convention.

70. Based on legal advice, the Government is of the view that the proportionate supervision of deputies by the Office of the Public Guardian ensures compliance with the UN Convention. However, we are aware of developing thinking amongst academics and others with an interest in the Mental Capacity Act that it may not be fully compliant with the UN Convention on the Rights of Persons with Disabilities. In light of this, we intend to review the Mental Capacity Act to consider this revised thinking by the end of the year.

5 September 2013
Ministry of Justice and the Department of Health – Further supplementary written evidence

MINISTERIAL EVIDENCE SESSION
3 DECEMBER 2013

During the joint evidence session with Norman Lamb MP, I offered to write to the Committee on a number of matters on which the Committee sought further clarification.

The matters in question were the mediation pilot being undertaken by the Office of the Public Guardian (OPG) and the nature of the offences that had been prosecuted under section 44 of the Mental Capacity Act (MCA) 2005 and the Fraud Act 2006. I will deal with each in turn.

Mediation pilot

The pilot will allow the OPG to determine whether an in-house mediation service is a feasible option. The tender for the selection of the external partner who will assist the OPG in setting up a pilot scheme began in the late summer with the final selection taking place on 26 September, when Browne Jacobson solicitors in Nottingham were selected.

Cases where mediation may be particularly useful are those involving disagreement between family members of 'P' (the person lacking capacity), usually involving one or more attorneys of a Lasting Power of Attorney, (LPA), or a Court appointed Deputy over a decision required for P’s best interests. The cases selected for inclusion in the pilot are likely to focus on the property and affairs issues in dispute between family members of P, though they may also include issues of health and welfare decision making, or a mixture of both.

The pilot will cover 15 to 20 cases which have been recommended by the Public Guardian (PG) as suitable for mediation. The mediation will be free to participants and it is hoped that they will be commenced in mid-January 2014, subject to the consent and availability of the involved parties. Mediation will take place via the telephone. Successful mediation will be particularly useful in cases where an attorney has been appointed as this will preserve the donors’ choice of attorney.

Browne Jacobson will report to the Public Guardian by April 2014 with recommendations.

Nature of offences under section 44 of the MCA and the Fraud Act 2006.

Unfortunately whist my department is able to provide statistics of the numbers of people who have been convicted under section 44 of the MCA and under the Fraud Act, we do not hold details of the exact nature of the offences. My officials have liaised with the Crown Prosecution Service. They do not hold details of the nature of the offences either and to obtain the information would require them to manually search through the case files.

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1219
However, from evidence recently collated from media articles by my officials, it would appear that the offence in the MCA is indeed being used to prosecute those who have the care of the person lacking capacity and that the Fraud Act is being used to prosecute where attorneys and deputies have abused their position and misappropriated funds.

Clearly there is work to be done to ensure that more use is made of the offence in the MCA and my officials will further discuss the matter with the CPS and will also contact the Association of Chief Police Officers.

You have also asked me to address question 8:

*The difficulty between providing the appropriate balance between safeguarding and protection has been a consistent theme in the evidence that we have heard. Given the understandable focus on safety within health and social services, how does the Government intend to prevent the empowering ethos of the MCA from being continually overshadowed?*

My colleague Norman Lamb MP has provided a substantive answer to this question but I would add that we are aware of the need to ensure that the empowerment message is understood, and my officials will continue to work with officials at the Department of Health to see how this can be achieved.

I look forward to reading the Committee’s recommendations in due course.

**TOM McNALLY**

10 December 2013
MM – Written evidence

This intended to provide a personal narrative of the experience and effects of the current implementation of the Mental Capacity Act specifically in relation to the Deprivation of Liberty Safeguards. It refers to information shared by [redacted] in her role as Relevant Persons Representation for [redacted]. In sharing this information with the committee it is intended that some of the concerns raised in the practical implementation can be shared with the committee in the hope that these experiences will lead to an improvement in the processes for other individuals and families. As it contains personally identifiable information, I ask that this be taken into account and removed where necessary.

Introduction

[redacted] [redacted] (WM) is an 89-year-old friend who was appointed as Relevant Persons Representative (RPR) for 80-year-old [redacted] [redacted] (MS) through a period where the latter was deprived of her liberty – both unlawfully and with an authorisation. WM has a history of health difficulties including two heart attacks. WM had months of experience of dealing with the distressing processes of the law when it felt like the full force of the state was battling against her. She wanted and continues to want the best for her friend (she continues to visit her to this day when in the eyes of the authorities MS fate has been neatly solved but she has been removed from any source of interest in life). WM experienced constant suspicion and disadvantage when challenging a local authority, which has taken its toll on her. WM accessed legal aid while she was able to as RPR, but when the DoL authorisation was withdrawn her legal aid was withdrawn and, with little expertise in a system which is designed for people with years of legal training, and fearing possible financial consequences, was not able to continue a legal fight for her friend’s wellbeing.

This submission is a reflection of her story and an illustration of why there is a desperate need to make the process for appeal simpler and cheaper to access if it really is to be a protection for people who are detained by the state.

BACKGROUND

MS is a woman who is 80 years old and was widowed in 2006. She has no family in the UK, but has a step-daughter in Australia. She is currently living in residential care. WM is a friend of MS who has known her since she was widowed. They belonged to the same church which is how they became acquainted. WM has had regular contact with MS through the period in which they have known each other, visiting her in her home and seeing how she coped with daily tasks, and continues the contact now that MS is in a care home.

MS lived alone with her cat in sheltered accommodation in [redacted], within the London Borough of [redacted]. She was a very private person. As her health deteriorated she had increased involvement from the local authority. Her wishes had consistently been that she remain at home and remain as independent as she was able to be. This was something that was very important to her.

Following an admission to hospital during which she was detained, for a period, under the Mental Health Act, and following a Best Interests Meeting, as she had been assessed as

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lacking the capacity to make a decision about her care needs, she was transferred to a care home on 17/11/11.

An urgent application to deprive her of her liberty was made on 4/1/12 after WM had raised concerns with a third party, who made a third party request to the local authority for an application to be made. This was not initiated by the care home or the local authority. A standard authorisation was granted on 11/1/12. WM was appointed as the Relevant Persons Representative. The Deprivation of Liberty was authorised initially for a period of three months and it was renewed on 12/3/12 until 11/5/12. After this, there was another Best Interests Assessment and there was a decision that, on the back of the Cheshire West judgement, MS was no longer being deprived of her liberty. As such WM no longer retained the position of her RPR and the legal aid to challenge the local authority was lost.

MS was moved to another care home eventually, where her care has improved (more appropriate to her state) but the process has been a difficult one to navigate without assistance, and challenging a local authority through the Court of Protection remains a channel that not all are able to take.

Issues

The processes that WM faced as the RPR when she felt that there should be a review of the Deprivation of Liberty Safeguard Authorisations were voluminous and full of legal terms and procedures that are not accessible for the general public who want to do the best for their friends, never mind for elderly people. WM consistently informed the local authority that she felt that MS would be provided with care which was more in line with her wishes outside a residential setting and where it would not be necessary to deprive MS of her liberty. There was never a genuine attempt made to test whether this was feasible (a much earlier abortive attempt could in no way be described as genuine). In addition, when WM challenged the quality of care that had been offered to MS she met with defensiveness, closed doors and falsified or mistaken reports. She had no recourse.

There was no attempt to try anything creative, including solutions that could have combined with offers from volunteers in the local community. It was clearly felt easier to lock MS away somewhere she didn’t want to be, which deprived her of her remaining familiar, small pleasures and opportunities for privacy, dignity and self-reliance, and which left her unkempt and unhappy, than to work on caring for her where she did want to be.

WM also challenged the period in which MS was in a residential setting between 17/11/11 and 4/1/12 as an ‘unauthorised deprivation of liberty’ as there had been no changes in the care regime between this time and the time when the urgent authorisation was requested. She had to take the initiative to do this herself as the council did not spot the omission or appeared not to find it significant. It was only through WM talking to a friend that she became aware there may be an issue of unlawful deprivation.

These two issues remain the key behind the concerns with the process as it stands – fundamentally, the difficulties which arise from making any kind of challenge to the processes of the local authority, as an individual, when acting as a relevant person’s representative and holding a different view from that of the local authority.

**Challenging the Deprivation of Liberty Safeguards Authorisation**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
As a part of her challenge as RPR, WM had legal aid to challenge the DoLs authorisation as it stood. As a s39D IMCA referral had been made, the IMCA was asked to support WM in her role as RPR. This IMCA supported WM in writing a letter to the supervisory body (XXXXX Council) and MS’ care manager. The first DoLs authorisation expired on 11/3/12 and this information was to be sent before a further application was made. The IMCA also discussed the situation of MS with the BIA who was appointed to carry out the second assessment.

On 7/3/12 WM was granted legal aid to challenge the authorisation in the court of protection, taking action against the London Borough of XXXXX. A further authorisation was granted on 11/3/12 for another period of two months. A subsequent request was made on 6/5/12 where it was deemed that MS was not being deprived of her liberty.

WM, as a private citizen trying to represent her friend and take the responsibilities of the RPR seriously in terms of acting as a protection against the state, a role which is embedded in the Human Rights Act (article 5) which indicates that a process of appeal should be possible, has experienced a labyrinthine process of trying to understand and operate within the systems which are built into the Mental Capacity Act (2005.) This suggests that these very processes are potentially a bar to others being able to bring challenges.

As an example WM, in a letter to the Best Interests Assessor involved in the case dated 31/7/12, refers to information and reports which were lengthy, and which she felt contained inaccuracies which should be corrected, being sent to her late, and proceeded to request making a formal complaint to the London Borough of XXXXX.

She says

“At the Court Hearing on May 25th, it was ordered that London Borough of XXXXX serve the information required by 4pm on July 13th, to which I was supposed to respond by July 27th. As the relevant information only reached me today [31/7/12] a response has not been possible for that date”.

This is just one clear example of the difficulty that WM has faced in challenging the local authority in the deprivation of liberty authorisation. Navigating the Court of Protection processes is complex for local authorities, but for private citizens it becomes even more so without specific advice.

What is a ‘protection’ has the risk of being far less than protective if the processes from which one is deemed to be protected are reliant on the acquiescence of the local authority.

I quote from the same letter to indicate WM’s feelings on the matter:

“We have been made to feel that we are the enemy in the eyes of London Borough of XXXXX, when we only wanted to bring some happiness to [MS] in the place she wished to be i.e., at home. The impression we have is that we are regarded as obstructing the process of incarcerating [MS]”

This statement is, I believe, indicative of the challenges that WM has faced and that RPRs potentially face when there is a difference of opinion with the LA that is not resolved through consultation.

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Section 4 (7) of the Mental Capacity Act states that, in determining a person’s best interests:

He [the decision maker] must take into account, if it is practicable and appropriate to consult them, the views of –

(b) anyone engaged in caring for the person or interested in his welfare

Regardless of the outcome, the lack of consultation and involvement of WM in the process has been evidenced above.

Unauthorised Deprivation of Liberty

For the period between 17/11/11 and 4/1/12, MS was deprived of her liberty and this was unauthorised. Her situation had not changed when the urgent application was made. WM challenged this in court and it was accepted that this was an unauthorised detention, however there was an end to the legal aid funding so damages could not be sought through the court.

This brings to bear issues of checks on managing authorised and supervisory bodies in relation to unauthorised detentions. As the obligation is on the managing authority to raise concerns in relation to making applications, there is a gap between legislation and application of legislation. The length of period that MS was away from her property with a potentially degenerative condition as relates to her cognitive impairment, meant that it was increasingly less likely that she would ever be able to return home. Serious concerns remain about the veracity of the local authority’s claim that all opportunities were taken to ensure that MS needs were met with the least possible restriction imposed on her.

A deprivation of liberty is, without question, the most restrictive way of protecting someone, especially if they have consistently stated that they wish to remain in their home environment – including when they did have capacity to make decisions about their care needs. A lack of redress, due to funds, in the effect of an authorised deprivation and the effects that it has had on the future progression of care, has meant that a gap can be seen in the system.

Changes

There are a number of issues which need to be addressed if the experiences of WM and MS are to be opportunities for learning.

a) The process of appealing against Deprivation of Liberty authorisations, even when supported by an IMCA, is made increasingly complex by the lack of a clear route to challenge. Re-assessments are often carried out by the same people or within the same local authorities. The ability to challenge needs to move to court to offer a more independent vantage.

b) There is little effective redress against periods of unauthorised deprivations of liberty. The court has to be aware of them to rule and if there is a degenerative cognitive impairment, the damage caused in the delay in the court processes could be permanent.

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c) The system is not built to be navigated by private citizens. It places individuals against organisations where the pieces are weighted in favour of the organisation. They have the resources and even when an inadequacy is their fault (e.g., failure to submit dense documents on time) it tends to disadvantage the individual.

d) Legal aid is limited but is necessary to make appeals through court systems available to all, as the cost can otherwise be too high.

e) The court never accepted or ordered what WM had requested — which was for MS to have a trial at home over a time period and with the support which would give her a real chance to live in the way that she had always wanted to. The time period became more and more important once the illegal (in)action of the council in depriving MS of her liberty had made it more likely that a significant period of re-adaptation would be necessary.

Conclusion

The effect of challenging DoLs authorisation as a RPR is complex and harrowing. Even with support provided by legal aid, the legal system can make assumptions about the levels of knowledge of applicants which can place the burden of proof on the applicant. WM as MS’s RPR endeavoured to do her best to defend MS’s rights and preferences as consistently expressed to her by MS — namely that she stay at home, with her cat and performing familiar small daily actions in an environment with which she was familiar. While the local authority provided evidence of their decision-making process, there was little evidence of working with WM as RPR. WM was treated as a nuisance and obstructed by incompetence and risk aversion.

This has had a serious impact on MS’s Human Rights. She was unlawfully deprived of her liberty. WM was relied on to act as an RPR without much support — through legal aid which was withdrawn and in the face of a belligerent local authority who could stamp over MS’s wishes in the guise of protection.

Professionals proved they lacked knowledge of the legislation and respect for WM’s position.

There was no help to understand the complex law for people who are ‘outside’ the system — unpaid carers/friends/family such as WM. Others without friends like her would be at risk of abuse of powerful organisations far more readily. The Act provided little protection for WM and its processes proved damaging and complex.

2 September 2013
Tussie Myerson – Written evidence

I am a parent who has gone through over 2 years of legal argument based on the premise that my daughter, who lacked capacity, should not be entitled to housing benefit. Despite the fact that I was her Court Appointed deputy.

It is my opinion that if a child is born with such complex and life limiting conditions then through the rigors of health and social care responsibility for Guardianship should follow on without the need to apply for it.

I was advised to apply to become a Deputy because at the time she was 16 there was a real risk that a care home at the time would apply for Guardianship when she was 18, on the basis that they did not agree with my care plan. Whether they would have been successful or not is another matter, but I was not prepared to go through that battle.

It was however only by chance that I was made aware of a/ the MCA b/ the relevance to our situation. No one within any authority had ever mentioned it.

And as my daughter was still a child with a limited life expectancy no one thought to bring it to our attention.

Your point 23 asks should other regulatory bodies such as health and social care professional regulators be acting in this area?

Absolutely. It is essential that all those involved in managing, delivering or involved in any element of care provision should be advising parents, giving guidance and ensuring that all avenues have been discussed, considered and weighed up. You cannot have a good provision of service if laws such as this are not understood.

I applied to be her Deputy in matters concerning her property and affairs in 2010 and eventually after almost a year (because paperwork was lost and the system is archaically slow) I was granted the order. – There are clearly too few people employed by the system.

The application process is poor. It is generic and attempts to tick the same box for every person.

I can’t stress often enough the fact that in THIS situation where it is a parent applying to protect or act on behalf of their child then there MUST be a simpler process.

In 2010 we also made an application for housing benefit on behalf of our daughter where we were also the landlords.

This was done on advice from the local authority.

However the application was refused 3 times on the grounds that as her parents we could not be her landlords. And because as she lacked capacity could not enter into a tenancy agreement.
The legal hurdles we had to jump through were inexcusable.

There was not enough knowledge on the part of the local authority. And the law surrounding Mental capacity and housing benefit was weak.

The communication between bodies non-existent. This is a common complaint for many when dealing with the move from Children’s services to adult. It is made even worse when the issue of Guardianship or Deputyship plays a part.

As a result of our legal battle eventually we won our case and Judge Mark in the Upper tribunal and at appeal, stated that our daughter could enter into a tenancy agreement despite lacking capacity.

It was a landmark case and the result is that others who lack capacity will not be prevented from claiming housing benefit.

It went through 3 hearings in the Tribunal system.

The positives.

My annual visit from the Court of protection was a positive. I was visited twice and on both occasions the person visiting spent time listening and hearing the issues we had. And on the last occasion was proactive in trying to improve provision of care for my daughter. However the lack of staff at the Court of Protection meant that the Visitors actions took over a year to be acted on and sadly by the time they did do anything my daughter had passed away.

Conclusion.

The act is not known or understood by families who are caring for children and young people who lack capacity.

Not enough is done to inform them.

Leaflets are no good.

There has to be a structured ‘marketing campaign’ through hospices, schools, social workers and even Consultant doctors to make parents aware.

Local authorities need to work with it rather than against it.

And staffing levels at the Welfare side need to be increased.

23 August 2013
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National Care Association – Written evidence

1 National Care Association

1.1 National Care Association is a Trade Association representing the interests of independent sector providers of social care, primarily residential care homes but we also have in membership both nursing homes and providers of nursing care.

1.2 National Care Association and the English Community Care Association recently announced that they are to merge and from 1 January 2014 will be known as Care England.

1.3 Currently National Care Association mainly represents small and medium sized organisations and English Community Care Association represents in the main larger organisations.

1.4 National Care Association welcomes this opportunity to comment on the Mental Capacity Act 2005.

2 The Introduction of the Mental Capacity Act 2005

2.1 When the Act was being introduced National Care Association believed that it was one of the most important pieces of legislation relevant to Care Homes that had been implemented in recent times. That view has not changed.

2.2 The Act most important of course sets out a set of principles which gives clear protection to so many people cared for by our members. The second aspect of this is important to our members because the Act sets out a framework which allows our members and the people they employ to make decisions which providing they can demonstrate that they acted in the best interests of the individual gives the member of staff protection too.

3 Overview and Context

3.1 From the viewpoint of National Care Association members the Act has been successful in that within the framework the decision making process needed for the running of a care home for people who may lack capacity has been clarified. We hear no complaints from our members about the Act itself.

3.2 There is however cause for concern when other professionals may be making major decisions about an individual who may lack capacity and they fail to take into account or even solicit the views of those people who care for the individual on a daily basis. This is an area that needs to be taken into account and may need at the least further clarification. On too many occasions decisions are still being made about where particularly younger adults with a learning disability should live without reference to the care staff of the current place of residence and in many cases failing to take into account the views of families as well.

3.3 National Care Association believes that the principles and definitions of capacity and best interests of the Mental Capacity Act are clear and transparent and easy to work within.

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for all levels of people who may have to make decisions within the Act. We believe that they remain appropriate and would not want to see any significant change to them.

4 Implementation

4.1 We believe that within providers of social care in the private and voluntary sector the five principles of the Mental Capacity Act are well understood. Managers are aware of their responsibilities and training is widely given to care staff. We believe that people working in the social care sector would recognise these five principles as best practice with or without the Act. People with more complex needs or younger adults with a learning disability sometimes give a real challenge to staff working in social care as to what the best decisions are but these principles are in that context very helpful.

4.2 For National Care Association we found the Government’s implementation plan very helpful. The guide for people who work in health and social care commissioned by the Department for Constitutional Affairs in 2006 continues to be widely used in the sector for training purposes.

National Care Association along with many other organisations was commissioned by the Department of Constitutional Affairs to deliver a series of seminars to providers of social care about the Mental Capacity Act. The seminars were very well attended and aroused a great deal of debate.

4.3 We believe that within the independent social care sector the Mental Capacity Act is well embedded amongst responsible providers and has made a real difference in the way mental capacity is approached by care staff. However, we are aware that there is a very small minority of providers who don’t fully understand the act and its implications.

5 Professional’s Understanding of the Act

5.1 National Care Association believes that people working in the field of social care have a wide understanding of the Mental Capacity Act and indeed National Care Association has continued to deliver training about the Act in individual care homes from time to time.

5.2 The various responsibilities relating to more complex decisions that from time to time need to be made are sometimes more difficult to make because not all professionals understand that they should and must contribute to decisions.

5.3 As referred to in 3.2 there is still a lack of understanding amongst some professionals that an assessment concluding that the individual does not have mental capacity does then allow the person carrying out the assessment to a complex decision.

6 Understanding of the Act by Service Users and their Informal Carers

6.1 We believe that informal carers do have an understanding of the Act and they are sometimes invited to participate in training undertaken by care homes.

6.2 There have been many occasions in care homes for younger adults where family members have concerned at the service user making decisions when the assessment has
identified that the individual has mental capacity. This can lead to difficult situations developing although with goodwill on both sides such situations can normally be resolved.

6.3 National Care Association have been disturbed by reports from providers that younger adults have been restricted from taking control of their finances as opening a bank account with all the major financial institutions can be blocked because of the banks concerns about the individual’s mental capacity. We believe an early resolution to this situation should be sought in the best interest of service providers so they can retain real choice and control over their lifestyles.

6.4 Although the issue of balance is difficult to assess in very complex and personal decisions we do believe that the current legislation remains fit for purpose.

7 Change in the Culture of Care

7.1 We had expected that the Act would lead to an increase in our and our member’s confidence that the right decisions were being made by the right people and that because the individual would be more likely to be able to make some decisions about their life if not all then that quality of life would be improved.

7.2 It is only natural that some providers having made the assessment and found that there is capacity should worry about the risks that some individuals may then take.

8 Decision Making

8.1 We believe that within care homes the Act has allowed individuals to make more important decisions for themselves. For instance if someone has temporarily lost capacity due to an infection or a similar illness decisions will now be delayed unless they are urgent for the person to recover capacity. We believe this is because the Act has focussed attention and therefore enhanced understanding about the importance of mental capacity to the wellbeing and dignity of people in receipt of social care.

9 IMCAs

9.1 We are unable to comment on the role of IMCAs except in the most general sense.

10 Deprivation of Liberty Safeguards

10.1 We believe that if a person lacks Mental Capacity it is an important element of care for the person living in a care home to have a risk assessment as to whether or not they should be free to come and go as they wish.

10.2 If the risk assessment identifies that the individual is unable to be outside the home and protect themselves we do not believe that they are being deprived of their liberty providing they are able to leave the home with a carer or a member of their family.

10.3 We believe that the Deprivation of Liberty Safeguards need to be much better understood than they currently are and that there needs to be an awareness raising initiative undertaken.

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11 The Court of Protection and the Office of the Public Guardian

11.1 We are unable to comment on The Court of Protection and the Office of the Public Guardian.

12 Regulation

12.1 National Care Association believes that not all CQC inspectors understand the Deprivation of Liberty Safeguards and would recommend that each inspector needs to understand the safeguards before making comment within an inspection report.

12.2 Apart from the above we believe that there needs to be no further involvement of any other bodies and that the current system works well.

2 September 2013
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not work quite as well as they had anticipated, then they would be protected. The work that our members do is some of the most challenging work that there is: working with people with dementia and people with very serious conditions that mean that they do not have mental capacity. Before that, there was a bit of hit-and-miss. Now, we do not think it is hit-and-miss.

**The Chairman:** Do you have anything to add to that?

**Nadra Ahmed:** I would just endorse it. It was very welcome. Once we were able to get the message out, providers began to see the positive impact this could have within their services, and they have embraced it. It is an important piece of legislation.

**The Chairman:** You referred to best interests, but to what extent do you take into account the need to empower the residents?

**Sheila Scott:** Absolutely, and it is one of the most difficult decisions. This Act of Parliament did empower younger adults with learning disabilities in particular, particularly those where families and the staff of care homes were very protective, to do an assessment. Sometimes, the person had capacity to make an individual decision; for other more complex decisions, they do not have the capacity. However, how to implement this has been quite a challenge for care homes, particularly those for younger adults. We undertook some awareness training in the very early days on behalf of the Department for Constitutional Affairs, and we had a parent who was also a care home owner who stood up and was very anxious about what was being said, in that she did not want anybody to be making the decisions for her daughter except herself. I happen to know that lady, and I know she has come a long way since then. Her daughter could not make complex decisions about a medical procedure, for instance, but she can make individual decisions. Sometimes those decisions are painful, particularly when it comes to people's social lives. I think for our members that is the most challenging thing: the care of younger adults with a learning disability who want to lead lives like everybody else, and the anxiety about whether they understand some of the decisions they are making.

**Q237 Baroness McIntosh of Hudnall:** It is very cheering, in a way, to hear your enthusiasm for the Act. We have heard that a lot. People have said this was an extremely enlightened piece of legislation; it was ground-breaking, life-changing and all of those things. What we also know is that the evidence is suggesting that there is a good deal of non-compliance, or difficulty in complying, amongst all those who have a responsibility to comply with it. I wondered whether you could tell us what you think this comes down to in terms of the perspective of your members, and how you can best model and promote good practice and what leads to that, and what are the things that are likely to lead to more compliance.

**Nadra Ahmed:** One of the most important bits about any piece of legislation, and what makes it work, is that everybody sings from the same hymn sheet. The compliance and the understanding must go across the board and not be just with social-care providers, just with families or just with clinicians. Wherever we have heard issues, it has been about this lack of multi-agency and multi-disciplinary working. That is very clear, because we talk about integration but we do not understand and develop it in the right way in various areas. In some areas it works perfectly. When you look at training and education and the work that we undertook, we know that local authorities undertook it in different ways and, just getting
the end of what was being said about GPs, they took it in a different way. One of the greatest barriers to anything working really well is when you are not putting the best interests of the service user at the heart of everything and multi-disciplinary work is going on around it without encompassing the good practice that might be coming from a social-care provider and not a GP, but the GP is not going to accept that because this is the way they understood it. Those are the main barriers that we find.

Baroness McIntosh of Hudnall: That is interesting as an analysis, but how do you begin to break through the walls of those silos? What are the mechanisms, or the tools, that you have to do that?

Nadra Ahmed: I was going to come on to say that. The best piece of work is to drive forward this working together. Training and education needs to take place not just in silos; it needs to be much more proactive about people working together and understanding the training, so the social care worker who does the Mental Capacity Act awareness training is the same as somebody else who may be working in a hospital or in the field. Indeed, why would parents not be involved in understanding what the Mental Capacity Act means to the wellbeing of the individual? When I ran care services, I had residents—those who wanted to—sitting in on my training. I had first-aiders among my residents—those that were able to complete that course. Some would walk in and out, but why would they not be involved in some of that if they choose to be so? There is a real public bit of this that we are missing. It always comes down to funding. I was talking to a local authority only yesterday about some piece of work, because there is money around for Mental Capacity Act awareness training, and they were telling me that the awareness training was not being taken up. I was talking to them about, “How do we open this up, then? Can I push the boundaries here?” There are always reasons why it is ring-fenced.

Baroness McIntosh of Hudnall: I was going to say: can you? Are people willing to be pushed?

Sheila Scott: This is about confidence, is it not?

Nadra Ahmed: Yes. We are in conversation, and Sheila and I spend a lot of time pushing those barriers. We will continue to work at pushing those barriers, because if we really want integration and we really want to work this, then that is what we have got to do.

Sheila Scott: We need to empower our care workers. Some of them may not have the most advanced education, but we wanted to empower them because every one of them has to use this Act, because the person that is doing the caring sometimes has to make a very quick decision. We developed a manual, which the Department of Health saw at the time and were happy with, which looked at the functions of daily living first of all, because if somebody cannot make a decision about anything, you would be doing an awful lot of assessment and not much caring. We developed a way through that, and then an assessment for more complex decisions, just to simplify it and to give people confidence. I could send you a copy if you would like to have one. However, I suspect that for some people, particularly those leading very busy professional lives, this is just one more hurdle to get over. I have no basis for saying that; I suspect that that might be the case. I was invited to go and speak at a Royal College of Nursing conference about the Mental Capacity Act when the Act was being implemented. I am a nurse, so I can say this. Nurses did not want to take the responsibility: “It is clearly for other people.” They have come a long way since then.

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am sure that nurses use the Mental Capacity Act. As I was listening to the NHS people, I was thinking, “There is a lack of confidence here that perhaps we need to find a way forward with.”

**Q238 Baroness Andrews:** I was fascinated, Ms Ahmed, when you said there is a real public bit of this we are missing. I think you were talking about involving families in that sense too, but will the changes in the NHS—particularly the health and wellbeing boards and that opportunity for integration—make a difference? Will that create opportunities for you?

**Nadra Ahmed:** I really hope so. I am a very optimistic person, so I really do hope so. The problem we have is that, as representatives of the social care sector, we find the barriers to get on to anything that works, like those health and wellbeing boards and the CCGs, are enormous.

**Baroness Andrews:** You are not invited, or you cannot get invited.

**Nadra Ahmed:** We cannot get invited. We try. We knock on doors, but there seem to be glass ceilings.

**Baroness Andrews:** Is that true now, when the health and wellbeing boards are being set up?

**Nadra Ahmed:** It is still true, yes.

**Sheila Scott:** Because we are providers.

**Nadra Ahmed:** When we speak at our events, where we have 200-plus providers sitting in a conference centre, we will say, “How many of you have engaged with your CCG?” We are lucky if we get one hand up. That is the barrier that we have. We really do feel very passionately about this. We are not talking about taking over the world; we just want a voice at the table, because there are a lot of care facilities out there—not all of them are members, sadly—and a lot of those people are doing really good work, and some of that practice can be shared and we can save money. We can actually save money with the NHS, because we do the Mental Capacity Act training for half the price that they are paying at this moment in time. I am not touting for work or anything like that; I am just saying that these are the little simple things. Sheila may be able to, but I cannot get to speak to a chairman of a CCG at the moment in my locality.

**Baroness Andrews:** Can we know exactly why? Is it that they are refusing your phone calls, or that you get blocked at some point?

**Sheila Scott:** It is because we are providers of services from the private sector.

**Nadra Ahmed:** It is because we are providers. We are seen as a conflict.

**Sheila Scott:** I think it is the private sector, maybe. Also, there are thousands of us, and I think sometimes people are nervous of engaging with us because they might have to engage with everybody, whereas we would like to think we could represent everybody.

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Q239 Lord Turnberg: You spoke very movingly about the balance that has to be struck between enabling and protecting. I just wonder how you will get your members to do that in an appropriate way.

Sheila Scott: That is a really interesting question. Sometimes we are really enabling people to make their own decisions to move forward with their lives. That is particularly true of younger adults. Young people leave the education sector, and if they come into a care home, it is our duty to try to move them to independent living, and then later in life they will come back to us, but sometimes we are having to protect people. I do not know if this has been raised with you at all up until now, but many local authorities—the cynic in me would say it is for financial reasons—are trying to move younger adults from living in care homes to independent living. We do not object to that, but people need some serious training and support to move from life in a care home to independent living. This is the moment to do a Mental Capacity Act assessment to see if the right decisions are being made for the people who are having these decisions made. Local authorities are tending to make those assessments—or perhaps not—without consulting the people who are closest. They will say they are thinking about it, but they will not use our members to be part of that very important decision that is being made for younger adults all over the country. This has been going on for several years now.

Lord Turnberg: So, local authorities will say that people in one of your homes should come out.

Sheila Scott: Yes.

Lord Turnberg: They do not ask. Do they say they are not going to pay for them anymore? Is that what it is?

Sheila Scott: They want them to go into supported living. That may well be right, but there need to be some fairly detailed assessments and support for those people. I am afraid that is not happening everywhere at the moment.

The Chairman: Are you saying that social workers do not engage with the care home staff in the assessment of residents?

Sheila Scott: Yes, I am.

Nadra Ahmed: We have heard of instances that are quite scary in that a provider has not even known. A social worker has come along and said, “I am going to take so-and-so out for coffee,” and they have gone and shown them a facility and said, “This is a lovely flat. Would you not like to live here?” Of course, they are seeing that as a lovely, beautiful new environment, and at the point where they are making that assessment there is no call on a provider or the people who care for them to discuss it. As Sheila says, we are not against supported living, because for some people it is absolutely great and it is right and they are living very happily, but when you do an assessment you have to take into consideration why somebody is stable in that facility. They may be stable because of the support that they are getting around them during the time that they are there. If you take that support away from them, what will the impact be on them when they are living alone? I am a trustee of a very large learning disability service, and we had a very scary incident where this happened. Two young girls were put into a flat together. They looked like they were fine, and all the

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assessments were done. We had our reservations, but they were not taken into consideration. These two young ladies went to the local pub for a drink in the evening, got chatted up and handed over their address and phone numbers. That night, we got a very panicky phone call in the middle of the night from one of the girls because there were these lads hammering on the door. So, whilst we are not against it, we have to be really clear about what we are saying and how that capacity assessment is done. If it was done properly and our considerations were taken into the equation, they may still be living there but we may be more careful about how we protect them.

Sheila Scott: Families are often not included at this point either. I am not saying every local authority is doing this, but there are too many to feel comfortable with it.

Q240 Baroness Shephard of Northwold: In your sector, there are clear workforce issues. One of them is that there can be high levels of staff turnover and quite low levels of pay. There are implications, if there is a high turnover, for knowledge of the Mental Capacity Act. How do you advise your members to cope with that? I am not saying that it will be the same in every part of the country; I do know for a fact that in rural areas there is a problem, simply because the population is sparse. How do you cope with that? Do you just keep on with the training?

Nadra Ahmed: Training is one of the most expensive activities in a care service. If we did not do it, we would not be providing a quality service. There is no quick fix or easy answer to not going down that route. People are training. I think the high turnover has made people look at different methodologies of training, which includes e-learning. Whilst that is okay if you have got the baseline knowledge, for me, being an ex-teacher, that face-to-face interaction is much better. It is a dilemma. You are absolutely right. With the turnover, what happens is that, as a provider, you take somebody on; you do the CRB or DBS check, which you are required to do; and then you do the five statutory training sessions with them. There is an investment in that person, but because of the pay scales or the situation, where that no longer suits the person, six months later they may be fishing around for another job and so you are doing it again. So, the providers are actually getting the trained and experienced people, which is fine. Mental capacity is not one of the first ones you put them through, but you do have that within the induction package. It is not a satisfactory answer, but I think it definitely is an issue. We see the Mental Capacity Act as being also something that is a protection for the staff. We are very keen that if you implement this properly and it is embedded in your service, you are protecting not only the service user but also the staff. That is where the quality agenda comes into our world.

Sheila Scott: This is a good moment, though, if I might, to mention that Camilla Cavendish has just submitted a report to the Department of Health. Work is just starting. Her recommendation of a basic certificate of fundamental care—I think that is what she called it—is something that we find quite exciting, because if you look at the Common Induction Standards that every new member of staff is supposed to have, they have got increasingly woolly.

Baroness Shephard of Northwold: Not practical, do you mean?

Sheila Scott: Yes. Thank you. This is the moment for us to be raising these sorts of issues with Ministers in the Department of Health about the training that is given around the Mental Capacity Act. I think it is there in the Common Induction Standards; it is just difficult

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to find it. I think it is there within the safeguarding part, but it should be part of that basic fundamental training that nobody can work unsupervised until they have had. They do not need to know it all, but they need to understand how you assess training, which is very simple and straightforward. The four points that demonstrate to whomever it is that this person can make a decision are fairly straightforward, and they just need to understand it. At that stage in their working life they are not going to be making very complex decisions, but they will be required from time to time to make decisions, so it is something that they need to understand.

Lord Swinfen: I will stay on decisions. How are they handled on a day-to-day basis? What types of decisions are made by the frontline staff and what are passed up the chain of control and responsibility? When you have best-interest decisions to make, are they formalised and documented?

Sheila Scott: Yes. What I call the functions of daily living, which just gives a little protection to care homes, where an assessment is made on a regular basis, but not for every decision, as to whether or not that person has mental capacity, is one thing. I would anticipate that a decision about anything more complex than that would be made by a senior care worker, assistant manager or manager, and I would expect it to be documented. I have no doubts about that. There is no point in having this piece of legislation that gives a framework and protection both to service users and to the staff if you do not document it, because if you do not document it, it does not exist.

Q241 Baroness Browning: The submissions that we have received, which have been a great many, have focused on the need for simplification of the deprivation of liberty safeguards, either through amendment of the Act or the Code of Practice or the regulations. I wonder what your view on this is. Do they need to be simplified?

Sheila Scott: My view is that we all need to be singing from the same hymn sheet first. Other professionals may come into our care homes, either from the local authority or from the regulator, and say to one of our members, “That person is being deprived of their liberty and you need to apply immediately to the local authority” or in another area the local authority area will come and say, “No, this is wrong.” Not everybody has a good understanding, because we still get plenty of phone calls about it, but I think we have a good understanding of what deprivation of liberty looks like. The first thing is that perhaps the regulator needs to make sure that all their staff have an understanding of what the Code of Practice says about what deprivation of liberty is. Secondly, everybody says how complex the paperwork is. I am not sure that that involves a change to regulation. I think it involves a complete review, not just of the public sector professionals but also the people who are involved with the assessments, to make sure. In many areas this has worked really well, first of all. Secondly, I have been surprised how many DoLS have been applied for and how many have been granted. I did not think there would be as many as there have been. I have to say I am not up to date with the figures now, but certainly in the early days I was surprised at how many people were the subject of DoLS. Apart from that, as long as everybody is working with the same understanding of how somebody is deprived of their liberty, I think that would be a really beneficial thing for us. We have got a couple of comments here from members who say the same thing: two different counties with two different interpretations of what a DoL looks like.
Nadra Ahmed: The concern would always be that, when you are going for simplification, you do not water things down; that this has been worked out. It is the implementation. It is the paperwork and the process. Perhaps that needs to be looked at in greater detail. It perhaps is a simplification of the process rather than the actual application. We are all blinded with science when it comes to paperwork now; there is so much of it and the bureaucracy is so great that people struggle with it. Perhaps that is more what we would be in line with.

Baroness Browning: Your main concern, then, is this variation in interpretation. I think you are going to get a question in a moment about definitions; I am going to leave that to the person who is going to ask you that.

Q242 Baroness Barker: It is very interesting, because I would say that the weight of evidence that we have had from a number of organisations—including the Alzheimer’s Society, the College of Emergency Medicine and Mind—is that the numbers on DoLS are much lower than they had anticipated. For example, the Alzheimer’s Society say there are about 200,000 people who have dementia, many of whom are in care homes; in 2012-13, there were just under 12,000 applications for DoLS, of which 50% were approved. They seem to think that is quite low. In that context and given what you said is a slightly different interpretation, what work have you undertaken to support people whom you work with in understanding how to meet their obligations under the Deprivation of Liberty Standards? I suppose that really means: how do they understand the law to apply in given situations?

Nadra Ahmed: Part of it is to do with the training, because we supply quite a lot of training and we still get quite a lot of requests for people to understand it. I do not know whether we have got specifics, Sheila, have we?

Sheila Scott: I was part of a working group with other people in the same position as me who were saying, “We do not think this applies to us, because people are not really kept in care homes. If you thought that people were being detained in care homes, then you would have to look for another arrangement.” However, we worked this through, because then some of the fears that arose were that because somebody is assessed within a risk assessment as not being able to leave the home on their own, that does not mean to say that they are detained against their will; it means that they can go out but they just should not go out unescorted. We had a great debate about whether that applied to DoLS or not, and the expectation was at that time, and I think the guidance within the Code of Practice is, that as long as people can go out when they want to, or, if they cannot go immediately, as soon as possible afterwards when there is somebody available, that is not directly a DoL. It is not just about us—members of staff—going out with them; it is about family and friends being able to go out with them as well, or volunteers or IMCAS. It is just about personal safety, say for a person with dementia. That is why we did not necessarily think that people would be subject to DoLS in most care homes. There have been different interpretations that have meant that DoLS have been made, but most of those have been granted at the request of the care home owner or manager, who wanted to be absolutely clear that, although this person could not go out, they had taken the appropriate steps. I know I am not necessarily answering your question, but I am trying.

Baroness Barker: I think you are perfectly highlighting to us what is lying behind some of these statistics, and that is extremely helpful to us. People seem to love the Act, but the application of it in practice has turned out to be very different.

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Sheila Scott: Yes. I think that the Bournewood decision and similar decisions—we were part of another case—were about where people really were not allowed to do anything.

Q243 Baroness McIntosh of Hudnall: It was more than them not being allowed to do anything; in that case, it was also about them losing contact with people who were important to them. Could you just take the Bournewood example and consider, just briefly if you can, from your experience in your care settings, how the effect of DoLS would now change the way in which you might approach that particular obviously quite difficult situation?

Sheila Scott: We were involved in an appeal case where it was an older person who, for their own protection, was separated from their family. This is where the complications arise, is it not? I know the vast majority of, but not all, care homes want people coming in; they want visitors. It is only to protect people, normally from physical or financial abuse. I think that the vast majority of care homes welcome people coming in. I certainly did when I was a care home owner; I am sure Nadra did too. It is the best thing that happens when people come in. I know that it applies to some settings, but in the sorts of settings that we represent, I do not think what happened is likely to happen. We all have to have our wits about us all the time; that is why we have a regulator, to push that protection barrier some more. I just do not think that it is that normal for people from the outside world coming into a care home; there are always people coming in and out. I think there is some more protection than there was in the Bournewood case.

Nadra Ahmed: I know of a care home where there is a gentleman who becomes violent whenever his wife comes. It is a major issue. He becomes a different person. It creates massive tension in that home for all the staff to control after she has left. He does not go out with her, and the sons are in agreement that he does not, but that has caused a massive issue with the wife, because she feels that if he was allowed to have more contact with her, he would be calmer. But the evidence does not show that. She feels very much as though she has been isolated by this decision, which the sons are in agreement with, and they have the history. The home have done absolutely the right things in the way they have approached it, but it has created a tension.

Baroness Barker: Seven years in to this Act, are you confident that people would recognise a deprivation of liberty and would know what the safeguards are that should be put in place?

Nadra Ahmed: I am not sure I would be confident, but I think we do have a piece of work that needs to go on around the way the process is working.

Sheila Scott: I am confident that the people that we represent know.

Nadra Ahmed: Yes, our members get advice.

Sheila Scott: They know how far they take it, because it has not proved to be the challenge that I had expected, but I am not confident that everybody knows, and I am not confident that some other services—different services from ours—know. I do not think it is too big a challenge; I just think that people have not got the information yet. I was surprised to have sat there and heard people say, “It is early days.” It is not early days. We are well in here. Some more awareness-raising and some more training and education needs to be done, and in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
I suspect it needs to be done by all of us together. I get more calls now about the ambulance service than I do about anything else. It is something new; people are more aware now. If somebody says, “My mother has said she does not want any active resuscitation to be going on,” for instance, even though it is there in writing, ambulance staff are nervous of that. I have started to speak to the ambulance service’s representatives just about the issue, not about training, but some joint training across the piece would be very helpful at this moment.

Q244 Baroness Hollins: Do you think your members get the appropriate combination of review, challenge and support about DoLS? If so, where from?

Sheila Scott: A lot of that responsibility lies with local authorities. Within our world, they are the lead authority. I would expect them to get it from us, but I would also expect them to be getting information from local authorities.

Baroness Hollins: I can see from your website that you do provide support to your members around such issues, but on the question of review and challenge, you would look to the local authorities.

Sheila Scott: Yes.

Baroness Hollins: Do you think it is happening?

Sheila Scott: It happens from both sides. It is one of the areas where a home is confident to challenge a decision that is made if they think it is wrong, and obviously local authorities do. There is some additional challenge from the Care Quality Commission inspectors, because they have a responsibility to check out anybody for whom a DoLS has been decided. It is one of those areas that people are prepared to have a professional talk about when there is a CQC visit, because I think that happens on both sides; it is both from the regulator themselves and from the provider.

Q245 Baroness Andrews: You have talked about the fact that you did not expect so many DoLS to be issued and you have talked a bit about many areas working well, but there are clearly big regional variations. I am just wondering whether you have any statistics that would allow us to see some of those patterns, and whether you can think of anything that can be done to address them.

Sheila Scott: I could write to you with more information. What has surprised us has been that there are some real regional variations about interpretation of the law and about paperwork—I would have thought the paperwork would be the same wherever—but also about what a DoLS is and what the responsibilities of the various parties are. One of our board members has raised quite frequently at board meetings the way DoLS is implemented in one particular area. She has got a care home in the North East and one in Somerset, so that is quite diverse. In one area she believes it is working the way it was intended to, and in the other area she thinks that the local authority is being over-strenuous in its actions.

Baroness Andrews: So, essentially, that is to say it is creating more DoLS. It is gold-plating, or misinterpreting—pushing the boundaries out.

Sheila Scott: That is what I think, yes.
**Nadra Ahmed:** There is too much inconsistency. A national understanding is not there at the moment.

**Baroness Andrews:** Is there anything that can be done with the Code of Practice or case studies or practice or further clarification or training or guidance? We know that is all a local variability as well, but thinking about the Code of Practice as the standard, is there anything that can be done?

**Sheila Scott:** There could be some much clearer statements around where a DoLS fits into, say, a care home for people with dementia. That does allow local interpretation. In my opinion, locking a front door is a normal safety precaution—I lock my own front door—but a front door may be locked following a risk assessment. It is whether or not the person can go out. The Code of Practice fudges that a little bit. It does not say yes; it does not say no. I think probably some people working on DoLS in the local authorities are looking to protect their own decision making as well as anything else. A bit more clarity around those particular areas might be helpful.

**Baroness Andrews:** Do you think that clarity can be attained?

**Sheila Scott:** Yes, I do.

**Q246 The Chairman:** Thank you. Could I ask you to provide some specific examples in writing of the local authorities that you mentioned who do not consult care homes or families before taking a decision to move, which you referred to in evidence? That might be quite helpful, if there are specific examples.

**Sheila Scott:** Yes.

**Nadra Ahmed:** We have some, yes.

**The Chairman:** You also offered a copy of your manual; please submit that as well.

**Baroness Andrews:** Lord Chairman, I wonder if we could ask Sheila and her colleague to provide two case studies for us that would show how the Code of Practice could pick up on those differences in terms of the application or the interpretation of DoLS that distinguish between the appropriate protection of people without capacity to go out and get confused and endanger themselves, and the actual deprivation of liberty, which is a human rights issue.

**Nadra Ahmed:** We would be happy to.

**The Chairman:** Thank you very much. Thank you very much for your evidence.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Centre for Disability Law and Policy welcomes the opportunity to make this submission on the Mental Capacity Act to the House of Lords Select Committee. The Centre for Disability Law and Policy (CDLP) at the National University of Ireland Galway was formally established in 2008. The Centre’s work is dedicated to producing research that informs national and international disability law reform, guided by the principles of the UN Convention on the Rights of Persons with Disabilities (CRPD). The Centre’s Director, Professor Gerard Quinn, led the delegation of Rehabilitation International during the negotiations of the CRPD in New York. Since its establishment, the CDLP has organised and participated in a number of key events regarding disability law reform and legal capacity. These include 3 national conferences in 2011, 2012 and 2013, held in conjunction with Amnesty Ireland, which explored how forthcoming Irish legislation can reflect the changes Article 12 of the Convention on the Rights of Persons with Disabilities demands. The Centre also participated in a Canadian conference titled ‘Taking Personhood Seriously: Legal Capacity Law Reform and the UN Disability Convention’ in 2011. The Centre is also a regular contributor of legislative and policy submissions on issues regarding legal capacity and made a submission on Legal Capacity to the Oireachtas Committee on Justice, Defence & Equality (2011).

**TABLE OF CONTENTS**

**EXECUTIVE SUMMARY**

1. The Centre for Disability Law and Policy (CDLP) welcomes the opportunity to make this submission in response to the Select Committee’s call for evidence on the Mental Capacity Act 2005 (MCA). The work of the CDLP is dedicated to producing research that informs national and international disability law reform, guided by the principles of the UN Convention on the Rights of Persons with Disabilities (CRPD). Since its establishment in 2008, the Centre continues to be a leading authority – nationally and internationally – on legal capacity and disability rights law, and will focus on these issues in its submission.

2. This submission aims to provide evidence for two key questions in the Select Committee’s call for evidence in the subsection on ‘Devolved administration and international context.’ It will first address question 27 by providing an analysis of the requirements of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and examine areas that the Mental Capacity Act 2005 may need reform in order to comply with the CRPD. In particular, this submission will focus on Article 12 CRPD, which sets out the right to equal recognition before the law, the right to recognition of legal capacity of persons with disabilities on an equal basis with others, and the right to support for the exercise of legal capacity. Further detail on the scope and application of this right will be provided with reference to the Concluding Observations of the Committee on the Rights of Persons with Disabilities. The application of these human rights norms to the content of the Mental Capacity Act is considered in this section.

3. This submission will then address question 26 by providing lessons learned from recent legal capacity reform efforts as well as good practices around the world. Particular
emphasis is placed on the Assisted Decision-Making (Capacity) Bill published in Ireland in July 2013, as an example of one attempt to legislate for systems of support to exercise legal capacity, in light of Article 12 CRPD. Other legislative examples are provided from the Representation Agreement Act of British Columbia, Canada, and the Persons with Disabilities Bill and National Trust Amendment Bill in India. Practical examples of good practice in developing support to exercise legal capacity are briefly considered, including supported decision-making pilot projects undertaken in a number of Australian States such as South Australia and Victoria.

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INTRODUCTION

4. Since the entry into force of the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2008, many countries around the world have struggled with the implementation of one of the Convention’s key articles – Article 12. This article recognises equality before the law, but also provides for the recognition of legal capacity of persons with disabilities in all aspects of life on an equal basis with others, and places an obligation on States Parties to provide persons with disabilities with the supports they may require to exercise their legal capacity.

5. Ireland is currently in the process of reforming its legal capacity legislation with a view to being able to ratify the UN CRPD. The CDLP led a coalition of NGOs in producing the Essential Principles for legal capacity law reform in Ireland, and gave evidence to the Houses of the Oireachtas Committee on Justice Defence and Equality in relation to the Scheme of the Mental Capacity Bill 2008. That submission provided evidence on legal capacity law reform from the perspective of the CRPD, and based on the CDLP’s experience of this process in Ireland and other jurisdictions.

6. The CDLP has been involved in numerous publications and projects worldwide related to the right to legal capacity, which are used to inform the present submission. For example, the CDLP co-ordinates the PERSON project to advocate for the reform of legal capacity and guardianship laws in several Balkan states. It also contributed to a series of recent reports by the European Union Agency for Fundamental Rights on legal capacity and independent living. Given this breadth of experience, the CDLP is well-placed to provide evidence to the House of Lords Select Committee on the compliance of the Mental Capacity Act with the CRPD, possible reforms which could enhance supports to exercise legal capacity for persons with disabilities in England and Wales, and other legal capacity reform processes around the world which may be relevant as the Committee considers possible amendments which could be tabled to the MCA.

Part I: UN CRPD Compliance

The requirements of the UN CRPD


228 See www.eu-person.com for more information.


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7. The United Kingdom ratified the CRPD on June 8, 2009 and its Optional Protocol on August 7, 2009.231 The UK has the potential to be a leader in implementing the Convention both because of its international obligations and because of its strong history of human rights protection.

ARTICLE 12: THE RIGHT TO LEGAL CAPACITY ON AN EQUAL BASIS

8. Article 12 of the CRPD protects the right to Equal Recognition Before the Law for people with disabilities. This right has its roots in both the Universal Declaration of Human Rights (Article 6) and the International Covenant on Civil and Political Rights (Article 16). The CRPD was the first international human rights instrument to enumerate the essential elements of this right for people with disabilities.

Article 12, CRPD

Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

9. The right to legal capacity in Article 12 refers both to the recognition of the individual as a holder of rights, as well as an actor under the law in “all aspects of life”.232 Article 12(3)


232 Office of the United Nations High Commissioner of Human Rights (OHCHR), Legal Capacity (Background Documents for the Sixth Session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
mandates that States “take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity”. Therefore, States must respect the legal agency and legal standing of people with disabilities on an equal basis with others and must provide access to support for the exercise of that agency and standing.

10. Article 12 of the CRPD demands a shift from substituted decision-making to supported decision-making mechanisms. While the UN Committee on the Rights of Persons with Disabilities has not yet provided a concrete definition of substituted decision-making regimes, it has found systems of adult guardianship, trusteeship, curatorship and judicial interdiction in the seven countries it has examined at the time of writing, to constitute substitute decision-making regimes which must be abolished in order to ensure compliance with Article 12. Drawing on these concluding observations, it can be surmised that impermissible substituted decision-making includes any system where 1) legal capacity is denied (even where this is only in respect of a single decision and based on an assessment of mental capacity), 2) a substituted decision-maker can be imposed on the individual against her will, and 3) any decision made is bound by what is believed to be in the objective ‘best interests’ of the individual — as opposed to the individual’s own will and preferences. This can happen through legislation, such as under the MCA, or through informal norms that allow others to make decisions using their judgment of what is best for the individual. In contrast, supported decision-making mechanisms for the exercise of legal capacity must respect the rights, will and preference of the individual. The aim of Article 12 is to guarantee the right to legal capacity and support for the exercise of legal capacity and thereby enable the realization of the right to equal recognition before the law for people with disabilities.

11. The support paradigm of Article 12 recognises that some people with disabilities will need access to informal or formal supported decision-making in order to exercise legal capacity. Supported decision-making models can vary greatly, and include practices such as setting up a specific decision-making agreement with chosen support people or receiving support from a community-based organization. A support paradigm demands that the people around the individual work hard to communicate with the individual and to provide the support necessary for the individual to express their will and preference and to act on it.

MCA Compliance with the UN CRPD


234 Ibid.

235 Canada, British Columbia, Representation Agreement Act, RSBC 1996, c. 405.

236 Swedish user-run service with Personal Ombud (PO) for psychiatric patients, PO-Skane, available at http://www.po-skane.org.

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12. England and Wales has been lauded for having a robust system of rights protections for people with disabilities. At the time of drafting the 2005 Mental Capacity Act (MCA), it was on the forefront of progressive legal capacity legislation. However, in recent years, since the adoption of the CRPD, there have been major advancements in the understanding of the rights of persons with disabilities. In particular, it has become clear that respecting equal legal personhood and ensuring the right to choice in decision-making is essential for human flourishing. Unfortunately, people with disabilities are often denied these opportunities and the MCA does not sufficiently protect against this. The MCA falls short in several aspects when compared with the standards established in Article 12 CRPD. The key problems with the legislation from the perspective of the CRPD are: the conflation of mental capacity and legal capacity in a functional test; the ‘best interests’ standard for substitute decision-making; and the legislative sanctioning of informal capacity assessments by third parties.

13. The MCA’s functional test of ‘capacity’ conflates the concepts of ‘legal capacity’ and ‘mental capacity.’ It is important for legislation to distinguish between decision-making ability (mental capacity) and legal capacity. All individuals have varying levels of decision-making ability. The right to legal capacity on an equal basis in Article 12 asks that regardless of an individual’s disability – which may include a decision-making impairment – his/her legal capacity is respected to the same degree as individuals without such disability or impairment. According to Article 12, every person has an inherent right to legal capacity and equal recognition before the law. It requires that states never deny legal capacity on the basis of disability, and instead provide appropriate assessments limited to what type of supports a particular individual needs in order to be able to exercise her legal capacity.

14. The MCA requires a two-stage test of mental capacity, which begins with determining whether the person has an impairment of the mind or brain. This automatically places individuals with cognitive disabilities (including learning disabilities, dementia, mental health issues, or neurological conditions) on unequal standing with all others being assessed for legal capacity, violating Article 12(2) of the Convention which states that...
persons with disabilities shall enjoy legal capacity on the same basis as others and in all aspects of life. The second step of the capacity test in the MCA is to ask whether the person is able to make the specific decision in question at the time it needs to be made. However, in order to recognize legal capacity for all, there should not be an assessment of whether a person is able to make a decision, but simply an assumption that they can and an effort to determine their wishes. By contrast, under Article 12, the more appropriate approach is to support the person to express their will and preferences, and use the individual’s will and preferences as the sole basis for the exercise of legal capacity. It is only where the will and preferences of the individual cannot be determined, after significant efforts to communicate with and support that person, that any other options, such as the introduction of a third party decision-maker, can be considered.

15. The MCA places the power to assess capacity in the hands of almost any third party who needs a decision to be made – without significant procedural protections. Article 12(4) requires that any assistance provided in decision-making must be accompanied with appropriate procedural safeguards, which are lacking when doctors, lawyers, and others are permitted to make ad hoc determinations of whether an individual has sufficient decision-making skills, and if they find that s/he does not, to make a substitute decision in that person’s ‘best interests.’

16. Finally, while the MCA does mention the importance of giving weight to the wishes of the individual, it still maintains the best interest standard as the primary means for decision-making. Article 12 makes no mention of best interests, and instead requires States to “respect the rights, will and preferences” of the individual. This is an important paradigm shift in decision-making assistance. It is putting the power back in the hands of the individual using the assistance. ‘Giving weight’ to wishes, beliefs and values, is a much lesser standard than the imperative to ‘respect’ the rights, will and preferences of the individual. In the best interest standard, it is judgment from outside the individual that substitutes the judgment of the individual him/herself. In a will and preference standard, the goal is to assist the individual to develop and/or express long and short term desires. This is an essential component of respecting the right to legal capacity. It ensures that people who need assistance in decision-making are able to receive that assistance, be respected as persons before the law, and have their will and preferences realized on the same basis as others.

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244 Mental Capacity Act 2005 Code of Practice, issued by Lord Falconer, Secretary of State for Constitutional Affairs and Lord Chancellor, Department for Constitutional Affairs, Page 41 (23 April 2007); The Mental Capacity Act (2005), Ch. 9, UK Public General Acts, Part I (2)(1) and Part I (3)(1) (England and Wales).


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17. The MCA is a substituted decision making model – whereby legal capacity is disproportionately denied to people with disabilities; the law validates third parties substituting their decision-making; and decision-making is based on the ‘best interest’ principle. Article 12 requires a move to supported decision-making where legal capacity is not disproportionately denied to people with disabilities and assistance with decision-making is based on the will and preference of the individual. While the principles underlying the MCA do require support for the individual prior to removing his or her capacity, the ultimate removal of legal capacity undermines the requirement of support. This does not fulfill the Article 12 requirement of support because support should occur in replace of, not merely as a supplement to, the removal of decision-making power from the individual. The UN Committee on the Rights of Persons with Disabilities has been extremely clear on this point – it is not appropriate to simply introduce supports to exercise legal capacity along with the maintenance of substituted decision-making systems.

18. The Mental Capacity Act of 2005 was a step in the right direction and is a distinct improvement upon the prior guardianship system in England and Wales. However, with the UK’s ratification of the CRPD, England and Wales must modify its system further to come into compliance with the Convention and to uphold the human rights of individuals with disabilities. This requires the eradication of substituted decision making under the MCA and its replacement with the supported decision making system required by the CRPD. This should include shifting of resources from the old system to a new system that is premised on support.

Part II: Learning from Other Jurisdictions

The Irish Law Reform Process

19. The Scheme of the Mental Capacity Bill published in Ireland in 2008 closely mirrored the MCA of England and Wales in several respects. However, in hearings on the Scheme held by the Oireachtas (Parliamentary) Committee on Justice, Defence and Equality in 2012, evidence was heard suggesting that the ‘best interests’ standard was inappropriately paternalistic, and its inclusion in the legislation was contrary to the UN CRPD. The Oireachtas Committee also heard evidence that ‘legislation must be based on supported decision making’ in accordance with the UN CRPD. The House of Lords Select Committee may find it instructive to look at the changes adopted under the new Assisted Decision-Making (Capacity) Bill in Ireland, in response to these concerns.


252 Gordon R. Ashton, Mental Capacity: The New Law, 5 P.C.B. 299-302 (2006). Gordon R. Ashton describes how the previous guardianship system was more restrictive, provided the individual with very little control, and did not provide an assumption of capacity.

253 Available at http://www.oireachtas.ie/viewdoc.asp?DocID=24147&&CatID=59. In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
20. **A ‘functional’ approach to capacity**

Disappointingly, the Irish Bill continues to retain a functional approach to ‘mental capacity’, which is very similar to the MCA (§3). Unlike the MCA, the Bill does not include a ‘diagnostic threshold’. This might be thought to reduce any discriminatory application of the functional approach to capacity, and therefore be more in accordance with the CRPD. We would caution against that view, as the functional test is still likely to be disproportionately applied to people with disabilities. Expanding the category of people potentially subject to substituted decisions would not help legislation better comply with the CRPD requirement that regimes of substituted decision making be replaced with supported decision making.

21. **‘Best interests’**

The new Bill does not include a single reference to ‘best interests’. The Bill does, however, permit some ‘interventions’ on the basis of functional incapacity. Since these ‘interventions’ may constitute a form of substituted decision-making, which has been prohibited by the Committee for the Rights of Persons with Disabilities, this is problematic from the perspective of the CRPD. Nevertheless, these interventions still differ in important respects from the ‘best interests’ approach of the MCA.

22. **The MCA uses an ‘objective’ test of best interests, where a person’s wishes and preferences are one factor among many to be considered – neither are they necessarily the most important factor (**ITW v Z & Ors [2009] EWHC 2525 (Fam)**). By contrast, §8(7)(b) of the Irish legislation specifies that those ‘intervening’ in respect of a person shall ‘give effect, in so far as is practicable, to the past and present will and preferences of the relevant person, in so far as that will and those preferences are reasonably ascertainable’. This accords respecting and fulfilling a person’s will and preference a much higher priority than under the MCA.

23. **The ‘least restriction’ principle**

The MCA requires that before any act is done in a person’s best interests, ‘regard must be had’ for whether it can be done in a way which is less restrictive of a person’s rights and freedom of action. As noted in **Re P [2009] EWHC 163 (Ch) §41**, this is merely an obligation to **consider** not to **follow** that course of action. By contrast the Irish Bill specifies that:

- (6) An intervention in respect of a relevant person shall—
  - (a) be made in a manner that minimises—
    - (i) the restriction of the relevant person’s rights, and
    - (ii) the restriction of the relevant person’s freedom of action, and
  - (b) have due regard to the need to respect the right of the relevant person to his or her dignity, bodily integrity, privacy and autonomy

This is a much higher threshold for any interventions which contravene a person’s will and preference or which otherwise restrict their autonomy, or interfere with their privacy or bodily integrity.

24. **Assisted Decision-Making and Co Decision Making**

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The Bill includes two specific statutory regimes of supported decision making: Assisted Decision-Making (§9-§12) and Co Decision-Making (§16-§22). Both types of support arrangements must be made with the consent of the relevant person, who may nominate a suitable person of their choice to act as an Assisted Decision-Maker or Co Decision-Maker. This person will very often be a relative or friend. An agreement sets out the duties of the Assisted Decision-Maker or the Co Decision-Maker. In the case of Co Decision Makers, this agreement only becomes valid when a court order has been made confirming that the agreement is in accordance with the relevant person’s will and preference. Both these arrangements reflect provisions in Canadian legislation, discussed below.

25. The functions of Assistants (under Assisted Decision-Making Agreements) are:

1. (a) to advise the appointer by explaining relevant information and considerations relating to a relevant decision,
2. (b) to ascertain the will and preferences of the appointer on a matter the subject or to be the subject of a relevant decision and to assist the appointer to communicate them,
3. (c) to assist the appointer to obtain any information or personal records (in this section referred to as “relevant information”) that the appointer is entitled to and that is or are required in relation to a relevant decision, and
4. (e) to endeavour to ensure that the appointer’s relevant decisions are implemented

26. In accordance with their role, Assistants may access the relevant information to help a person to understand the relevant decision. Although many people with impairments affecting communication and understanding may informally benefit from somebody playing such a role, giving the relationship statutory footing may help many difficulties they can experience. The agreement may help friends, carers or non-statutory advocates acting as Assistants to access the relevant information to support a person. Often health and social care professionals are unfamiliar with a person’s mode of communication, and this can help to formalise the role of an Assistant in understanding and facilitating their communication. The role of the Assistant in endeavouring to ensure that a person’s decisions are implemented is also important from an advocacy perspective, where people may struggle to follow up on their decisions without support.

27. Although the MCA does say ‘A person is not to be treated as unable to make a decision unless all practicable steps to help’ have been made (§1(3)) and ‘A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means)’ (§3(2)), this is framed in the passive voice. This is problematic, as those assessing capacity may not be familiar with a person’s communication method, and they may not have the time or a relationship of trust with the relevant person which enables them to provide appropriate support. Whilst these general provisions for support are retained under the Irish Bill, Assistant Decision-Makers are much more sensitive to the importance of recognising relationships which underpin support.

28. Co Decision Making Agreements, when they have the force of a court order, mean that any decisions within the scope of the agreement (and any relevant documentation signed) are only valid if both a person and their co decision maker have signed them. In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
effect, both the relevant person and the co-decision maker retain a veto for decisions which will affect a person. This is advantageous for (at least) two groups. Some people may find it difficult to make some decisions, enter into contracts and so on for themselves, but may have a trusted person in their lives who they would like to do so on their behalf. These agreements would enable them to nominate that person but – unlike a Lasting or Enduring Power of Attorney – they can still exercise a veto over any decisions that person makes which they disagree with. Secondly, people who consider that their ability to make good decisions fluctuates, or they are prone to making impulsive decisions which they later regret, may think that requiring a person whose judgment they trust to sign off on any decisions would be desirable. Co decision-makers must acquiesce to their decisions if it is clear that ‘a reasonable person could have made that relevant decision’ and ‘no harm to the appointer or any other person is likely to result from that relevant decision’. Although some questions remain about how easily a person may be able to extricate themselves from co decision-making if they find it does not work for them, this measure provides much more concrete requirements for collaborative and consensual working with people than frameworks like §4 MCA which merely require that they are ‘involved’ in, and consulted about, decisions about their lives.

29. Court procedure

Many jurisdictions, including England and Wales under the Court of Protection Rules 2007, do not require judges making major decisions relating to a person’s legal capacity to meet the person him or herself. Insofar as this relates to a failure to facilitate a person’s attendance in court, this is not in accordance with the requirement of Article 13 CRPD on access to justice (and Article 9, on accessibility). If the failure to facilitate the person’s attendance at court is premised on a person’s alleged ‘incapacity’, it will also fall afoul of Article 12 CRPD and the enjoyment of equal recognition before the law. Given the centrality of the principle of inclusion, and respect for a person’s will and preferences for the exercise of their legal capacity, under the UN CRPD, it is not tenable for courts to fail to meet parties to proceedings on disability-related grounds. It is also increasingly unacceptable under the European Convention on Human Rights for them to fail to do so (e.g. X and Y v Croatia (App no 5193/09) [2011] ECHR 1835; Lashin v Russia (Application no. 33117/02) [2012] ECHR 63). Under §107 of the Assisted Decision-Making (Capacity) Bill, there is a presumption in favour of any applications under the Bill being heard in the presence of the relevant person.

30. Advocacy

One important element missing from the Irish Bill is the provision of independent advocacy to support people in exercising their legal capacity. We note that the MCA does provide for ‘Independent Mental Capacity Advocates’, for which England and Wales is to be applauded. However, we are concerned that this form of ‘best interests’ advocacy may not be effective in ensuring that people’s will and preferences are given centrality, nor that people are entitled to statutory support in making decisions for themselves and avoiding ‘best interests’ decisions. It is also concerning that it is unclear whether IMCAs are required to support a person to challenge decisions which do not accord with their will and preferences if the IMCA themselves does not regard this as being in their best interests. We submit that whilst non-instructed advocacy is very important for people with communication impairments, this

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does not reflect best practice where a person is able to communicate their will and preferences.

**Legal capacity in India, Canada and Australia**

31. In light of the requirements of the CRPD as well as a decades-long push from civil society, several other jurisdictions are currently in the process of reforming their legal capacity laws. Much can be gained from examining these processes and their successes. While there is still some question about whether Canadian jurisdictions are fully compliant with Article 12, some provinces have made significant progress on instigating supported decision-making mechanisms within their substituted decision-making regimes. For example, in 1996, after a groundswell of civil-society advocacy, British Columbia enacted the Representation Agreement Act (RAA). The RAA allows an individual to nominate one or more people to act as their supporters or representatives in making legally binding decisions and exercising legal capacity. Importantly, the diagnostic threshold to determine who is permitted to create a representation agreement is flexible enough to allow a person with a diversity of decision-making skills to enter into agreements.

32. Similar to Ireland, India currently has a new legal capacity bill that will shortly be put before the parliament. It also has a separate bill that proposes amendments to its National Trust Act, which would provide the structure for the blossoming of a new supported decision-making mechanism. Interestingly, the Indian bill reforming legal capacity law proposes to maintain a substituted decision-making partial guardianship regime for those that are currently under guardianship. However, all individuals in the future who are in need of decision-making assistance, will be provided with access to the support system set up in the National Trust Act.

33. There are several pilot programs on supported decision-making happening around the globe. Some of the most successful and well developed are in Australia. The South Australia Office of the Public Advocate successfully completed a supported decision-making pilot in 2012 and continues to expand activities in this area. The Victoria Office of the Public Advocate is currently undertaking a similar pilot program and has received a sizable grant to do so.

34. Finally, it is worth noting that the Good Friday/Belfast Agreement contained a commitment to ensure that “equivalence” of human rights protection (in particular

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related to equality of opportunity) would be ensured in Northern Ireland and in the Republic. Northern Ireland is currently developing new legislation on mental capacity and mental health, and meetings of officials from the Departments of Justice in both Northern Ireland and the Republic have been held, to discuss the proposed legislative reforms in both jurisdictions. Developments in Northern Ireland are therefore also worth following, especially as the new legislation on capacity purports to implement Article 12 CRPD.

Conclusion: ‘Nothing About us Without Us’

35. ‘Nothing about us without us’ is a common refrain within the disability rights movement, meaning that policy decisions which affect people with disabilities should be made in close consultation with them. This concept animates several elements of the UN CRPD, in particular Article 33 (on monitoring the CRPD) and Article 4(4):

5. In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.

36. We note in passing that this call for evidence was drafted in language which may be inaccessible to many people directly affected by the MCA. We hope that the Committee will take steps to capture their voices, views and experiences in other ways.

37. There is a wealth of research evidence which suggests that people with disabilities, and older people, experience considerable frustration and distress by the denial of choices about their lives which are available to others, and that this can lead to mental health problems in its own right. Yet there is a paucity of evidence about the experiences of those said to ‘lack capacity’ under the MCA. To the best of our knowledge, not a single published research project has explored capacity assessments and best interests decisions from their perspective. Consequently, the literature on the MCA is generally informed by the perspectives of those empowered to make substituted decisions under the Act: caregivers, and health and social care practitioners. The Committee must be very cautious of accepting their views at face value. The empirical research by the European Union Agency for Fundamental Rights did collect the views of citizens denied legal capacity within the EU; here is the only available quote from the UK:


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6. ‘My mum is my guardian and I can’t say ‘no’ to her. If she wants me she can phone up the house. And the house phones her. Everything is controlled by her. And I can’t breathe. Because she’s there – in my face. In this. In that. And you know she’s everywhere. […] I know she’s my mum but I’ve tried to move away from her slowly but it’s not working.’

38. We suggest that the Committee work with user-led organisations for people with disabilities and older adults to explore the experiences of those directly affected by the MCA.

2 September 2013


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Mark Neary – Written evidence

I am submitting my contribution to the House of Lord’s Committee’s call for evidence on the Mental Capacity Act. I am the father of Steven Neary, who in 2011, was at the centre of the Neary vs Hillingdon case (EWHC 1377 COP) which attracted a huge amount of media and public interest. During that time and since, I have gained a large personal experience of the MCA and the Deprivation of Liberty Safeguards and due to the public profile of our case, I am regularly contacted by people seeking advice and support, who are caught up in similar situations to the one Steven and I found ourselves in 2010. At this present moment in time, I am in the process of setting up a charity, the Steven Neary Foundation. One of the aims of the foundation is to provide emotional and psychological support to people caught in disputes, including disputes over application of the MCA. This submission is, therefore, a distillation of my own experience and of hundreds of people I have met since 2010.

Nailing my colours to the mast early on, I believe that the core principles of the MCA are sound and appropriate for the people the Act is meant to serve. In my experience, it is the interpretation and operational application of the Act, that at times, leaves a lot to be desired. The evidence I am submitting shows that, at worst, the MCA is either completely ignored or is manipulated to either conceal or pursue another agenda. Either way, these actions have grave implications for justice for the people who fall under the scope of the Act. I’d like to think that the Neary vs Hillingdon case is untypical but I think it graphically illustrates what can happen when the mental capacity act is ignored, turned on its head or used to prevent proper scrutiny of the professional’s actions. Sadly though, through my contact with other parents and carers, I know that Steven’s case is not a one off and without proper external scrutiny, the Act can be easily misused. As Justice Peter Jackson stated in the judgement he made in the Neary Case:

“In this case, far from being a safeguard, the way in which the DoLs process was used masked the real deprivation of liberty, which was the refusal to allow Steven to go home” (Para 33)

The following submission will substantiate these two main concerns:

1. The interpretation and implementation of the MCA
2. The lack of adequate scrutiny of the outcomes of the Act.

It will examine these concerns arising in four main areas: Mental Capacity and Best Interests; Mental Capacity Assessments; the Deprivation of Liberty Safeguards; and the relationship between the Mental Capacity Act & The ECHR.

2. Mental Capacity & Best Interests:

I believe that an assessment of capacity, followed by, if appropriate, an assessment of best interests, is the right way of supporting people covered by the MCA.

However, I know from our case and from others’, that these two foundation stones are quite frequently ignored. In our case, a decision was made from very early on – that Steven could not return home and instead be sent to a residential establishment. Neither Steven,
myself or any other independent person were involved in that decision. Having made that
decision, the LA then launched into proving that Steven did not have the capacity to decide
where he wanted to live. The referral letters as shown in court were incredibly leading and
Justice Jackson declared that they: “hardly provided a neutral summary of events as a basis
for professional advice” (Para 77). Having contrived the outcome of the mental capacity
assessment, the next step should have been to carry out a best interests assessment but as
Justice Jackson stated, “no attempt was made at the outset to carry out a genuinely balanced
best interests assessment, nor was one attempted subsequently” (Para 155). So, the
consequences of a contrived capacity assessment and an unbalanced best interests
assessment was that the LA had carte blanche to carry out their original decision with only a
cursory nod towards the MCA. I have heard several stories of the cart being put before the
horse (i.e. the best interests’ assessment preceding the mental capacity assessment) but as
our case shows, sometimes a decision will be made about an incapacitated person without
any reference to the horse or the cart!

Ultimately, I feel that the principles of the MCA, like many other innovations in social care
(personalisation, independent living, and individual budgets to name three) are always at risk
of being misappropriated. And when that happens it can be doubly damaging for the service
user. The huge difference between the presentation/rhetoric and the person’s reality can add
considerably to the problems they are experiencing. In our case, I became terribly confused
in the early days about the Deprivation of Liberty Safeguards. What I was reading and the
fundamental use of the word “safeguards” seemed very positive; they certainly provided a
mechanism for getting out of the nightmare situation we were in. However, our reality
couldn’t have been more negative. “Safeguards” were in place but Steven wasn’t allowed to
come home; plans were being made to move him 200 miles away; all his activities that give
him his quality of life had been stopped; and his important relationships, especially with me,
were being severely curtailed. There didn’t appear to be anything that was happening that
even remotely resembled a safeguard. Once it became clear that the LA had misappropriated
the DoLs legislation to serve their hidden agenda, perversely things became better. The
outward situation didn’t change but I was able to see the MCA for how it was intended to
be; rather than how it was being manipulated and presented. From that point, challenge
became easier and Steven was soon returned home.

To sum up, the principles of the Act can be transformative when applied correctly and
genuinely in P’s best interests. But when they are abused and leave the service user
struggling between the ways the Act is being presented and the real experience they are
having, this is hugely problematic. I have worked with many people for whom the
presentation of a reality that is at huge odds with their own perception of their reality can
be extremely challenging. Obviously, the MCA does not set out to create these sorts of
situations but as I have found, they can all too frequently occur through improper application
of the Act.

3. Mental Capacity Assessments:

In the last three years, Steven has had five mental capacity assessments; three to determine if
he has the capacity to decide where he wants to live; one to determine if he can manage his
own finances after receiving damages for the events of 2010; and one to determine if he has
the capacity to manage a tenancy. Three of those assessments were carried out by people
meeting Steven for the first time; one by a person who had had cursory contact with Steven
a few years previously. This doesn’t help the person being assessed at all. There is a huge

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submissions.
pressure on P in these assessments; they are having to demonstrate many things that a non learning disabled person would never have to be assessed on. The Act requires P to be supported through the assessment but if the assessor is meeting P for the first time, they won’t have the knowledge to provide adequate support. At the three assessments Steven had whilst he was detained, neither myself nor his regular support workers were allowed to be present (in case we led Steven, or prejudiced the outcome). This puts P at a considerable disadvantage and from the outset, shows that a supportive process has turned into an adversarial one. Steven communicates a lot through song. He will try to communicate verbally but if he gets stuck or is not being heard, he will search his extensive database of songs, for a lyric that he believes will try and convey his message. Anyone who knows Steven will be aware of this and will be especially alert for this type of communication. At Steven’s assessment to determine if he could manage a tenancy, he showed me that he understood some of the concepts. Unfortunately for him, he used a Pet Shop Boys song to convey his understanding and this was dismissed by the assessor. I’m not saying that this would have made any difference to the final outcome but by taking this way of communicating on board, she may have opened up a door for Steven that could have been used further to explore his capacity. My point is, in order for P to be fully assessed, the assessor needs a solid understanding of how P communicates and that takes time and commitment that isn’t often available. Certainly, in my experience, the time and commitment doing the assessment nowhere near matches the seriousness of the issues at stake for P.

By far, I believe the biggest problem with a mental capacity assessment is the almost total reliance on capacity being determined by assessing P’s cognitive functioning. Sadly, like the previous paragraph, I have read the Act and can see that the problem lies in the application rather than with the Act itself. The Act does give the assessor the opportunity to take other functioning resources into account but these are barely acknowledged in an assessment. If, like in Steven’s case, P is being assessed on their capacity to decide where they should live, they are expected to demonstrate that they can make a “rational” decision, by retaining and weighing up several pieces of data. That is extremely restricting and dare I suggest it, verges on discriminatory. I work as a psychotherapist and know that most people draw on several internal resources when making a decision. We use our intuitive response; we use our emotional feeling; we act on fear and anxiety; we put off making decisions; we even make decisions that we know are wrong. We have a bank of resources to call upon. So does P but he/she is not afforded that same latitude. Their parameters are narrowed to a purely cognitive process, which for many learning disabled people may be the hardest of their resources to access or articulate. In his assessment, Steven was asked why he wanted to live in his own home. He came up with a long list of reasons, all important to him in regards to the quality of his life. He talked about using his computer, listening to his CDs, watching his DVDs; seeing his friends out of the window; talking to his uncle on the phone (none of which he’d been allowed to do in the Unit). I thought these were brilliant reasons but when I got the report, their main emphasis was that Steven didn’t understand the risks his behaviour might represent in his home. I agree that Steven would have found this a difficult subject to reflect on cognitively, not least because the idea was based on an assumption by the LA and bore no resemblance to his actual behaviour at home. But somehow, the conclusion was drawn without any direct questions asked on the subject. He answered what he was asked. I understand the preference of using cognitive functioning as the sole gauge of capacity. We live in times when everything has to be measured and if something is not immediately measurable, we are suspicious and intolerant of it. We diminish it’s importance. That may be fine in certain situations, but when we are dealing with vulnerable people, who
are likely to have communication difficulties, we are setting them a task that is weighted against them from the outset.

The very nature of mental capacity assessments means that they are always about the most major life decisions, so it cannot be right that a disadvantaged person is at a disadvantage before the first question is asked. The day after Steven was deemed to lack capacity to decide where he wanted to live, I conducted a quick poll at work of four clients, each wrestling with major life decisions (whether to get married; whether to stop chemotherapy; whether to leave their job and move abroad; whether to place their mother in a care home). Two people made a decision mainly using their gut instinct; one made a decision that they were unhappy with but felt it would rock the boat the least; the other still hasn’t made a decision three years later. That is how most people make decisions; it’s a shame that P has to go through so many hoops and even more of a shame that resources that may help them with those hoops are denied them. For a mental capacity assessment to be fair, to be supportive of P, and to be realistic, it has to take all those internal resources and functioning into account.

4. Deprivation of Liberty Safeguards:

As a result of the Neary case, my main personal experience of the Mental Capacity Act is with the Deprivation of Liberty Safeguards. I take a keen interest in the scheme and am regularly invited to speak at conferences on the subject.

This section addresses several issues relating to DoLs that I believe warrant attention. These include; the possibility that the DoLs scheme is being avoided; the inconsistent use of DoLs; the difficulties of securing IMCA representation; the lack of clarity about deprivation; the potential resistance to the scheme; and the lack of effective monitoring of the scheme.

4.1 Challenging a detention without a DoL: I am often contacted by people who have a relative in a care home and both the person detained and their relative don’t want them to be there but somewhere else instead. That seems to me that we are immediately in DoL territory. But in none of these cases (and I’m estimating near to 100 people since 2011) is a DoL in place. Despite its faults and the cumbersome and at times, impenetrable nature of the DoL legislation, the scheme does give the means to the detained or the representative to challenge the detention. Without a DoL, a challenge is nigh on impossible. Justice Jackson said that DoLs must not be used by authorities to get their own way; I suspect that many authorities may not be even using DoLs as a means of getting their own way. Just this morning, I was contacted by a man whose mother has been trapped in a care home for the last seven months without a DoL, despite the fact that both mother and son want to be at home. She has been diagnosed with early stage dementia and her son maintains that at this stage, a mental capacity assessor would be hard pushed to determine that she lacks capacity. She had a minor operation last year and a condition of her discharge was that she went initially to the care home. It was never suggested to either P or her son at the time, that the move might be a permanent arrangement. Part of the Authority’s rationale for keeping her in the home is that she has a degenerative condition, with the implication being that she is going to get worse in the future. They might be right but a mental capacity assessment only works in the present tense. But by not considering a DoL, the authority believes it is under no obligation to consider a mental capacity assessment – they are of course, but by bypassing one piece of legislation, it is easier for them to bypass another. A DoL would offer the family legal aid to challenge the detention but as there is no DoL, the family don’t qualify.
for legal aid but cannot afford representation themselves. The absence of a DoL leads to many locked doors.

4.2 Variations in DoLs across the country: I have read many speculative discussions about the reasons for the huge variations in DoLs’ authorisations across the country. How can you have two neighbouring boroughs with the lowest and highest authorisation rates in the country? I’d suggest that the main reason is the one I’ve mentioned in the above paragraph; Authorities, for whatever reason, are choosing not to implement DoLs. There can’t be many areas of law where the persons given the power to carry out the law, select to ignore it. For me, that raises questions about the monitoring of the DoL scheme. I’ve seen the official statistics published by the Department of Health and read the analysis of those statistics but they all seemed based on an assumption that doesn’t include the possibility that some authorities are quite simply ignoring the scheme. I may be wrong but I haven’t seen any analysis of the non authorisation of DoLs and no scrutiny into the paucity of DoLs in certain areas. It is one thing to monitor a DoL that has been authorised but quite another thing, if it neglects a crucial first stage in the process and leads to situations like the mother and son above find themselves in.

4.3 IMCA Provision: In the Neary vs Hillingdon case, Justice Jackson decided that many things that could have progressed the natural process of justice were blocked: important reports were suppressed; “window dressing” plans were put in place; and crucially in relation to DoLs, Steven was denied an IMCA. If I could have one wish about changes to the DoLs scheme, it would be that P or their representative could be able to contact the IMCA service directly and not have to rely on a referral from the supervisory body. To put it bluntly, if the supervisory body, for whatever reason, does not want P to have an IMCA, then you cannot get independent advocacy. I have met several IMCAs since 2011, who commonly express their frustration that there is little they can do if they receive a self referral. Part of the problem may be the funding; who is going to pay the IMCA service if the supervisory body won’t instigate the process. Also, rightly or wrongly, it is a common perception that an IMCA carries more weight than P or their relevant person representative. To act alone, without an IMCA is indeed a daunting process and obviously an IMCA will have an understanding of the law and the process that the RPR is unlikely to have. The absence of an IMCA slows down the process and ultimately slows down the process of bringing a case before the court, and therefore depriving P of a speedy decision by the court under Article 5 (4) ECHR. I understand the official DoH statistics reveal that the actual appointment of an IMCA has been much lower than expected. I believe the lack of an IMCA in so many cases can only be down to two things: ignorance of the Act, or a conscious decision has been taken by the supervisory body not to instigate an IMCA referral. Either way, this is very bad news for P. And like other points I have raised in this submission, where is the external scrutiny?

4.4 Definition of a DoL: This may be stating the obvious but I do feel that for everyone involved in a DoLs case, much clearer guidance needs to be given as to what constitutes a deprivation of liberty. I acknowledge that there was a small body of case law emerging that was starting to bring clarification. I have been involved in training for best interest assessors both before and after the Cheshire West case and I can see that the Cheshire judgement has led to lot of uncertainty amongst professionals. It feels like the DoLs scheme is in a state of unhelpful limbo until the outcome of the appeal this autumn. I have observed through attending the training, that even when a specific case is presented as a case study, there is often endless discussion about defining what the actual deprivation of liberty is and no
concrete agreement is reached by the end. Whilst I accept the reasons for the lack of clarity, if you are P, this can be very damaging and can lead to large variations in the content and conditions of the authorisations.

4.5 Resistance to a DoL: In a similar vein, it seems to me from conversations I have had with some professionals charged with administering the DoLs scheme, that the name itself causes problems for some involved. Not a lack of understanding but a resistance to the negative connotations of the scheme’s name. I know that my LA view the positive behaviour unit where Steven was detained, as a jewel in their crown. They see it as an open, positive establishment founded on strong person centred principles. My experience of the place may be different but that is besides the point. It follows that there will be a natural resistance to viewing the unit, which the management see as a beacon of good, as a place where someone might be deprived of their liberty (the the negative sound of “deprivation of liberty” outweighing the positive sound of “safeguards”). I remember from Steven’s time in the unit (and this is before DoLs became part of the LA’s agenda), feeling that certain “house rules” were endemically “depriving” but not recognised as such. For example, the residents weren’t allowed to invite guests to their rooms; the important private, family contact had to take place in the very public bustling dining room. If nothing else, that one rule, compromises P’s right to a private life and space but the managing authority would not view that as a deprivation. To them, it was a perfectly valid house rule based on health and safety, and “respect for all residents”. Obviously, one single example of a house rule does not make a deprivation of liberty, but a whole set of rules and practices can add up to a deprivation.

4.6 The Commercial World & DoLs: Many care homes are commercial enterprises and their first priority will be their revenue stream. I would question whether, with the negative connotations of the phrase “deprivation of liberty”, those care homes would be keen to announce on their attractive websites the number of people in their properties under a DoLs authorisation. I have met someone who works in a privately owned care home and he told me that they are actively discouraged from adopting any practices that might jeopardise the home’s commercial standing. I was shocked to hear that his management team would include the deprivation of liberty safeguards under the banner of “practices” and therefore important safeguards for their residents were put second to commercial interests. Whether this action stems solely from the name of the scheme is hard to tell, but it can hardly help.

4.7 Monitoring the DoLs Scheme: Some time ago, I was discussing the annual DoLs statistics produced by the Department of Health with a work colleague. My colleague was fully aware of the Neary vs Hillingdon case and had a background in social care, albeit before the MCA. We were discussing two neighbouring boroughs, both close to our workplace. Authority A had issued 212 DoLs authorisations; Authority B had issued 19. Both boroughs were very similar in terms of its age demographic and the number of care homes. After reading the documentation, my colleague asked me: “So which is better – who is doing their job properly? The one with 212 or the one with 19”? The question stopped me in my tracks because the answer is that the statistics reveal absolutely nothing about the propriety of the implementation of the scheme. There seems to be a totally inadequate monitoring of the data produced by the DoLs scheme.

4.8 Monitoring the LA: One final point and it follows on from the previous paragraph, is that I feel that there is a gaping hole in the monitoring of how the scheme is being implemented, notwithstanding the concerns I expressed above. The CQC can monitor the care homes, the hospitals but it not within their remit to monitor the local authorities. That in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
seems like a massive oversight to me. As our case proves, the local authority can get it seriously wrong and luckily the court of protection was there to provide a thorough scrutiny. But few DoLs cases come before the court, so presumably those supervisory bodies, that don’t activate the court process, receive no attention at all. That cannot be right.

5. ECHR
I find it also striking that there seems to be a lack of a working interface between the MCA and the ECHR, especially amongst those charged with implementing the Act. There are many court judgements that appear to be primarily about an MCA best interests decision but where the final judgement is heavily informed by or driven by the ECHR.

In Neary vs Hillingdon, Justice Jackson said: “Hillingdon approached matters without proper regard to the principles set out in the previous paragraph” (i.e. a best interests assessment that takes into account P’s rights under Article 8 ECHR) (Para 155 (1))

I believe the articles held in the ECHR should lead the decision making of the MCA, especially when it is a best interests decision. I’m not convinced that the professionals working with the MCA factor into their decision making, the rights of the convention. Certainly, in Steven’s case, in the many reports written during his time in care, there is absolutely no mention of the ECHR. Considering that so much of the final judgment rested on Article 8, I find it shocking that nobody within the supervisory authority or the managing authority felt that Steven’s right to a family life was important.

Steven’s case, from the point of view of the LA, was all about risk; the drive to eliminate risk trumping a fundamental human right. The same could be said of the case of Peggy Ross, the elderly lady who was prevented from going on her annual cruise with her partner because the LA considered the risk too great. In fact, like Neary, Cardiff CC used the DoLs scheme as leverage for their own position.

With LA’s fixation on risk, which probably stems from a fear of liability, not only are P’s human rights ignored but the MCA is used against P, rather than for them.

6. Conclusion
I hope that my evidence demonstrates the real life experience of the MCA and DoLs from the point of view of the service user and their representative. The main body of my evidence comes from my direct involvement in the Neary vs Hillingdon case but I hope that I have established the concerns held by many people that come under the remit of the scheme.

2 July 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
TUESDAY 12 NOVEMBER 2013

Members present

Lord Hardie (Chairman)
Baroness Barker
Baroness Browning
Lord Faulks
Baroness Hollins
Baroness McIntosh of Hudnall
Baroness Shephard of Northwold
Lord Swinfen

Examination of Witnesses

Elmari Bishop, Statutory Development and Training Lead, MCA and DoLS, South Essex Partnership University NHS Foundation Trust (SEPT), and Mark Neary, parent of adult son found to be unlawfully deprived of his liberty by London Borough of Hillingdon in 2010

Q260 The Chairman: Good morning and welcome to this second part of today’s Committee. As with the previous witnesses, I would like to thank you for your written submissions. This session is intended to supplement the submissions and to go into more detail about issues that the Committee wish to explore. Could I ask you to be as concise as possible in your answers? We have a lot to cover and there is limited time available. As I said to the other witnesses, if you agree with the other witness, simply say so and do not repeat the evidence, because it does not make it any better. I should remind you that the session is being recorded, transcribed and currently broadcast on the parliamentary channel.

Could I start by asking the first question of this session? There has been a lot of evidence about non-compliance with the Act. Both of you have experience of poor practice of the Act in relation particularly to deprivation of liberty, but from different perspectives. Despite that, in each of your written submissions you are supportive of the Act. Can you explain why?

Mark Neary: In my case, my son Steven was held unlawfully under a deprivation of liberty for a year, and for all the way in which the Act was turned on its head, as the judge said, I am...
in no doubt that without the Act Steven would now be in that care home in Wales that Hillingdon intended to send Steven to. It was due to the Act being in place that we were able to get an IMCA to act as support for Steven and me, and then bring the matter before the courts. I have no idea whatever, if the Act had not been in place, how on earth we would have been able to have challenged that.

Elmari Bishop: The Mental Capacity Act and Deprivation of Liberty Safeguards are quite vital pieces of legislations. If applied correctly, it provides really valuable safeguards, as in Steven’s case, to a very vulnerable group of people. However, the problem is that it is not always applied in the spirit that was intended, and this is the main reason why we see so many failures. For me, the Mental Capacity Act is a piece of legislation that professionals should use to empower and protect people who cannot make decisions for themselves and to involve the person and the family, look at all available options and consider what would be the best for that person. However, in my experience, not necessarily in my organisation but more nationally, the cases that I come across where there has been particularly poor practice are ones where it was used not to empower or to protect but to compel and to coerce and for professionals to get their way in doing what they want to do. Many families have told me, “The social worker said they are using Section 4 of the Mental Capacity Act to do this”, and families do not seem to quite understand that there is no such power, especially like in Steven’s case, to just override the person or family’s wishes without going to court. If the Mental Capacity Act is applied correctly, it should protect people, and I find that a lot of professionals still apply it as a way of getting what they think would be best.

The Chairman: Thank you. Why do you think the non-compliance is so widespread?

Elmari Bishop: A lack of understanding amongst professionals, not a lack of awareness. Everyone knows there is a Mental Capacity Act and there are Deprivation of Liberty Safeguards, but people do not always understand how to apply it in practice and to individual cases. Many professionals blame the Mental Capacity Act for being overcomplicated, but you have quite a simple piece of legislation, a very workable piece of legislation, that you are trying to apply to very complex situations. Professionals do not always understand how to apply it in different cases, and specifically how to resolve conflict. When they are trying to make best-interest decisions and there is a lot of conflict, they do not always understand how to deal with that, and then they blame the Mental Capacity Act or DoLS. It is just a very complex situation and professionals do not quite understand how to maybe adapt or apply it in different situations.

There is also another reason for the failings: a lack of support for individual practitioners from managers and organisations, maybe because the organisation or the manager does not understand it that well either. What has worked pretty well in our organisation is the fact that from board level through to front-line staff they understand the importance of it, they are supportive of it and their managers are supportive of it. We have invested so much resource, time and effort into getting the message across. It is not just about a half an hour, face to face training session or e-learning; it is really about investing in a co-ordinated effort.

The other big problem is if you do not comply with the Mental Capacity Act or DoLS, there just does not seem to be a lot of repercussion or penalties. Some organisations are really good at it and drive it forward, while other practitioners or organisations might not comply and they are not auditing it—they are not looking at what they are doing. There just do not seem to be enough external drivers to impose penalties. At the end of the day, this is about
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

Mark Neary: Sadly, the Mental Capacity Act is like most things in the adult social care world: at some point it is going to be hijacked. Like lots of initiatives within social care—personalisation, inclusion, person-centred planning—all those things seem to start with a brilliant idea but at some point seem to become misappropriated for cost-cutting or other agendas. As I said, sadly, it seems inevitable that the Mental Capacity Act will be used in the same way.

Q261 Baroness McIntosh of Hudnall: We have covered, to some extent, what this question is trying to clarify, but you said, Ms Bishop, that your perception is that the Act is a good Act. It is capable of being applied and people just do not do it, for a variety of reasons that might include not being properly trained and informed. I find it very difficult to understand why this particular Act, which has so much support, appears to be so hard to enforce. You suggested that it is because not enough sanctions are attached to it or that that might be a reason. Mr Neary has a rather more broadly cynical view, I think it would be fair to say, that it is inevitable because of the area in which it is being applied. Do you think the law itself has any inherent shortcomings that make it difficult to apply, or is it just about the amount of time and resource that is being put into making sure that people understand it and are able to apply it?

Elmari Bishop: When it comes to the Mental Capacity Act, it is not only about applying a relatively new piece of legislation. There is a lot of change and cultural change that needs to happen alongside it, and that is one of the biggest problems here. I honestly do not think there is anything wrong with the Mental Capacity Act. The Deprivation of Liberty Safeguards could perhaps be simplified, but the Mental Capacity Act, in essence, is a very good piece of legislation. However, it is not just about teaching professionals how to implement it; as mentioned - there are a lot of cultural changes that are also needed alongside it. Historically, doctors, nurses and social workers would base an assessment of a person’s capacity or what would be in their best interest on their own professional judgment, which would be informed by years of training and experience. They knew that when a person with dementia reached a certain stage and lacked capacity, the best thing would probably be for them to go into a care home. This was all down to their professional judgment, and now we are asking those professionals, especially doctors, to apply this professional judgment within this different legal framework. In my experience, many of them see that as an attack on their ability to make professional decisions: “Do you think I cannot make this decision? Why do I need to do it in this way?”. Quite often, the outcome is more or less the same, but it is the process that they do not follow.

I find the biggest problem is that they still do not involve the family and they still do not look at the person and what their views and wishes would be. In the past, they would say, “You have dementia and therefore you lack capacity. Therefore you need to go into a care home”. That was the process that professionals would follow. The Mental Capacity Act now says that you need to stop, you need to look at the person, you need to look at their views, listen to the family, listen to what everyone is saying, look at what has worked, consider the least restrictive options, and then you need to base your professional opinion on what would be best for them and not just what you have always done for a person in that

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situation. That is where the real challenge comes. It is not just about saying that this is a new piece of legislation, it is about changing cultures; and changing the way professionals make decisions; and challenging the way professionals make decisions; and it is really hard to do this sometimes. Some of them are quite precious about it: “This is my professional opinion. I am a doctor. I have been a doctor for so many years”, or “a nurse for so many years”. The real challenge is to get professionals to take ownership of the implementation of the MCA and DOLS; they need make sense of it for themselves. Changing the Act will not really change that. It is about changing the cultures.

Mark Neary: I do not think there is enough in the Act about scrutiny, in the case of the DoLS, of the supervisory body. Who checks that they are doing the right thing by the Act and the right thing by the person who is under a DoL? That seems to me quite a big hole in the Act, but I also agree with Elmari that there is a big cultural shift as well. In all the meetings I attended in the year Steven was away, there was absolute certainty from the professionals that their decision was right; it was just impossible to get them to reflect on that, and that is a big cultural thing.

Q262 Baroness Barker: Assessment of capacity under the Act is decision-specific rather than a one-off statement. Do you think that is part of the problem with the Act and its implementation, or do you think that front-line staff fully understand that and have the capacity to implement that? I notice that you said in an earlier answer that DoLS perhaps needs to be simplified. Could you expand on that in your answer?

Elmari Bishop: For me, the problem is not so much around assessment of capacity. Most professionals now seem to understand that you need to assess capacity. They seem to understand the process. The quality of the assessments are not always that good though. Some people will spend two or three minutes with a person and not look at the practical steps to help the person to make their own decision or understand that unwise decisions are not necessarily an indication of lack of capacity. People understand that they need to assess capacity and seem to understand the process now, but, as mentioned, it is not always applied within the principles of the Mental Capacity Act or to the quality that we would expect. We audit a lot of capacity assessments and the evidence to support decision-making is not always there. That leads to the next problem that if you do not assess capacity properly, your best-interest decisions probably will not be based on the proper process or sufficient evidence either.

Once professionals truly understand the process of assessing capacity and what evidence is needed to support decisions, then I think they can assess capacity and they are properly equipped to do that. Initially, there were a lot of cases where lack of capacity was still presumed, whereas now that is less—people are assessing capacity. However, the problem then comes when you are trying to make best-interest decisions or trying to make decisions around DoLS. For me, that is where the biggest problem lies, not in the assessment of capacity, but the subsequent decision-making processes.

In terms of DoLS and simplifying the process, everything from the application process to how you challenge it can sometimes be quite complicated. The biggest complaint I hear from managing authorities, care homes and hospitals is about the paperwork. To request an assessment under DoLS, you need to complete 18 pages of paperwork. Normally, you would do the urgent authorisation, which is six pages long. The request for the standard authorisation is 12 pages long. I work within psychiatric settings. If you are working on a
ward for people with dementia, it is very busy. It is really hard to find time to sit down and complete 18 pages of paperwork. On some of our wards, I have gone in and said, “I will help you with the application”. I do not work on these wards, and even for me to find three or four hours to sit down on these wards and do the paperwork is hard, especially in that environment where you constantly have people needing certain things. The application process is also complicated. Generally there is a very poor understanding of when you need to apply for a DOLS and of what a deprivation of liberty might look like. I know that it should be case-specific, and you need to look at individual circumstances and you have case law and guidance, but it is just too open to interpretation. You have professionals struggling to understand best interest decisions and how to assess capacity, and now you are asking them to interpret very complex pieces of case law as well. As in the Neary case and many others, they talk about objection and family objection, but then if you place a person in a different setting, like a psychiatric ward, there are different criteria that apply. Therefore, care homes and hospitals struggle to just understand when they need to apply it.

One of the other questions is around a simplified definition, and that would make a huge difference. You could still have the best interests assessor coming in and having the final say as to whether it is or is not a deprivation of liberty, but for the people having to initiate the process in the first instance, the definition of a deprivation of liberty needs to be simplified. They need to be given clearer guidance on when you need to apply to have somebody assessed under DOLS, which would make it much easier for them. There is another big problem. I know that you can challenge it through the Court of Protection and there are ways of challenging it, but that could be simplified. These are the things that I would like to see change.

**Mark Neary:** Of course the people assigned to do a capacity assessment are able to carry them out, but I have three “buts”. The number one “but” is that it seems that often the cart is put before the horse, so the best-interest decision is made and then they think about assessing capacity. That seems problematic.

I know that the Act says that the person should be supported through the decision-making process, and that calls on drawing upon the people who know the person best to have an active involvement in the assessment. Steven has had five mental capacity assessments in the last three years. The very first one he had was when he was away in the unit, and the decision then was whether he had the capacity to decide where he wanted to live. I went to that assessment with him with two of his support workers, but it was made very clear to us that we were not allowed to have any input at all. Steven was doing fine during the assessment, and then he was asked a comparative question by the psychiatrist: which is better, the unit or his home? I could see Steven was very thrown by this because, for him, it is the word “better”. For Steven, “better” is what you become after you have been ill, so he was really struggling to understand the question. I chipped in to help him understand the question and was asked to leave the room. That was the end of my involvement in the assessment.

Steven has had two this year. The first one was after he was awarded damages for the unlawful deprivation, so that was about whether he had the capacity to manage his damages. The second one was about whether he had the capacity to manage the tenancy. The first assessment was about 15 minutes and the second one was probably about half an hour. That is my third “but”: it is very difficult to assess somebody who is experiencing something for the first time. Steven had never even had to think about managing a tenancy before, and
all of a sudden he was being put in a position where he was being tested and examined on his understanding of that when it was not something he has ever come across in his life before, so it felt very, very unweighted.

Q263 Lord Swinfen: Many submissions to the inquiry have asked for a statutory definition of what constitutes a deprivation of liberty. Would you agree with that proposal and what difference would it have made, in your experience?

The Chairman: I think you have dealt with that, Ms Bishop.

Elmari Bishop: I have said that it would be really useful, Lord Chairman, yes.

Mark Neary: I think the name is very problematic. I am pretty sure that the care home that Steven was in did not like the name “deprivation of liberty”. Something like “appropriate care safeguards” would seem less threatening. A statutory definition would be brilliant. I also think it should be weighed against what the person’s life was like before the deprivation took place and then afterwards, as a gauge. I know it is a very thin line between restriction and deprivation, but I would like to see a bigger comparison made with what the person has lost through the situation they now find themselves in.

Lord Swinfen: Do you think it would be possible to produce a definition that suited everyone? I think everyone is inclined to be different.

Mark Neary: No.

Elmari Bishop: There definitely needs to be clearer guidance and clearer indicators of when you should be thinking of requesting further assessment. Clearly defining what a deprivation of liberty is could still be left to the best-interest assessor and a judge in the Court of Protection. However, the care home and the hospital need clearer guidance. You possibly could revise the DoLS Code of Practice, but there needs to be clearer guidance. In case law, there is a distinction between the care home and the psychiatric hospital setting, for instance, and that needs to be made clear as well. Care homes and hospitals are really struggling to understand when they are depriving a person of their liberty, and they hear so many conflicting messages. We will go to our hospitals and care homes and say, “This is what you need to look out for”, and then a best-interest assessor might come and assess someone and give them a completely different message. Even amongst best-interest assessors and other professionals, there are so many different ideas of what is and is not a deprivation of liberty, and that is causing a lot of confusion. It is also excluding a lot of people from the Deprivation of Liberty Safeguards who could benefit from that. Therefore, in my mind, it would be better to give clearer guidance or a clearer definition and get more people assessed. It should still be left to the best interest assessor to decide in the end whether it is a deprivation of liberty or not, but from the start there needs to be much clearer guidance for the care home manager or the hospital manager. They do not get the training in case law that best interest assessors receive, so they need much clearer guidance about when it needs to be requested.

The name is quite problematic. One of the biggest obstacles that we had when we started visiting our psychiatric units and tried to identify people who were being deprived of liberty was that you would talk to a psychiatrist who thought that they were providing a high standard of care, and they were, but they would see a person with dementia or with learning...
disabilities who they were looking after and treating to the best possible standard, and we would call it a deprivation of liberty. That was quite hard for them. They think that they are providing good care and we are saying, “You are depriving a person of their liberty”. There is a very negative connotation to the phrase “deprivation of liberty”.

Q264 Baroness Hollins: My question is for Mr Neary and it is about IMCAs, who are commissioned by the local authority. Some of the submissions that we have received suggested that there could be a conflict of interest in that IMCAs may not be able to adequately challenge local authorities. Has that been part of your experience?

Mark Neary: I can understand how that could happen, but in our case it was the absolute opposite. The judge said that Steven’s IMCA produced the first best-interest assessment that deserved the name. She was completely independent. I never had any sense at all that she felt under pressure to follow the local authority line, and the report that she produced was completely different from all the other best-interest assessments that had gone before.

I would love it to be the situation that the person detained or the family could approach the IMCA service direct and not have to wait for the local authority to refer them. In our case, Steven was coming up for the fourth renewal of his deprivation of liberty before we got an IMCA. It took from April to November, and the judge said if we had had an IMCA back in April, Steven would have been home within weeks, but there was no access whatever for me or Steven to approach the advocacy service direct.

Baroness Hollins: You have to wait for referral by the local authority.

Mark Neary: Yes.

Baroness Hollins: That is one change you would recommend. Are there any other challenges that might facilitate access?

Mark Neary: No. That is such an important one. For me, that is the big one.

Elmari Bishop: I have a slightly different experience with IMCAs. I think they are quite good and a really valuable resource, but they do not always have enough power to challenge. I have been involved in a few cases, not in our organisation but externally, where IMCAs have become involved. They have challenged professionals’ decisions, mainly professionals working within local authorities—social workers who probably wanted to move somebody to somewhere else and the family objected and the person might also have been objecting. IMCAs have challenged the social workers’ decision-making and what they wanted to do, and in some cases social workers have made official complaints about IMCAs and the IMCAs have been told to back off. There are cases where IMCAs try to challenge, but the social workers just seem to be more powerful. In many cases, the IMCAs are commissioned, as you are aware, through the local authorities that the social workers work for and there is a bit of a power imbalance there. The IMCAs should be commissioned completely independently and there should be easier ways of accessing them. It is very much down to the social workers to refer for IMCAs or for independent best-interest assessors to request that an IMCA becomes involved.

The Chairman: That is the same point as Mr Neary was making.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Elmari Bishop: Yes. There are certain points where there should be access where there is none.

Q265 Baroness Browning: Ms Bishop, you have outlined quite a few of your concerns about the need for cultural change, and that it is really the culture change that is going to make a difference. You have also identified, I think I am right in saying, clinicians where there is a weakness. I do not know if I have interpreted what you were saying correctly, but what lessons have you learnt about how to improve implementation? What recommendations would you make to the Committee about how this should be promulgated more widely?

Elmari Bishop: The biggest thing that we have learnt is that it is not just about implementing new legislation; it is about managing change, managing resistance to change and getting support from all levels. When we started the work in our organisation, we did a big audit and through this we realised we had a problem and we went to our board of directors with this information. We received a lot of support from them because they also saw what the potential risks to the organisation of not assessing capacity and not making best-interest decisions in accordance with the law and potentially depriving people unlawfully. We got sign-up from our board of directors, and we thought that that would be all that we needed: we had support from the top level and we had all the resources necessary. But we encountered so much resistance from all professionals, not just doctors, and we quickly realised it was not just, as I said, about implementing new legislation; it was about managing change and resistance to change. The main source of a lot of the resistance was, as I mentioned before, that the professionals felt that we were challenging their professional decision-making abilities. So we had to explain it to them in terms that they could understand. I work for an NHS trust, and we started to explain to them that it is about consent to treatment - at the end of the day: you need a person's consent. If they cannot consent because they lack capacity, then you have to use the Mental Capacity Act to gain that consent. When it came to Deprivation of Liberty Safeguards, especially in our psychiatric settings, we had to explain to staff that this is about their legal authority to keep a person on the ward and provide treatment to them. We had to find ways to explain to them in terms that they understood. We had to get all the different professional groups on board and help them take ownership of it. We particularly struggled with certain groups, one of them being doctors. However, as soon as we got our medical director and some of the key doctors in our organisation on board, they started to drive the message forward. Indeed, the change that we saw was not because of the work that we did but because of the support we started to get from different professional groups, and the fact that they were carrying the message forward. It was only then that we saw any real improvement, so that was key.

The other thing that really helped was a few bad CQC inspections. We were doing all this work with doctors, nurses and ward managers within the organisation, trying to get them to take it on board and take ownership of it, but what really gave us that final push was a few bad CQC inspections. There were two inspections in particular where the CQC inspector seemed to be quite clued up on this whole issue of deprivation of liberty in psychiatric settings, and that gave us the final push. It was not just us saying, “This is what you need to do”, it was the CQC saying, “This is what needs to happen”.

Our commissioners then also caught on to the whole idea of the Mental Capacity Act and DoLS, and they started asking us every three months to report on what we were doing in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
that regard: what training we were doing, how many assessments we had done, what we had
done to improve staff understanding, how we were monitoring it, and how often we were
auditing it.

To summarise - We started off thinking that we were just going to implement new
legislation, but then, due to resistance, we had to create a robust action plan to implement
the change and get everyone on board, and then we had a few external drivers that really
pushed the change forward. For us, we learnt that it is not just the internal support but also
the external drivers that you need to deliver the necessary changes.

Baroness Browning: Thank you. That is very useful to know.

Q266 The Chairman: Was the risk of facing substantial damages a feature as well that
encouraged the trust to move forward?

Elmari Bishop: That is how we got the initial support, because we did an audit and looked
at how many potential cases we had of people who either were not assessed properly or
who might be deprived of their liberty. We took that information and presented it to our
board of directors. We quoted cases such as G v E, the Manchester case, where the person
was paid substantial damages, so it was about the risk of litigation as well as the risk to the
organisation from the CQC inspecting and finding these things on our wards. The CQC is
now focussing more on compliance around the Mental Capacity Act and this also been set as
one of their corporate objectives, if I am correct. Therefore, the CQC is becoming more
aware, and that really does help, because in the health setting especially the CQC has a lot
of power to reinforce these messages.

Baroness McIntosh of Hudnall: That is a really interesting response, because it begins to
indicate that perhaps the external sanctions that you were referring to do not necessarily
have to come through the courts but can come through inspection regimes and other forms
of pressure that have a very direct bearing on how people work in their own professional
settings.

Mr Neary, I imagine by now that you have acquired almost as much knowledge as most
professionals, but you do not start from a professional perspective. Therefore, can you
answer the same question from the point of view of families and other supporters of people
who lack capacity and what lessons you have learnt through your own experience about
how the DoLS can be better and less riskily applied?

Mark Neary: I had never heard of the Act or DoLS at all before the first urgent seven-day
authorisation took place, and that is probably the case for most families. I set up an internet
group when Steven was away, more out of desperation really, to try to get some help. The
group is still going, and I will be regularly contacted by a family member who has a son,
daughter or another family member in a home. The question is always, “Where do we start
with this?”. More often than not, a DoL is not in place. The person will tell me the story,
and it seems to me pretty obvious there should be an authorisation or at least an
authorisation should be considered. My advice is always the same, and it is to speak to the
care home and talk to them about doing a best-interest assessment. Is it really in the
person’s best interests to be in this place? As Elmari said a while ago, there is often
resistance to that, I think because of the power imbalance. There are normally a lot of
professionals making those best-interest decisions against one or two family members and

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submissions.
the person being deprived of their liberty. That is my starting point, because people do not know that the Act exists.

Baroness McIntosh of Hudnall: Just on that point, do you think that there is enough investment in public information about the Mental Capacity Act or about the issues that could arise that the Mental Capacity Act is there to try to help with? Some of our evidence suggests that compared with, say, other kinds of risk that people face, the risks that come with incapacity, both to the person incapacitated and the families of that person, are relatively poorly understood through public health information, for example. Would you agree with that?

Mark Neary: One thing I experienced and I know lots and lots of others do, because it is a conversation that takes place all the time, is that the shift from children’s services to adult services is enormous. The input from the family, which is quite high when the person is in children’s services, suddenly evaporates when the person hits 18. I do not remember being given any information at all when Steven entered adult services about the Mental Capacity Act. I may have been, but I do not remember it at all. I think that is a prerequisite really, because your thinking, as a parent, as a carer, when your son or daughter reaches 18 has to completely change. You have made decisions on their behalf up until now. Now every decision that is needed about your son or daughter has to go through that best-interest funnel, and it is not something you would think about unless you knew the Act existed. Therefore, it should be an important part. As the person is being transitioned from children’s services to adult services, their families, who are going to continue to be looking after them, also need some transition stuff around the Mental Capacity Act.

The Chairman: On that point, I seem to recall evidence some time ago from a witness who suggested that there should be education and information at the stage that a child was maybe 14, or just going on, to the child and the parents about the Mental Capacity Act and about the difference in responsibilities that the parents might have. Would you go along with that?

Mark Neary: Yes, absolutely. I take for granted most of the day-to-day decisions I make on Steven’s behalf. Steven has just been allocated his new home and in the last two weeks we have moved, and I have probably made hundreds of little decisions over the last three or four weeks about how Steven is going to live in his home. Now, because I know about the Act, I know that they are best-interest decisions, but three years ago I would not have had the first clue on that.

Q267 Baroness Mclntosh of Hudnall: I just want to follow that up one tiny step further. Clearly, in your case, Mr Neary, you have been aware of your son’s needs over a long period of time, and you have correctly identified the difficulty in transitioning from child to adult services. There are other forms of incapacity that come either very late in life or as a result of a sudden intervention, like an accident or stroke or something of that kind. People are not going to have been thinking before those things started to be an issue for them about the possibility of the Mental Capacity Act ever being relevant to them. Therefore, I am wondering, from both your points of view, whether some of the difficulty is simply that the Act itself is understood by the people who need to understand it but it has no public profile. Is there something that we should be thinking about in respect of that?
Elmari Bishop: One big factor probably when it comes to the Mental Capacity Act is that families are not told what their rights are. The process is not explained to them. Looking at older people, a person will be living at home independently on their own without any support apart from their family. They will have a minor fall or an infection and go on to a general ward. On the ward, the staff will realise that they are confused and they might have dementia, and they will automatically say that the person cannot be discharged back home; they have to be discharged to a care home. The family are just told, “It is in their best interests. We are making this decision under the Mental Capacity Act”, and they simply do not know any better. Many of these family members track me down and ask me for advice, and when you explain to them that a best-interest decision will involve looking at the person, their views and wishes and talking to the family and looking at the least restrictive options, this is complete news to them. It is almost as though you need a statutory duty placed upon professionals to inform the family of their rights and what powers they do and do not have. Unlike under the Mental Capacity Act, if you want to detain somebody under the Mental Health Act the professional has a statutory obligation to explain to the nearest relatives what their rights are—such as that they can appeal, and what can and cannot be done. I think the MCA needs something similar. What professionals will explain to a family about the Mental Capacity Act is that that is what they are using to move the person or to make their decisions, and I am sure in Mr Neary’s case as well they never explained to him from the start that he needed to be involved or he could object or take it to the Court of Protection. They never explain any of that. Family members hear this from Mencap or organisations like that. Voluntary organisations are very good at explaining it to them, but the family needs to access Mencap and they do not always know that is even available.

Baroness Hollins: Mr Neary, just a quick question to pick up on something you said. Are you aware of any very good, straightforward, practical information that you can recommend to families so they understand how best-interest decisions need to be made? What do you recommend to people?

Mark Neary: The guidance manual is pretty good, although I know the cost of that, and most families are not going to go out and buy a copy. There are some really useful internet sites, particularly for carers. There is some wonderful stuff around the Mental Capacity Act.

Baroness Hollins: Could you possibly write to us and tell us what you think is the best?

Mark Neary: Yes.

The Chairman: Yes, that would be quite useful. It will give you time to reflect and if there are several, let us know.

Mark Neary: Okay.

Q268 Lord Swinfen: The Government currently monitor the number of deprivation of liberty applications across England and Wales, and we know that there are regional variations, but we do not know why. How do you measure whether the DoLS scheme is being properly implemented, and do you think that there would be a more effective form of quality control?

Mark Neary: I cannot make head or tail of the figures at all. If you have two neighbouring boroughs and, say, one has authorised two DoLS and the next borough has authorised 52, I

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am not quite sure, if it is a broad statistic like that—is two good, or is 52 good? I do not think we can get any strong message from the figures as they are presented at the moment. This may exist and I have just never seen it, but a starting point would be how many people fall under the scope of the DoLS scheme. I do not know whether that is recorded anywhere, but then there would at least be a comparison between the number of DoLS that have been authorised and the people who are in the DoLS realm, so to speak.

Elmari Bishop: It is really hard to quality control DoLS because it is specific to individual cases. You cannot say you need a 20% increase in DoLS applications year on year. There is no way of doing that. You need to look at it case by case and look at people who potentially fall within the scope of DoLS and whether that has been considered. That is what we do in our organisation. For everyone on our psychiatric wards who lacks capacity, we ask staff to complete what we call an informal admissions checklist, so we know how many patients we have, how many have capacity and how many lack capacity. Of those who lack capacity, for each of them there will be a written consideration of whether you are depriving them of their liberty or not and whether you have considered these factors.

The Chairman: People can lack capacity for some things but not others.

Elmari Bishop: These people lack capacity to consent to the admission and to the treatment. That is how we try to do it. We look at all our patients and at the ones who might fall within the scope of DoLS and see whether DoLS have been considered for them. That is the only way we have found that we can do it, because you cannot really say you need X amount of DoLS or a certain percentage increase every year, because it is so case by case.

What has really worked for us is the strong internal drive to keep an eye on it. We have quite a robust monitoring system in place now, which I have talked about, where every week our wards will feed back to us how many patients they have and how many lack capacity. They will say to us, “Out of the group who lack capacity, this is the amount who would be DoLS and these are the ones who are not”, and they will give us quite clear reasons for that. We have an internal mechanism to monitor quality, and we also have yearly audits to make sure no one is falling through the net.

Apart from that, we also have the strong external drivers, the CQC and our commissioners, who also keep an eye on what we are doing. That is what has driven up the quality in terms of how we have implemented DoLS - it is the internal and external drivers, as I mentioned earlier.

Q269 Lord Swinfen: I know that groups of magistrates and groups of judges get together to discuss cases and to see if they would come up with the same punishment, to see that there is consistency throughout the country. Do groups of local authorities get together and discuss cases to see whether they would agree on a deprivation of liberty or is there no such cross-fertilisation throughout the system?

Elmari Bishop: Some local authorities do peer reviews, where they will look at each other’s DoLS applications.

Lord Swinfen: Within the same authority?
Elmari Bishop: No, the neighbouring local authorities. I know some neighbouring local authorities will do peer reviews.

Lord Swinfen: Just neighbouring ones, though. You would not discuss this with someone from Northumberland or Cumberland or Cornwall or anything like that.

Elmari Bishop: Not as a standard procedure, no. In the east of England, for instance, we have a regional implementation network where we discuss guidance and cases. We also do a lot of regional training events, where case discussions will come up, but there is no formal process or obligation to do this. It is quite often local authorities taking the initiative, thinking that they would like someone else’s opinion on what they are doing. A lot of local authorities have also brought external auditors in to look at everyone in their care home and hospital settings to see who might potentially be deprived of their liberty, but it is very much down to individual organisations realising that it is important and then take the initiative and find the resources to do it.

Lord Swinfen: Therefore, there is no method of ensuring consistency throughout the whole nation.

Elmari Bishop: No, it is down to the organisation to realise the importance.

Lord Swinfen: I realise that it would cost the ratepayers money, which no one wants to do, but I was just wondering about it.

The Chairman: Thank you very much. That ends this session. We are very grateful to both of you for your evidence and for coming along today.

Elmari Bishop: Thank you.
NHS England welcomes the opportunity to contribute to the scrutiny of the Mental Capacity Act (MCA). As an organisation we remain committed to its principles and this is apparent in the higher focus that vulnerable people, including those that lack the capacity to consent, receive in our strategic business plan.

Much progress has been made since the Act was implemented in 2005, though more is to be done to ensure that all patients who lack capacity are appropriately safeguarded. NHS England believes that the principles and definitions in the Act remain appropriate; the challenge is to ensure that this is applied to all patients covered under the Act in all NHS commissioned services.

To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

Generally the Mental Capacity Act (MCA) prior to addition of DOLS, achieved its aims well. In many instances it has changed practice immeasurably and amongst NHS provider organisations the professionals often state that the MCA has succeeded in raising awareness of the issues around mental capacity and prompted consideration of the issue of capacity in the decision making process.

The five principles of the MCA and the 2-stage test for capacity are generally well understood by professionals, however there have been practical examples since 2008 which indicate some professionals (clinicians and health and social care professionals) do not fully understand the complexities of the MCA and the code of practice. This should be addressed in any further consideration and implementation.

Crucially, the interface between the MCA and the Mental Health Act (MHA) 1983 could be clarified and perhaps made more robust and explicit in the explanation and application principles. This applies particularly to the consideration of ‘best interests’, the use of restraint, the Deprivation of Liberty safeguards, and the different mechanisms of enabling the individual to make decisions such as power of attorney, advance decisions and applications to the court of protection.

Which areas of the Act, if any, require amendment; and how?

NHS England has not identified any specific amendments for the Act.

At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

The five principles enshrined in the MCA appear fit for purpose. The principles explain clearly how the MCA should be implemented and how the assessment of capacity should be approached. The third principle (the right to make a “wrong” decision) is a useful reminder that practitioners should not conclude that an individual lacks capacity just because they arrive at a different decision from the practitioner.
8. However, the complexities of the MCA are often not understood by those directly affected by MCA and by nonprofessional carers. Explanation by professionals who implement the MCA is usually required which can create significant confusion where the MCA is also not understood by the professional in the first instance. There is also confusion around how much involvement friends and families of individuals should have in the decision making process. This confusion has been reported amongst professionals as well as friends and families. The issue of best interest decisions therefore needs to be clarified in mental health settings and also who should be involved with these key decisions and the level of involvement.

9. **To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?**

The implementation of the MCA is a welcome advance and has increased knowledge and awareness around the issue of capacity, enabling and supporting individuals to make decisions for themselves to a greater extent that in the past.

10. However, the quality of decision making when making a decision in someone’s best interests has not necessarily been improved by the Act. The concept of ‘best interests’ has always been difficult for professionals to apply in practice. There can be many different views of what is in the person’s best interests and many different considerations. The risk has always been that public interests are perceived as being in the person’s personal best interests. This is a major point of clarification that is required.

11. Another difficulty is assessment of capacity, especially where capacity is fluctuating (as often occurs in the end of life care situation) and also the fact that capacity is still often seen as global, rather than being decision specific. Decisions that have to be made in a hurry are more difficult than those where there is time to work things out, wait and consult – but such is the nature of real life practice.

12. **How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?**

The five principles are easily understood and the practical examples provided in the 2007 code of practice provide useful additional guidance for professionals involved in the decision making process.

13. MCA training for all staff to promote awareness and increase practical working knowledge of the MCA should be mandatory for all providers. However the initial implementation of the Act was not robust enough to ensure all front line staff received appropriate training from NHS Providers and limited guidance was available on what training should involve and frequency etc. The whole system needs to ensure that the delivery and quality of training is consistent across all organisations.

14. **Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?**

For the past three years Strategic Health Authorities assured themselves via two In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
mechanisms of the implementation of the Mental Capacity Act (MCA): the Learning Disability Health Self Assessment and the Safeguarding Adult Assurance Framework (SAAF). Both Quality Assurance vehicles have been transitioned to NHS England and will be rolled out again this year (though the SAAF may be revised). This gave regions a good understanding of the MCA in NHS organisations.

15. Within NHS England, a head of safeguarding has been appointed to support the organisation to deliver its safeguarding functions through the new structures. There are four Regional Teams across NHS England and all have a safeguarding lead who supports and co-ordinates the newly formed commissioning structures through the Area Teams and CCGs to deliver safeguarding assurance and accountability, using the new assurance framework. Roles and responsibilities are clearly defined; each CCG must have a designated MCA lead as part of their authorisation.

16. MCA / Deprivation of Liberty Safeguards (DOLs) training is offered to staff using e learning tools and through multi-agency workshops with local safeguarding adult Boards. Provider Trusts should ensure MCA/DOLs form part of induction and mandatory training and each provider and commissioner has a named lead, usually the safeguarding lead with responsibility for support clinicians with advice relating to any issues. NHS England is constantly striving to improve quality. Examples of national and local awareness raising work include:

- Dedicated MCA and DOLs networks and Safeguarding Networks covering MCA
- Commissioned Masterclasses
- MCA e Learning tool (Nottinghamshire) rolled out
- London CQUIN on vulnerable patients (included audit regarding consent)
- East Midland Safeguarding Prompt Cards: In London alone this was disseminated to 12,000 staff in hard copy, more in e-versions.

17. However, experiences have shown that training and knowledge and skills amongst staff are still variable and the quality and depth of training equally. There is also misunderstanding amongst professionals and public about advanced decisions to refuse treatment, role and responsibility of LPAs, deprivation of liberty safeguards, etc.

18. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?
   As referenced in response to questions three and four, the complexities of the MCA are often not understood by those directly affected by MCA and by nonprofessional carers. There is also confusion around how much involvement friends and families of individuals should have in the decision making process. This confusion has been reported amongst professionals as well as friends and families.

19. Has the Act ushered in the expected, or any, change in the culture of care?
   NHS England feels that yes, the Act has created raised awareness and consideration in the decision-making process. The code of the practice is an excellent resource
written in plain English with many illustrative case studies; it is widely used by clinicians to assist with the implementation of the Act and help safeguard vulnerable adults.

20. **Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?**
   Data monitoring, publishing and sharing across all protected characteristics is variable across the NHS due to varying legacy IT systems and the ability to collect certain data. Research shows that lesbian, gay, bisexual and transgender communities, BME, and men and women experience and access mental health services in different ways. However accurate data is not available to create an adequate national picture of how the MCA has impacted on all of the protected characteristics to ensure the data, on MCA outcomes or experience is meaningful. Understanding this is pivotal to reducing mental health to.

21. **Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?**
   NHS England has no comment to make on this question.

22. **What evidence is there that advance decisions to refuse treatment are being made and followed?**
   NHS England has no comment to make on this question.

23. **Has the MCA fostered appropriate involvement of carers and families in decision-making?**
   Experience of NHS England’s senior clinicians is that yes, the Act has fostered some involvement of carers and families in decision-making. However, as per our response to Question 3 there is room for improvement to help carers and families better understand the MCA.

24. **Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?**
   On the whole, IMCAs have played a critical role for improving the experience of service users and ensure a voice and improve empowerment for the individual. However, it has been reported via provider NHS organisation that IMCAs vary in their skill and knowledge and this can have a significant impact on the individual who depends on the IMCA to ensure they are heard and to protect them from abuse/exploitation. There does not seem to be a code of practice to ensure IMCA have an established suite of approaches and tools to raise issues.

25. **Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?**
   NHS England has no comment to make on this question.

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26. **Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?**

   It has been reported the IMCA can often have varying levels of skills and approaches; a developed code of practice and standards should be established to assist in a level of consistency to ensure the quality of experience for the individual who will be relying on this support.

27. **Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?**

   The DoLS are adequate, however consistent training and continued awareness raising is critical to ensure the safeguards are applied appropriately and sensitively. There is wide variation in use, the implication being that in some places (eg some nursing homes) they don’t recognise that there is a deprivation of liberty, so do not ensure the safeguards are applied.

28. **Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?**

   On the whole it is felt that the process works, however changes to the NHS structures and transfer of function to the Local Authority has caused some initial capacity issues.

29. **Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?**

   NHS England has no comment to make on this question.

30. **What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?**

   NHS England has no comment to make on this question.

31. **What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?**

   Concerns have been raised in relation to the cost associated with registering an LPA, or making an application to the Court of Protection; feedback is that the costs are high and this is considered an expensive process.

32. **Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?**

   NHS England has no comment to make on this question.

33. **Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?**

   NHS England welcomes strengthening the role of all regulators to ensure the protection of vulnerable adults is improved.
34. **Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?**
   See response to previous question.

35. **How well is the relationship with the mental health system and legislation understood in practice?**
   Although there are professionals with a good understanding of the interface between the MCA and Mental Health Act (MHA), this is not consistent across all clinicians. The interface between MHA, MCA and DOLS has on occasion been reported by NHS provider organisations as generally poorly understood. Although case law has provided some clarity around the priority of application where an individual meets the criteria for detention under the MHA there is still confusion about this in practice. Clinicians are reluctant to apply the MHA even where its application is wholly appropriate because of the seemingly restrictive nature of the provisions and the extremely vulnerable nature of the individual.

36. The principles of the two frameworks can often be conflated which can result in the inappropriate use of both pieces of legislation. For instance the consideration of whether an individual has the capacity to agree to detention under the MHA 1983.

37. **Does the implementation of the Mental Capacity Act differ significantly in Wales?**
   NHS England has no comment to make on this question.

38. **What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?**
   NHS England has no comment to make on this question.

39. **Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?**
   NHS England has no comment to make on this question.

2 September 2013
TUESDAY 5 NOVEMBER 2013

Members present

Lord Hardie (Chairman)
Baroness McIntosh of Hudnall
Baroness Andrews
Baroness Barker
Baroness Browning
Baroness Hollins
Baroness Shephard of Northwold
Lord Swinfen
Lord Turnberg

Examination of Witnesses

Hilary Garratt, Director of Nursing, Commissioning and Health Improvement, NHS England, Moya Sutton, Head of Safeguarding, NHS England, and Dr Katherine Rake OBE, Chief Executive Officer, Healthwatch England

Q221 The Chairman: Good morning. Welcome to this evidence session. Thank you for your written submissions. The evidence is video recorded and also transcribed, so you should be aware of that. Can I start by referring to the changes that have taken place in the NHS and the reforms in the NHS, and also the changes in the local authorities and the likely changes in social care? How has the Mental Capacity Act featured in those changes and are the health and social care systems in a better or worse position?

Hilary Garratt: I will open on that question. Our new system, from an NHS perspective, creates opportunities for us. There are two major reasons for that. First, it is a clinically led system now, which is different from the system we had before, which was largely managerially led. It is a system that is based on outcomes and measured on outcomes, which includes patients, experience and quality. That means we are on a journey in respect

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of accountability for process to one that is more around achieving outcomes for patients, particularly our most vulnerable. Those are the two key characteristics of the changes.

Just to explain the changes, we have got 211 CCGs now across the country that are led predominantly by clinicians at governing body level. To support those we have got 27 area teams that have a medical director and a nursing director with responsibility for safeguarding. At CCG level, I should mention that each CCG has to have a lead for the Mental Capacity Act and safeguarding.

We have got 27 area teams and then we have four regions. Of the four regional levels, we have got two key people giving a clinical perspective: the director of nursing, who is responsible for safeguarding, who works in partnership with a medical director as well. That just gives you a flavour of how we have put leadership for safeguarding and the Mental Capacity Act at every level of the system.

At national level, we have got an accountability for safeguarding and the Mental Capacity Act invested in the Chief Nursing Officer portfolio, and I work directly for the Chief Nursing Officer in my director capacity for NHS England. Moya, who I appointed some six months ago, is our Head of Safeguarding. Throughout that whole system, we have got clinical leadership at every level and, with that, an accountability for outcomes as well.

The other big thing that we need to take advantage of, which has the greatest opportunity to work, is the establishment of our partnerships—partnerships locally between CCGs, health and wellbeing boards, local safeguarding boards for adults, our regulators locally, and with the whole range of providers, including the third sector. It is working through those relationships in a new system that we need to take advantage of.

Then we have our partnerships nationally with NHS England, the Department of Health, our regulators, Health Education England. That is demonstrated for one through the new national steering group, which you may have heard about, through the Department of Health. That gives a national steer on the Mental Capacity Act. We have got other forums too, where we work with the Department of Health and other national bodies.

To steer our practice, in terms of mental capacity and safeguarding, we have an assurance and accountability framework for safeguarding our vulnerable people. That sets out clearly our roles, responsibilities and the duties of NHS England at all levels of the system. It sets out how we have to work clearly in partnership to discharge those duties. I will just stop there in case you want to ask any questions.

The Chairman: You are setting out the duties on various people, but what systems are in place to ensure these duties are implemented?

Hilary Garratt: It is a national system. I chair a national safeguarding board for adults and children. On that, we have representatives from each part of the system in NHS England. We have designated professionals, clinical leaders from CCGs, from area teams, from regional groups, and we have clear work streams there. One of the work streams is making sure that we have got clear implementation of the Mental Capacity Act. We have done some rapid appraisals about where we are in terms of capability, confidence, training, etc.
Locally, we have local safeguarding forums for each area team, which bring together safeguarding experts from the CCGs that they support and, equally, they do the same. At a local level, our CCGs and area teams are present at local safeguarding boards as well, and some safeguarding boards have sub-groups—sub-boards—that clearly focus on the Mental Capacity Act as well. So, again, it is mirroring the partnerships nationally. It is mirroring those locally and making sure we have shared protocols and shared arrangements.

**Q222 Baroness Andrews:** Can I ask you to go further into your particular statement that you have done appraisals of where we are? I know that at a time of enormous change—top to bottom, sideways and everything else—it is not going to be easy to hang on to some of the professional understandings because teams will have changed, expertise will have moved and so on. It is obviously really important that what is understood about the MCA and where it is understood is held on to. Can you say where you are without going into huge structural descriptions?

**Hilary Garratt:** I am very mindful of the changes and the potential loss of expertise. In April—first of all within the first couple of months—we did a rapid appraisal and, within that, we asked frontline staff at CCG level, representative of a number of CCGs nationally, three key questions: A) have you got a Mental Capacity Act lead and what is their background? B) have you got access to training and advice when you need it? The third question slips my mind.

**Moya Sutton:** The third question related to the changes from 1 April with regard to the local authority becoming the supervisory body and whether that arrangement had impacted adversely and negatively on the system. I think, if I can perhaps take over from Hilary here, the focus of the questions was very timely for us, prompted by, I have to say, the House of Lords inquiry, because it made us want to test at the frontline how things have moved in a very short period of time.

You are absolutely right: holding on to teams and organisational memory with such major change is obviously very challenging. It is fair to say that we were quite impressed with the response. The rapid reference group responded through the CCGs to say that they felt there was great support with the local authority arrangements and that they had access to advice as and when they required it.

There is an issue with regard to training—we know that—and inconsistency of application. Certainly, after today, that has prompted us to further interrogate a number of key areas. Although we have asked a number of CCGs about the new arrangements, what we want to do is ask every CCG about the new arrangements. What we do not want—we do know there is regional variation—is the CCG in Sefton absolutely flying the flag and everything being fantastic, and our vulnerable patients and families having access to fantastic service and then, down the road in Knowsley, you have got a completely different set of systems.

However, the initial feedback was positive, and we are pleased about that.

**Q223 Baroness McIntosh of Hudnall:** I just wanted to ask you about this much-used phrase “culture change”, which has come up both from people giving us evidence and in the discourse as we have gone along. There is frequent reference to the need for culture change in order for the provisions of the Mental Capacity Act to be better understood and implemented. First of all, how do you go about creating culture change, particularly within

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the NHS, which is a very complex organisation and operates at many levels, as you have just described?

Also, it has a systemic responsibility. Clearly, there are areas where it operates at the micro level, but it is a macro-policy level certainly that you are operating at. In particular, can you identify whether there are any aspects of the way that people view the Mental Capacity Act that might make them anxious about implementing it or understanding how to implement it? One of the examples that has been put up to us is that, at a ground level, as it were, people are anxious about the possibility of becoming embroiled in litigation—court cases—and that makes them nervous and not as front foot, if I can put it that way, as they might need to be in order to make the Mental Capacity Act work well. Do you have any reflections on that?

Hilary Garratt: I will open that in terms of the general response around culture. One of the things we have learned through some of national cases—Francis and Winterbourne—is the need to return to the basics and to have clear expressions of what our values are. Throughout the strategies that we have developed in NHS England, we refer to what we call now our six Cs. I will just refer to that.

This was developed by over 10,000 clinicians and care staff, predominantly led originally through nursing—there are a lot of us—but it is inclusive of everybody; it relates to everybody who works in the NHS. It contains a clear articulation—this came from the frontline—that we need to go back to express what we were trained to do and what we came to do. We have got the values of care, compassion, competence, communication, courage and commitment. However, they are not just words; we have got clear action areas that will support us to implement these. Those action areas are leading to some clear changes, which gives us more confidence. We are just about to issue some guidance to the system on getting the staff right within organisations in terms of using evidence-based tools for making sure you have got the right amount of staff at the right level at the right time.

There is also a work stream, for example, on measuring culture, but we need to do that frequently, so it is not just a one-off test. We need to make sure that in measuring culture we are measuring how staff feel, how patients feel and how we correlate that with patient outcomes. Investing in leadership is really important to us as well. We have invested quite a significant amount of money to make sure that our ward managers and team leaders in the community get the right leadership development and we give them the confidence to do the right things.

Measuring outcomes is a real clear action area in there, and we need to be transparent about those outcomes as well. They include patient experience—how people feel about the services—and making sure that the correlation, as I said, between positive staff and positive patient experience is really clearly demonstrated.

The other thing about culture is really making sure our medical leadership of the CCGs—clinical leadership of the CCGs—is a real signal generator and role model for these values. We need to make sure they have appropriate value-based conversations with their other colleagues—be that in primary care or within any provider, with the local authorities, in terms of partners or whatever.

One of the key features is to make sure we recruit for values and retain for values, so people’s PDAs and appraisals feature value-based competencies, and that we get feedback.
from patients on how people are performing as well. The other really key thing for us is about fostering teamwork: nurses influence doctors; doctors influence allied health professionals. It is that sense of teamwork that gives patients more confidence that they are being cared for in a holistic way. The measurement of values has to feature in all that we do now, and this will be a journey. We are talking about the measurement of values we need to measure an individual’s performance on, and values of teamwork performance on values and organisational work performance on values as well.

The other thing about values is that we need to collaborate at a local level so we develop early warning systems, which will give us a sense when the culture is not quite right. We really need to keep an eye on safety, quality and performance issues at a local level. That is where our commissioners, providers, regulators and partners get together locally through our quality surveillance groups, so that they can have honest discussions around culture and values.

Q224 The Chairman: Can I just stop you? We are fairly constrained for time, so it is important that you try to get the message over as concisely as possible. Can I move to Dr Rake to see what contribution you wish to make at this point?

Dr Rake: Thank you very much. Just to briefly introduce the new role of Healthwatch: we are a new organisation, with Healthwatch locally in 152 local areas. We have been specifically tasked to look at the health and social care system through the eyes of the individual consumer. You get quite a different perspective, so I just wanted to reflect a little bit both on the reforms that you were talking about and the cultural issue.

One of the things I would say around the reforms is, whilst there is an enormous potential there, individuals are actually incredibly confused by the array of reforms that we see currently. Clearly, one of the culture changes that we need to see happening across health particularly, but health and social care, is the move from the practitioner knowing best and doing to people, to one where individuals feel fully empowered and engaged. We know that currently people do not feel adequately listened to, engaged and involved in the decisions that affect their lives. Whilst, clearly, professional competence and expertise is absolutely critical, it is only a part of the issue and the individual also brings their own understanding and knowledge of their condition and their outcomes.

Part of our role is to be independent of the system and to operate as a national challenge, but also locally, to make sure that the policy statements—the strong policy statements that you have in the MCA and elsewhere—are reflected in reality. One of the pictures that we are seeing right across the country is of enormous diversity. We think it is absolutely critical that we narrow the gap between policy and practice and we use every tool possible to do that—not least the inspection regimes—to make sure the MCA is properly embedded in training, but also that we work locally with those who are consuming the services to make sure that they feel empowered in order to challenge and take up their rights.

Q225 Baroness Hollins: I want to ask about the response to Winterbourne View and the confidential inquiry for people with learning disabilities and premature mortality. I also wanted to pick up on this issue of culture, because the responses have been very much about the role of clinicians in establishing the culture. I pick up from doctors and psychiatry that actually non-clinical managers are often seen as constraining a values-based approach. I
just wondered if you had a quick comment, any of you, about the role of non-clinical managers in culture change.

**Hilary Garratt:** The six Cs apply to everybody working in health. They equally apply to non-clinical managers. It is part of what I said before: making sure that appraisals are based on values as much as managerial competence. Training equally applies to non-clinical managers as well, so I do not really see a distinction there.

**Baroness Hollins:** Of course, but I suppose I just wondered whether you had picked up any concerns about those issues.

**Moya Sutton:** Certainly my experience working in a number of provider trusts has been that there has been a move over the past few years to develop what is commonly known as clinical business units. Now forget the word “business” for a moment in terms of this conversation. The power of that particular organisational culture that is prevalent in provider trusts is that, within those units, they have non-clinical managers working very much in partnership with a senior doctor—a senior clinical director—and a senior nurse at deputy director or assistant director level, so that they can all try to understand the impact of managerial decisions on clinical practice and vice versa.

I would say that it is perhaps not 100%, but certainly there are areas across the country where that tripartite relationship works really well. I think the opportunity is to really ensure that, at board level, at governing body level—and it is what we have seen following the Francis report—the clinical outcomes and the outcomes for patients are absolutely the critical key performance indicators, indicators of success, alongside any of the other information that the non-clinical manager may have to assure themselves on.

**Baroness Hollins:** I suspect that there may be some barriers there to achieving culture change, but let us move on.

**Q226 Lord Turnberg:** I just wanted to follow up on Dr Rake’s comments about Healthwatch. What she said chimes very much with the evidence we have been receiving, but I just wonder: who listens to you? Where do you put your influence? Can you get anyone to do anything in response to your comments?

**Dr Rake:** At a local level, Healthwatch has a statutory place on the health and wellbeing boards and so has some influence. They also have the power to escalate to us at a national level. Healthwatch England has advisory powers over quite a wide range of bodies: the Care Quality Commission, Monitor, NHS England, each individual local authority and, critically, the Secretary of State for Health. Whilst people are not obliged to take on board our advice, they are obliged to respond to our advice on the record. We feel that this will give us strong statutory authority, with a strong evidence base. One of the issues we want to deal with is building an evidence base from the grassroots up in relation to what the application of things like the MCA is at a local level, and to take local issues up to the national level. So there is a local level influencing role on the health and wellbeing board, and then Healthwatch England’s specific statutory powers over a wide range of bodies.

**Lord Turnberg:** Have you any examples of where that has worked?
Dr Rake: Not yet, because we are a brand new organisation and one must use one’s statutory powers advisedly. That certainly keeps them sharp. However, we will be doing so and we have already raised concerns right across the health and social care system with the operation of complaints advocacy and the complaints system. We think there is a very critical issue with IMCAs and making sure that, where people have worries about how the Mental Capacity Act is being applied, they have ready recourse to independent mental capacity advocates in order to make sure that their concerns are quickly and appropriately redressed. One of the advantages, if you like, of our very broad remit across health and social care is that we see the breadth of the challenge in getting an effective complaints and concerns system.

Q227 Baroness Hollins: The Government is looking very much to NHS England to respond to Winterbourne View and the confidential inquiry into the premature mortality of people with learning disabilities, who are a particularly vulnerable group. There have been very serious failings. How does NHS England work with the Department of Health in its response—in planning its response—and how are you making sure that the Mental Capacity Act is fully embedded in the way that you are responding to these failings?

Hilary Garratt: We have been working very closely with the DH, and the response to Winterbourne is a specific example. We have got a concordat that sets down our actions clearly and we have key people in post that are focusing on those actions, mainly around people and place. What was the second part of the question?

Baroness Hollins: It was really: how are you working? You are working with the Department of Health on the Winterbourne View response, presumably.

Hilary Garratt: Absolutely. So, we are clear about the actions that we need to take. We have got clear governance structures within NHS England, so we can report on progress with clear timelines and key people’s names. We have invested support so CCGs are clear about their responsibilities and we are tracking progress. I am not sure you are aware of some of the actions, but we are tracking everybody with learning difficulties who is receiving care to make sure that their plan is personalised and that they are receiving care in the most appropriate place.

Baroness Hollins: Can I just interrupt you for a minute? One of the difficulties, for example, arising from the confidential inquiry is the difficulty in identifying people with learning disabilities, and I wondered whether you were doing anything in response to that as part of your response.

Hilary Garratt: Yes. We have some resource allocated to that. We are working at a primary care level—at GP practice level—to make sure that they are identifying people appropriately with learning difficulties. We have a register.

Baroness Hollins: That has been in place for a really long time, but what about when people arrive in hospital because that is where the simple failings really seemed to show there was an issue? A lot of the failings were in hospitals, were they not?

Hilary Garratt: Yes. Again, it is about providing support to providers as well. I was going to come on to that. We have got primary care and we have got provider support as well; making sure we have people in the right places who can support people when they need
support and obviously work through into making sure that they have got the right package of care. There are clear work streams associated with the Winterbourne recommendations and a clear line of sight, so that gets reported at board level through appropriate structures.

**Baroness Hollins:** Is the Mental Capacity Act—the use of the Mental Capacity Act—embedded in the response?

**Hilary Garratt:** What we need to do is go back and check that. We are investing resource. We have advertised for more resource to come into NHS England to do that cross-check in terms of what we now know from the mental capacity review that we have done. We have to go back in terms of Francis and Winterbourne to make sure that, in relation to the Mental Capacity Act, the actions are as strong as they can be in terms of recommendations.

**Moya Sutton:** Just very briefly, your comments are very well made about the failings in the provider trusts in hospitals. Certainly my experience has been that, over the past year, board reports have had to be presented to the board outlining progress against the Monitor framework around caring for patients with learning disabilities. Certainly some of the good practice that has emerged is that, once a patient is identified as having a learning disability, they have a bespoke passport that they bring with them whenever they are admitted to the A&E department, which sets out their personal-centred planning requirements. There is a lot more to be done in terms of really focusing and using the six Cs on caring for patients who have particular needs with learning disabilities and really trying to get the system understanding what their requirements are—what the patient’s needs are.

**Baroness Hollins:** The difficulty is about identifying people. You said, “Once people have been identified”; do you think the Mental Capacity Act will help people to identify?

**Moya Sutton:** I think it is probably a question that will come in a moment. Our horizon scanning of how the Act has been implemented and where it has touched patients and frontline practice shows there is a whole range of inconsistencies. There are some individual approaches to how the Mental Capacity Act is viewed, which is perhaps not in the best interest of our patients. There is a huge piece of work to do in terms of training staff and getting some expert within NHS England who has got this subject matter and is really leading on this subject matter to help us move forward. There is still a fair way to go. In truth, we started to put a forensic lens on what the issues are here, which is very helpful. What we need to do now is to identify those things that need to be put in place to address those sorts of issues and be held accountable on that.

**Q228 Baroness Barker:** I have two questions—I have a question and a supplementary. I would like to ask the first question primarily of Dr Rake. On the relationship between the Mental Capacity Act and safeguarding, how does the work of your organisation contribute to ensuring that there is an appropriate balance between safeguarding and empowerment, given that you work principally within medical settings?

**Dr Rake:** We work across health and social care. We are there as a watchdog. We have a watchdog function at a local level. Our role for local Healthwatch is to signpost people to appropriate support at a local level and, where they have direct concerns, to make sure those are escalated. It is useful to have this question, because it follows on in a sense from what is going to be the response to Winterbourne View and the other tragedies that have affected the health system. We need to make sure that there are appropriate early warning
systems in place. That is a responsibility across a whole range of organisations, but we have taken that responsibility particularly seriously with the new inspectorate regimes.

We have had early meetings with the new Chief Inspector of Hospitals, the new Chief Inspector of Social Care and we are due a meeting with the new Chief Inspector of Primary Care to make sure that, where Healthwatch locally are hearing concerns either directly from individuals or from family and friends, they are either escalating that directly into safeguarding or they are signalling to the inspectorates that there are issues at a local level, so they can upgrade their inspection function locally.

We are not there to do safeguarding and are not there unfortunately in all instances to do complaints advocacy, although we would very much like to be in a position where we could offer that sort of service across the country. But at the moment, as you will be aware, complaints advocacy is commissioned locally and it is a matter of local discretion as to exactly how that is commissioned. One of our concerns is making sure that we have a more consistent offer of support to individuals that are concerned around mental capacity, but also around health and social care issues in general, so that they know where to go to get the support they need if they have got a concern or a complaint about the services they are receiving.

The Chairman: Did I understand that you would like to take over the responsibility for complaints advocacy?

Dr Rake: Currently the system is enormously complicated and very few people are aware of that advocacy support function or what to expect when they access that advocacy function. At a minimum, we would like to suggest some standards for complaint advocacy across health and social care. But we also think there is a piece of work to be done to raise awareness of the fact that you can get support if you need it, and we think we have a powerful brand offer in that space.

Q229 Baroness Barker: Following on from that, to NHS England, is it correct to say that your work on the Mental Capacity Act is carried out and evaluated through safeguarding objectives? If it is, is that appropriate? How do you ensure there is an appropriate balance between safeguarding and empowerment?

Moya Sutton: Certainly, safeguarding within the new structure incorporates a whole range of areas—from child sexual exploitation right the way through to safeguarding adults. Certainly, we felt that the leadership, cultures and values of individuals working in the safeguarding field were perhaps appropriately equipped to also lead on the Mental Capacity Act agenda. It is fair to say that what we have been trying to do since we came into being is to establish some very high level and very practical leadership development programmes for the new system, so that we can make sure that everybody has access to the appropriate training and information and support as necessary.

It is probably fair to say that we have found some areas where somebody may have a whole gamut of experience of child safeguarding and perhaps needs further development in terms of adult safeguarding. It is fair to say that we have recognised that. It is a very interesting point. We talk about, certainly in NHS England, the importance of safeguarding and safety being hand in hand, and that the Francis inquiry was about safeguarding individuals, not about clinical issues. It was about a myriad of issues. However, for me, there are a number of
points where we have to be very clear about the balance between safeguarding and empowerment. That is about our staff—our frontline staff—being very clear about capacity. It is being very clear about the risk of our patients making unwise decisions, and managing those risks and allowing them the liberty to make some of those decisions.

That is about people understanding that this is not about being subjective; this is about being very objective in your assessment. We hear examples up and down the country whereby we have patients perhaps that have been admitted to residential care homes, where there have been some issues and the home staff have thought, “We need to actually deprive this individual of their liberty because they are trying to leave and are a risk to themselves and to others.”

We use this piece of information. It is actually very helpful as a training tool, but it needs massively updating. It talks about the power of really thinking about the patient’s safety, thinking about the patient as a person or the person as a person—the resident as a person—and really understanding why they are behaving in the way that they are behaving. We have examples where we have had residents wanting to leave the home and being very concerned about their safety. Actually, when they have really tried to understand the behaviours, what they have recognised is the individual was a prolific pianist, was a librarian, or loved gardening, and she or he is in a setting that is alien to them. They have lost all their connection with their past, and we have been able to demonstrate that, when we have really tried to understand the person as a person, we have actually been able to empower them to be safe without taking specific steps to stop them being an individual.

That is where we hope, as NHS England, we can try to embed this across the whole of the system—that our patients should be empowered and that we should support their decision-making. I would hope that we will try to strike that balance between safeguarding and empowerment. However, it is difficult, and if you speak to some of consultants, they would say that they think perhaps our patients are making unwise decisions, so there is a lot of work to be done there.

The Chairman: We have a lot to get through in a limited time. I wonder if witnesses could try to keep their answers to the point and be as concise as possible.

Q230 Baroness Shephard of Northwold: In oral evidence, the Department of Health has argued that it is the responsibility of NHS England to address the regional variations in the applications of deprivation of liberty safeguards. Now, we have had mention of regional variations already in a slightly broader context. Do you agree with the fact that they are placing responsibility on NHS England and, if so, what are you doing to address variations? In your answer, would you like to give perhaps a very brief example of the kinds of variations that you are experiencing—in other words, best and worst?

Moya Sutton: We have got a number of sources. I will try to be very succinct. We have got the national steering group which is led by DH, of which we are an active partner. We have met once. We have been given a list of homework to do, which we are currently compiling. What that is asking from NHS England is: what data sources do we currently have; what information are we collecting; what information we would like to collect; where is it showing best practice and not-so-best practice? I think it is fair to say that what we found when the Mental Capacity Act was implemented in 2005 and then over the subsequent years was that we had national and regional leaders gathering some of this data.
Now, under the new system, that has become quite fragmented and we are going to appoint an individual, as I said, to try to develop a minimum data set for NHS England to be really clear about the information that we need to collect.

It is about staff that are trained. It is about leadership at every level. It is about how many DoLS referrals have been made and what the outcomes of those DoLS referrals have been. It is also about the patient experience and where we have found frontline staff, patients and their families understanding the processes. We have some great examples in the Midlands, in Birmingham, where they present to their safeguarding adults board a whole myriad of data that they collect showing performance against some key performance indicators. We have some examples in Yorkshire, in the Barnsley area, of frontline investigation with staff about their understanding of mental capacity and DoLS. We want to try to get the minimum data set for both qualitative information and quantitative information that sets the benchmark. Then it will be easier for us to see where those variations are happening and where we need to put some of our efforts.

**Baroness Shephard of Northwold:** What would you do with those that are performing the least effectively? How would you actually deal with it?

**Moya Sutton:** We need to understand what the issues are. If there are fundamental failings in terms of not achieving targets that have been set for training staff, etc., then we need to put a focus on the governing body or the board in terms of what those issues are and how we can support them. We have to be supportive in terms of trying to get the system in place, but then I think we have to be very critical and challenging where we have got areas of outstanding practice compared with areas of practice that is not acceptable.

**Baroness Shephard of Northwold:** Do you have meetings with providers of Healthwatch as well?

**Moya Sutton:** Most definitely. We ran a national conference two weeks ago last Friday on safeguarding, and Healthwatch colleagues were at that conference. I suppose, as you said, Katherine, these are fairly new relationships that we are needing to develop, but certainly that intelligence, and the intelligence from our quality surveillance groups, should focus our attention on areas where performance is not acceptable.

**Dr Rake:** The general reflection is the direct levers for improvement are complex, and we are very concerned that regional variation will become even more of a pattern across health and social care. I am very keen that we do everything we can to raise concerns, but the ability to directly intervene has become very complex.

**Q231 Baroness Browning:** Hilary Garratt was talking about a measuring culture, but the only real tangible statistics in relation to the MCA are really around the provision of IMCAs and also the application of DoLS. Without wanting to ask you to go into the tick-box culture, I wonder if you have got any suggestions to make about how we can gather and quantify so that we can evaluate statistical evidence about how well the MCA is working, given that it covers such a wide range and you have got the geographic spread as well.

**Moya Sutton:** I think it ties into my previous question. What was very helpful at the national steering group, which had representation from Public Health England, Monitor, CQC, Social Care, etc., was that we recognised we do not collect an awful lot of information in terms of the effective implementation of the Mental Capacity Act. I suppose, in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
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going back to being very clear about the national minimum data sets, we can compare areas and try to minimise the regional variation. However, the importance for us is it is not just about collecting the data; it is about what the experience was, and the equality and diversity issues of accessing support, etc. Do we know—and I do not know if we do know—how many of our IMCAs are accessing interpreter services if they are required, etc.?

I think we can gather data at that level, but it does not really describe the cultural impact of: so what difference did the Mental Capacity Act make to that patient, that family, etc.? I think we know what the issues are; the challenge for us is to try to get the system in place whereby we can be really clear about the outcomes.

Baroness Browning: You did mention earlier, for learning disabled people, the use of the personal passport. I am a great fan of the personal passport because they cover more than just the learning disabled; I can see all sorts of things. Can you just explain this to us? When somebody has a personal passport—we have had examples of them given to the Committee—who initiates that someone needs one and where do they tangibly, physically, get the passport from? It seems to me that if they arrive in hospital, they could be given one in hospital and people help them fill it in then. However, that patient experience is all about them and their having an input into it. How does that work in practice? Presumably, the use of a passport could also be an indicator as far as the MCA is concerned.

Moya Sutton: That is a very valid question. I would cite, as an example, my experience of working in a provider trust that cared for patients with neurological difficulties. We worked with an outstanding mental health trust that had learning disability services—Mersey Care, who are, in my view, real exemplars of working with people with learning disabilities to empower them to describe, through whatever medium they can, their own particular personal needs.

It is probably fair to say that, in a huge acute trust, having that focus is probably more of a challenge. I am a great fan of them, not just for, as you say, patients with learning disabilities but for patients who are terminally ill and who want to describe their wishes. I am also a great fan of using them with babies—parents describing what makes their baby happy when they are not at the bedside.

This is a piece of work that nationally we would want to champion using the best in the business. Our national steering group, which is very much about the minimum data set, is one particular body to which we have worked, but we also have our own NHS England steering group. We want to have a work stream looking at all of these issues after this inquiry, and we will appoint a lead, as I said, who has that expertise, so we will be able to demonstrate some really good practice going forward.

Q232 Lord Swinfen: NHS England is the commissioner of primary care. How do you ensure that GPs and other providers adhere to the Mental Capacity Act?

Moya Sutton: It is a challenge. I think it would be unfair for us to say that it is not a challenge. In the new system, the area teams are responsible for managing the performance of primary care. We have to look at it at a number of levels. We have got GPs that sit on the governing bodies of the CCGs. We have got GPs who work in practices as a federation of GPs. Then we have got the individual GP. Training is an issue; we know that. What we also need to consider is using appraisal, using revalidation, using the standard contract, and
using leadership at the area team level to work with our GPs. Most practices do have a safeguarding lead. We have got to really work with them to support their leadership at a local level of safeguarding generally, including mental capacity. It is an issue where we have got a lot of work to do.

**Hilary Garratt:** It is also about working with our Chief Inspector of Primary Care to make sure that we can support them as regulators to enable GPs to be the best practitioners they can be and also the best employers they can be as well, because they obviously are independent employers of other staff too.

**Lord Swinfen:** Thinking of my own GP and practice, it is rare to see exactly the same GP each time. Do you find it easier to work where GPs see the same patients the whole time, or the same families the whole time, so that they build up a picture of the patient? Very often they seem to be coming to it absolutely cold.

**Moya Sutton:** That is a very valid point. I think any of us would talk about the positive experience of seeing a GP that knows you and your family, and can really understand the community and the environment in which you live. Where possible, we would want to aspire to that. I think our Chief Inspector of Primary Care would want that to be an aspiration and an ambition. Practically, it may well be something that is challenging in some areas, as opposed to other areas. There is the whole debate about out-of-hours. We are trying to really bring that clinical focus right through the CCGs to the local primary care services to try to get some safe systems in place in terms of really understanding family need.

**Q233 Lord Turnberg:** The CCGs have got to have an MCA/DoLS lead. What requirements do you place on CCGs to have that, and have any been refused authorisation because they did not meet the standard?

**Hilary Garratt:** You are absolutely right. The relevant criteria for CCG authorisation is that they did have to have a DoLS lead, a clear job plan and clear policies and procedures to support the role. As I said before, after the authorisation, we did a rapid appraisal about who the people were and whether they were confident, etc. Were any CCGs refused and delayed? Yes. They were not refused; they were delayed authorisation with conditions. It was just a couple actually, who were in the process of recruiting. Those delays—delaying authorisations or authorisations with conditions—have now been lifted because recruitment is complete. I think that demonstrates that we do have rigour in the assurance systems.

Through our national steering group work, we are now supporting area teams to dig a bit deeper in terms of their competence—MCA lead competence at CCG level. Through their regular governance meetings, they can have a more in-depth conversation and more in-depth review of what is happening locally at CCG levels in terms of their being able to exercise their duties under the MCA.

**Lord Turnberg:** From what you say, it sounds as if you have set up all the processes and the mechanisms to ensure that things happen in the right way, but what we hear on the ground is that there is a long way to go—a discrepancy between what you are putting out and what is happening. How do we fill that gap?

**Hilary Garratt:** First of all, it is about being realistic about the challenges and getting to know what the challenges are. Through the rapid appraisal and the deep dives we are doing in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
now, we are getting to grips with some of the issues that Moya and I have already highlighted in terms of confidence, training, and the ability to be exemplars of personalised care. It is using our resources wisely to make sure that we fill those gaps through areas we have already highlighted. Another one is information: the minimum data set, how to performance manage, and how to support people.

Lord Turnberg: I suppose you produce all those very nice documents with all the right words in them, but does anyone read them? That is part of the problem.

Hilary Garratt: Some of this is about having the right clinical conversations at the clinical level with patients, with communities, with the public and with our partners. It is the human application of what we have described.

Q234 Baroness McIntosh of Hudnall: Since you have used the word “human”, can I pick this up and take you back to the question I asked some while ago about the impediments to people being able to fulfil the obligations that you are asking them to meet? It often is not about whether they have got the right documents or whether you have got the right documents; it is often about how they feel. What I am wondering is whether you have identified, or have ways of identifying, what the obstacles are. What are the fears and the apprehensions that staff who are actually having to do this stuff feel may make them less likely to do all the things that you, quite rightly, want them to do?

Moya Sutton: It comes back to the culture and it comes back to the training. Because I have worked at the frontline and I have managed nurses who have sought advice with regard to mental capacity and DoLS, I know that it is an area whereby they need to feel very confident in their decision-making. Certainly, going back to your point about it being all very well having the documents, I can guarantee you that this was produced by NHS Midlands and East. Around 20,000 of them were issued to frontline staff. It is an aide-memoir. They keep it in their pocket. It is very easy to assess capacity using the tools within here. They have actually asked for us to update this and to put it on a mobile phone as an application, because they want to be able to get the right information to help them make the right decisions. They are faced with so many other challenges that they need the best tools.

In the ambulance service across the North, what they produced was some keyrings with some capacity-assessing information, so if they arrived at a house, they could very quickly remind themselves. It is a specific area whereby we need to give more confidence to the frontline practitioners. You are right: there is an issue perhaps with people being concerned about litigation, and that comes back to a lack of real understanding about what will happen if you do and what will happen if you do not. Actually, if it is the right thing to do it, let us make sure that the structure in your organisation supports you to make that right decision.

Dr Rake: Imagine the power of that multiplied if you had an equivalent tool in the hand of the individual or family and friends. I do think one of the challenges here in terms of narrowing the gap between policy and practice is to recognise that there are several people involved in this transaction, and actually the most important person is the person receiving the services. We need to make sure there is an equivalent weight on the kinds of tools that empower the individual consumer as well.

Q235 Baroness Andrews: This is another variation on the training question. First of all, can I ask you: what are the terms of reference of the national steering committee that you
have been referring to and on which you now sit, which is obviously very recent and is, for example, collecting data? Where, in those terms of reference, does training consistency feature?

Hilary Garratt: This is the multi-agency training group I have been referring to. I do not think we have the terms of reference with us, but they do centre on establishing what the gaps are and how we can offer mutual support.

Baroness Andrews: Mutual professional support?

Hilary Garratt: Organisational support.

Baroness Andrews: Including Healthwatch, we were told.

Dr Rake: I am not aware that we are a member of that group. I do not think we are.

Hilary Garratt: I do not think you are a member of the group. We have the membership with us. We will just make a quick reference to it.

Moya Sutton: I will find it—carry on.

Hilary Garratt: This is from memory: minimum data set; making sure recommendations are carried forward from particularly this inquiry. Those are the main things that I recall from memory.

Baroness Andrews: However, you are not addressing these longer issues, quite clearly. I am thinking of the direction, quality and consistency of training.

Hilary Garratt: We are looking at consistency of training. We have Health Education England on the group.

Baroness Andrews: Very good. You have referred to training a lot and you talked specifically about doctors. You have talked about having tools for nursing and care staff. What is the real priority in training? If you could do something over the next year, which group would you focus on and what would you do that would be different? Secondly, how does this feed into the new CCG requirement? Is there a requirement on CCGs to take some of this forward as well?

Moya Sutton: I would not want to say, “Well, let’s just train the GPs and put our focus there.” I think we cannot do that. This agenda is too diverse for us to put our attention in one area. It is about frontline staff across the whole board. How would we do it different? My experience has been that the difference—and I would equate it to the difference of multi-agency training for safeguarding children—is that when you put professionals around a table with a virtual situation in the middle of that table, they talk about the importance of the individual and what the individual wants. I absolutely endorse that fact. We have to put our patients, residents and service users right in the middle of this—not do it to them but work with them on this agenda.

Multi-agency training, using scenarios and thinking about the contribution that you as individual practitioners make and what outcome you are looking to achieve based on the

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needs of the individual is absolutely critical. Where I have seen that work really well, it has been empowering for the practitioners, but it has been majorly empowering for the individual.

Baroness Andrews: So it is cross-disciplinary, and that includes the care staff as well.

Moya Sutton: Most definitely.

Baroness Andrews: Absolutely. And it is patient focused, with the patient with you helping to inform your own training.

Moya Sutton: Personally, I think there is great benefit from doing that. I am a real admirer of patients and families being involved in interviewing and recruitment. We know that the CQC new inspection regime with regard to outcome-driven care certainly for children is about really listening to the voice of the child and the family. We know that when the CQC inspect organisations against learning disability care, they will be taking patients and families with them. I think that this agenda is growing in its importance.

The Chairman: Thank you very much. Before you leave, could I ask you to send to the clerk the terms of reference that you mentioned and also the various pamphlets that you have referred to? It might be useful if we had a copy of them so that they can go into the record—and a copy of the membership of the steering group. Thank you very much.
Further to your correspondence of 18 November, inviting Health Education England (HEE) to respond to the questions set by the Committee on the Mental Capacity Act, please see our responses as below.

1. How does Health Education England relate to the other actors with a role in ensuring that the healthcare workforce implements the MCA in practice, such as the Care Quality Commission, NHS England, the professional regulators such as the GMC and HCPC, and the Royal Colleges?

We are promoting the Mental Capacity Act through e-learning using the HEE e-learning for health platform. This initiative delivers on MCA training in general and also on the recommendation of the Winterbourne View Inquiry. Health care professionals need to understand the MCA particularly when working with individuals with learning disabilities.

Stephen Dalton (Chief Executive of the Mental Health Network) is the co-chair of the new HEE Advisory Group on Mental Health and is very keen to be engaged in any work on the Mental Capacity Act, as he recognises that the MH HEEAG would be a good place to have the debate about developing a more cohesive approach to the Act. Please feel free to get in contact should you wish to discuss the MH HEEAG’s possible engagement in this work.

2. Much of the evidence that we have heard has argued that if the empowering aims of the MCA are to be achieved there is a need for a change in the culture of services, particularly in medical settings. Can you explain the work that Health Education England is doing that is relevant to such culture change and how you expect it to impact on implementation of the MCA?

Section 2.2 (Treating Mental and Physical Health Conditions with Equal Priority) of the Mandate that the Government has given to HEE for the period of April 2013 to March 2015, recognises that the NHS, public health and social care system must treat mental health and physical health conditions with equal priority.

HEE has a key role in building a workforce with the right values and behaviours to provide a quality service to those with mental health conditions. Detail on our work on values based recruitment is included in our response to question 3.

HEE will ensure that there are sufficient therapists and other staff with the right skills to support the delivery of the Improving Access to Psychological Therapies (IAPT) programme.

HEE will also focus on the mental health workforce more widely and ensure that sufficient numbers of psychiatrists, other clinicians and care staff are trained to meet service needs. We will work towards delivering a mental health workforce with the skills and values needed to continually improve services and promote a culture of recovery and aspiration for all of their patients.

Recognising that mental health is a matter for all health professionals, HEE will also contribute to the development of training programmes that will enable employers to ensure that staff have an awareness of mental health conditions and how they may affect their
patients. For example, we are on course to ensuring that 100,000 staff have dementia awareness foundation level training by March 2014.

3. The MCA requires professionals to implement a set of principles, including the presumption of capacity, the right to make unwise decisions and the best interests principle. This has been contrasted with the specific rules set out in other legislation, such as the Mental Health Act 1983. How does your work on workforce planning and professional education promote the use of values and principles in guiding the actions of care staff and is the MCA part of this work?

HEE is leading a national programme on values based recruitment (VBR), which is comprised of three key projects. The first project will ensure that selection onto all new NHS funded training posts incorporates testing of values by March 2015; whilst the second project will support employers to assess candidates’ values as part of their recruitment process.

It is envisaged that this will be achieved through the development of a national framework for values based recruitment and a suite of tools and resources, which will be made available to both higher education institutions (HEIs) and employers to support VBR and to enable sharing of good practice. The third project will be an evaluation of recruiting for values, including the development of a methodology for measuring long term impact and benefits.

Whilst the Mental Capacity Act is not specifically cited in this work, values based recruitment will focus on the values outlined in the NHS constitution. These include respect & dignity, compassion, and commitment to quality of care.

4. (a) The Committee have heard of good practice in a hospital trust where there is a learning disability nurse consultant employed as an expert in both learning disability and the Mental Capacity Act, but it appears that there are not similar posts in other hospitals or care settings. Does your workforce planning role encompass this type of specialism? Are you undertaking work to monitor the need for such specialist services and if so do you factor in the need for expert knowledge and leadership on the MCA into this?

HEE is primarily responsible for securing sufficient supply of new clinical professionals. This covers education and training to the standard required to register as a professional and for medicine only training post registration to become a CCT holder in order to support the consultant workforce.

HEE does not (yet) systematically support the training of existing staff to become specialised practitioners; this is currently the responsibility of employers themselves to develop their own staff.

HEE intends in future to explore further such roles, however currently HEE has a cap, imposed by the Department of Health, on the amount of resource it could deploy on such development.

The LD Nurse Consultant is one example of such specialised practitioners who require post registration training whilst in employment to equip them to undertake such roles.

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NHS Health Education England – Written evidence

HEE does not therefore undertake specific workforce forecasting for this group a) as it is not responsible for acting on any observed shortfall and b) the group is not readily identifiable within the wider workforce in a way that would allow us to establish current staffing, vacancies and future demand and supply.

(b) Does successful implementation of the MCA require specialist, dedicated lead roles or can this be delivered through other means?

It is likely that the answer to this will be set within local context and is perhaps a question which the MH HEEAG will be able to explore in more detail.

Ian Cumming
Chief Executive

25 November 2013
Niamh (Northern Ireland Association for Mental Health) – Written evidence

1. Introduction

1.1 We at Niamh welcome the opportunity to make this submission to the Inquiry on The Mental Capacity Act 2005 by the Select Committee on the Mental Capacity Act 2005.

1.2 Niamh is the largest and longest established mental health charity in Northern Ireland. Since 1959, we have been providing community mental health services for people with experience of significant mental illness / diagnosis of mental illness. This includes people with complex needs who have physical and learning disabilities as a secondary diagnosis. The Niamh group consists of Beacon, Carecall and Compass. Through Beacon we provide 24 hour and non 24 hour supported housing (391 places), day support (1440 clients) and floating support (98 clients), advocacy (9313 cases) and a range of tailored programmes and support groups. Carecall covers over 435,000 lives in Northern Ireland and Ireland through contracts with employers and third level educational institutions. It provides counselling and psychological therapies as well as mental health and wellbeing programmes. [Figures 2012/2013] Compass undertakes research focussing on mental health promotion, models of mental health care, suicide, stigma, recovery and social inclusion.

1.3 This submission focuses on the Inquiry’s Call For Evidence Section: ‘Devolved administrations and international context’, Question 26: “What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions”. It provides background information on the development of mental capacity legislation in Northern Ireland; our analysis of current policy issues; and commentary on the challenge of cultural change. We conclude with a recommendation of areas for the Committee’s consideration.
2. Background
2.1 The Northern Ireland Executive is currently drafting the Mental Capacity (Health, Finance and Welfare) that will introduce mental capacity legislation and replace the Mental Health (NI) Order (1986). It will be a unified piece of legislation covering both the civil and criminal justice systems, and is being developed by the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ).

2.2 The Northern Ireland Executive’s Programme for Government (2008) identified Mental Capacity legislation as one of the building blocks to realising Priority 2: Creating Opportunities Tackling Disadvantage and Improving Health and Wellbeing. The Programme for Government states that it will deliver a range of measures to tackle poverty and social inclusion through its Delivering Social Change framework including: “actions to ensure compliance with the United Nations Convention in the Rights of Persons with Disabilities”. The ‘Strategy to improve the lives of disabled people 2012 – 2015’ published in 2013 references the Mental Capacity (Health, Finance and Welfare) Bill under the theme Justice and Community Safety and relates this to the progressive realisation of UNCRPD Article 12. We note that the Northern Ireland (Miscellaneous Provisions) Bill recently introduced in Westminster contains a provision which will extend the mandate of the Assembly for a further year (to 2016) and thus extend the period of time in which the Executive has to achieve enactment by the end of the mandate.

2.3 The Department of Justice (DOJ) and the Department of Health, Social Services and Public Safety (DHSSPS) have each established a confidential reference group to inform the drafting of legislation. We are a member of both reference groups. We note that the early drafting of the legislation was undertaken by the DHSSPS before Justice was devolved.

2.4 Niamh is a member of the Mental Health and Learning Disability Alliance (MHLDA). The MHLDA brings together organisations committed to the development of modern and ethical capacity and mental health law that is firmly based in international human rights law and principles. We welcome the proposal that the NI Executive will bring forward a Mental Capacity (Health, Welfare and Finance) Bill that will introduce mental capacity legislation and replace the Mental Health (NI) Order (1986). The Alliance’s vision for legislation is of a principles-based Bill that:

- Promotes the rights and ability of individuals to control their own lives
- Ensures everyone’s rights are respected equally
- Provides appropriate safeguards and support, and prevents discrimination.

MHLDA Members are signed up to Common Cause document, which articulates our shared views on the legislative framework (see Appendix I).

2.5 Niamh is a member of the Advocacy Network NI.
3. Current Policy Issues

3.1 We in Niamh have identified the following issues in relation to the development of Mental Capacity legislation in Northern Ireland, which will are seeking to secure through our policy advocacy.

- Legislative principles founded on UNCRPD.
- Independent, accredited advocacy to facilitate individual’s voice, choice and control.
- Systems that promote supported decision making (rather than substitute decision making).
- Systems that facilitate and respect advanced care planning.
- Capacity in relation to decision making around: health and financial and welfare (not only health interventions).

3.2 We will publish our review paper: ‘Statutory Advocacy Provision under Mental Health and Capacity Legislation’ in the autumn. This paper has been informed by the contributions of members of the MHLDA and ANNI and discussion at meetings attended by Departmental Officials. It considers advocacy provision within England, Wales and Scotland, and Ireland; and outlines our views on the provision of statutory and non-statutory advocacy in Northern Ireland.

4. The Challenge of Cultural Change

4.1 We welcome the Select Committee’s interest in how guiding principles can be realised in every day practice and impact the culture of care. As inferred by the indicative list of emerging issues in Section 3, our concerns about the development of legislation in Northern Ireland include the service and societal contexts in which the legislation will be implemented.

4.2 We are concerned that one of the outworkings of the leadership role played by DHSSPS is that we have not reached pre-legislative discussions on the challenges of decision making in finance and welfare contexts.

4.3 Further the recent devolution of Justice means that we are at an early stage of discussions about ensuring that appropriate legislation is brought forward for the criminal justice system. As stated in our Policy Submission to the Department of Justice’s ‘Consultation on proposals to extend Mental Capacity Legislation in Northern Ireland and implications for Mental Health powers’ 262 (October 2012), we are concerned that the Department is trying to resolve a wide range of issues regarding mental health and the criminal justice system through the Mental Capacity legislation. We think that the legislation provides a good way to engage in wider discussions about mental health within the criminal justice system and to highlight/address some of the problems that exist. However we believe that these issues will need their own approach instead of being addressed within Mental Capacity legislation.

262 http://www.niamhwellbeing.org/SiteDocuments/Niamh%20ConsultationResponse%20DOJMentalCapacity%20Final%2010-2012.pdf

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
4.4 We note the recent House of Commons Health Committee report ‘Post-legislative scrutiny of the Mental Health Act 2007’ (14 August 2013) and the following issues, which it considered:

- the rising numbers of people being detained under the Mental Health Act or subject to Community Treatment Orders;
- whether one factor in the rising number of detentions was the introduction of a new ‘appropriate treatment’ test, which broadened the definition of which treatments a person may be detained to receive;
- whether another factor in the growth in detention was the difficulty in securing voluntary admission due to the high levels of occupancy;
- concerns about knowledge of and access to advocates; and
- the operation of Deprivation of Liberty Safeguards.

We note that the report focussed on the rights of mental health patients guaranteed by Article 5 ECHR and the Mental Health Act itself but did not engage with the UN CRPD.

4.5 We consider the Fundamental Rights Agency report ‘Involuntary Placement and Involuntary Treatment of Persons with Mental Health Problems’ (June 2012) and the OHCHR ‘Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities’ (January 2009) to be valuable resources in understanding the implications of the UK’s human rights commitments in the area of mental capacity.

4.6 In order to address the challenges of cultural change, we are co-hosting a symposium on disability, decision making and human rights with Mencap ‘Our Lives, Our Decisions’ later this year. The event will take in the context of UN CRPD, the Disability Strategy and the forthcoming mental capacity legislation. It will bring together international experts with people who experience mental ill-health and people with intellectual disabilities, their family members and carers, and other key informants from Northern Ireland. Participants will have an opportunity to be informed and contribute to the debates around: the realisation of human rights within everyday decisions including welfare, health and finance; advocacy; family life and interdependence; and stigma. The symposium report with recommendations is intended to inform: the Mental Capacity (Health, Finance and Welfare) Bill consultation; the UK report on UNCRPD (anticipated in 2014); Inclusion International’s 'Right to Decide' evidence gathering process for the 2014 World Report on who makes decisions; and the implementation of regional health and disability strategies.

5. Concluding Comments

5.1 In this submission we provided our analysis of the current situation in Northern Ireland regarding the development of Mental Capacity legislation. We have stressed the importance of addressing contextual, systemic and cultural matters in order to ensure successful implementation.

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In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
5.2 We recommend that the Select Committee considers the following areas in its deliberations: progressive realisation of the UK’s human rights commitments; the establishment of robust supported decision making systems; the development of advanced care planning, and the provision of accessible and appropriate independent statutory and non statutory advocacy.

Appendix I: Mental Health and Learning Disability Alliance: Our Common Cause

Members of the Alliance share the following views on a legislative framework for new mental capacity law in Northern Ireland:

Principles

1. The ‘Bamford principles’ of autonomy, justice, benefit and least harm should be enacted on the face of the legislation and applied in all decision-making under the new law.

Presumption of Capacity

2. The legislation should strengthen the common law position that individuals have the right to make their own decisions and must be presumed to have the capacity to do so.

Definition & Assessment

3. There should be one legal definition of capacity for all situations in which the legislation applies.

4. An individual can only be found to lack capacity with respect to a particular decision. Assessment of a person’s capacity must be appropriate to the individual and circumstances and proportionate to the significance of the particular decision. Support should be provided to people where concern exists about their capacity to make decisions so that their right to make decisions are protected. The Bill should contain provisions to ensure that no one is discriminated against on the grounds of their lack of capacity.

Framework & Safeguards

5. The legislation should provide a framework for decisions about the health, welfare and financial matters of a person deemed to lack capacity to make a decision for themselves. A system of appropriate safeguards, including a single mechanism for challenging decisions under the legislation, should protect everyone subject to this law.

Advanced Planning

6. Everyone should be facilitated to state their wishes and preferences while they have capacity to do so. These should be respected. Mechanisms for this should be included in the legislation.
Right to Advocacy

7. There should be a legal duty to provide independent advocacy to people whose decision-making capacity is impaired, appropriate to their needs and circumstances. Information on advocacy services must be provided to individuals, their families and carers who may be affected by or come within the scope of the legislation.

Interventions

8. Interventions, including those in the community must respond holistically to the needs of the person. Safeguards should ensure any compulsory community interventions are only used as a least restrictive option.

Children

9. Children and young people who come within the scope of the legislation must be afforded the same safeguards as adults and have their rights, distinct needs and interests protected and promoted in accordance with the requirements of international human rights law.

People with Disabilities

10. People with disabilities who come within the scope of the legislation must be afforded the same safeguards as others and have their rights, distinct needs and interests protected and promoted on an equal basis with others in accordance with the requirements of the United Nations Convention on the Rights of Persons with Disabilities.

27 August 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Overview and context

1. To what extent has the MCA achieved its aims?

Our Trust believes that the answer is broadly that the basic aims have been achieved. The MCA has brought together a large body of common law and added it to some new provisions to create a modern and largely workable Act which provides greater protection to both people who lack capacity and the carers and professionals who look after them. It has succeeded in giving greater focus to issues around capacity or the lack of it and has sharpened overall staff perception to the rights and needs of people who lack capacity. However see below point 6.

We are concerned that in the evidence already given to the Select Committee the occurrences at Winterbourne should have been used as evidence that the MCA is failing. We do not point to the prevalence of theft to illustrate the failure of the Theft Act. Abuse of vulnerable people will always occur. It will not be prevented by a piece of statutory legislation, however good or effectively implemented. The answer to Winterbourne, in so far as there is a complete answer, must lie in: tighter regulation of care homes; better inspections by the CQC with an emphasis (as Lord Patel said in the Committee) on a visitorial system such as the MHA Commissioners use, rather than on mere compliance inspections, such as has become the norm in the CQC; improved payment, recruitment and training of non-professional care staff. It does not lie in amendments to the MCA, whatever the case for these may be in other respects.

2. Which areas of the Act if any require amendment and how

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate

We believe the principles are the single best feature of the Act and their positioning at the start of the Act in S.1 is wholly helpful. They still have the potential to revolutionise healthcare if they were fully acted upon, which of course they are not, but they are of help; as is being able to point to them as statutory principles. In this respect they are stronger and better positioned than those in the Mental Health Act, which are not in the Act itself, only in the Code of Practice and therefore have less authority.

The definition and test of capacity is helpful and well used. As a Trust with substantial mental health services we have always regretted the omission of ‘belief’ from the four-fold statutory test of capacity. It is crucial to us as many of our mentally ill patients have the cognitive functioning to understand something; they just don’t believe it due to paranoia and other psychotic distortions to their thinking. We have accepted the assurances of commentators like Richard Jones that belief should be subsumed within the test so that a patient who does not believe something that is demonstratably true either does not understand or is not capable of weighing the issue in the balance. Still, a more explicit alert to staff (such as in fact was in the original case law of Re C (Adult: Refusal of Medical Treatment, 1994) would be helpful.
The question refers to a definition of best interests. Surely there isn’t one and this has made the Act the subject of intense criticism from, in particular, lawyers, who believe it confers too great a discretion on doctors to make the best interests decisions they wish to make? Our own position is contrary to this: we are not critical of the lack of a definition. Our view is that it would not be possible to define best interests as they are individually determined. We accept that this introduces an element of flexibility into decision-making. It is evident to anyone who has used the Act that the best interests checklist is susceptible of manipulation to obtain the decision the professional or other decision maker wants. Our view is that mostly doctors and others do not manipulate it unduly and that there are certain situations when a decision would arise from use of the checklist that is completely contrary to the patient’s medical interests. An obvious example would be Jehovah Witnesses and blood transplants. This is proof that the check list cannot be infinitely manipulated. This can cause some professional angst but is inevitable if the Act is to work, as by and large, it does. We do not think the ‘definition’ or even the check list could be much improved.

Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

No comment except that as already said the principles are extremely useful and easy to publicise in training with a potential to transform health services.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to better practice?

No comment

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

Our view is that the Act, though known about, is not as widely and fully known as it should be and that there are wide variations in knowledge according to the sector of care. It is undoubtedly more widely known in Mental Health, including Learning Disability, than in medical services. Our experience of medical trusts is that their staff are far less likely to be familiar with the Act or to have its principles embedded in their practice. The word ‘Mental’ attached to Capacity has of course been partly responsible for this and this is regrettable. In reality, as the Committee must know, issues of capacity are at least as common in medical services as in mental health services.

Even within Mental Health services there are failures of knowledge amongst frontline staff. This would cause greater problems than it does were it not that the Act has built upon existing practice and legal positions. The result is that many staff use the Act without knowing that they are using it. Nurses who stop an elderly confused person wandering off the ward and coming to harm often have no idea that they are thereby using the MCA. One of our staff with a role relating to the MCA has tried the experiment of going onto an over...
65s psychiatric assessment ward and asking nurses two questions: how many people have you got detained under S.2 or 3 of the MHA?; how many patients subject to Section 5 of the MCA? Typically staff will give an exact answer to the first question. To the second they often respond that they do not have any as they do not use the MCA. This on a ward where a majority of patients have dementia. At first we believed the term ‘Section 5 actions’ would catch on as a convenient shorthand for use of the MCA but it never has. If this position is accurate how much greater must be the staff’s ignorance of the finer points of the Act? It is also true of a Trust where there has been considerable investment of time and resources in training staff on the MCA. One answer might be to make training on the MCA mandatory for frontline clinicians and to make wider use of e-learning in order to reach more staff.

The above has caused one member of staff here to refer to the MCA as the ‘invisible Act.’ This is in contrast to the MHA. One reason is undoubtedly the absence of statutory forms. It is not possible to do much for a detained patient without completion of the appropriate statutory form. With the MCA even the most important assessments and decisions do not require a statutory form, though our Trust has introduced its own local forms for some things e.g. assessment and best interest decisions. We are far from asking that there should be statutory forms: however, there might be case for a standard form for assessment of capacity. The incorporation of the MCA on electronic information systems such as RIO is a welcome step forward and the Trust has recently taken steps to ensure that doctors use this functionality as a means of more obvious recording of capacity status. We have also taken steps to ensure that in Mental Health all patients have capacity assessed on admission. There is a danger otherwise that this is not done, either because it is not thought necessary, or because doctors who know the MCA rely upon the principle of presumption of capacity in adults.

Staff within the Trust have reported on the basis of first hand observation that the MCA is blatantly misunderstood in some areas outside the NHS, such as private nursing homes. One very experienced ward manager for the elderly reported on homes where patients where being left in soiled clothing on the basis that this is their right and as such staff have no power to intervene. In reality it is beyond belief that such patients have capacity and genuinely want to make such decisions. One effect of an act is that garbled and distorted versions of what it means become current. This has happened with the Human Rights Act and there is some evidence that it has happened with the MCA. It is also possible that this occurs because of misunderstandings of the HRA, such as that people have the right to refuse to have soiled clothing changed i.e. even though they lack capacity.

One anecdote from within the NHS may say something. This concerned a young detained patient on an acute ward who was losing weight and was alarmingly thin. His level of capacity in most areas was low. He did not like hospital food and had to be prompted to eat it but did like to have take-a-aways. However, he never joined in the twice-a-week organized ward take-a-way because by then he had spent all of his money, usually on cigarettes. Nurses had to be instructed that they were well within their powers under Sections 5 and 7 of the MCA to withhold some of his benefits money to allow him to take part in the take-a-way as being in his best interests. In this sense greater knowledge of the MCA could be empowering for staff.

Lack of focused monitoring by the CQC has also not helped (see below.)
7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

It is difficult for us to comment on this. By and large non-professional carers are not very familiar with the MCA: some doubtless become more familiar once they are caring for someone who lacks capacity. Professionals do see themselves as having a role in education of carers in the MCA and this can be very effective. One common misconception is worth highlighting, which is that carers will often see themselves as the decision maker as of right. They do not understand that the MCA gives decision making powers to professionals in many situations, albeit that they should involve carers before a decision is made. This is probably what the question refers to as ‘striking a balance’ between the protection of the carer and the protection of the individual lacking capacity. When a care or treatment decision needs to be taken it is right that it should be made by a professional and removed from non-professionals. However, it creates difficulties for staff who are confronted with family members who believe that their caring role or closeness of relationship to the patient gives them powers over and above that of professionals. It also creates great difficulties when professionals explain that they cannot impose treatment, however medically necessary, since the patient has capacity and is refusing it. Non-professionals often fail to understand this even when it is explained to them. Their view is that the patient is unwell, needs treatment and that it is the duty of professionals to provide that treatment. This is particularly a problem within mental health services where it is difficult for non-professionals to grasp that someone with a serious mental illness nevertheless has capacity.

It is worth drawing a parallel with use of the Mental Health Act. When a patient is detained the MHA Administrator sends a letter and pack of information to the nearest relative as well as to the patient. There is also regular referral to IMHAs. This helps to ensure that knowledge of the MHA is spread to those with a need to know. Nothing comparable happens with the use of the MCA.

8. Has the Act ushered in the expected, or any, change in the culture of care?

The short answer is probably yes, but it is a long process of gradual evolution rather than one of sudden revolution.

It is worth commenting that in so far as there is a change of culture one sign is that there has been a greater number of decisions not to impose treatment on the basis that since the person has capacity it would be unlawful to do so. In the past it is much more likely that such treatment decisions would have been imposed anyways.

9 Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

The Trust has no direct comment on this except that it has no experience of ethnicity affecting decision-making for people lacking capacity.

Decision Making
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

We feel that there is some evidence that staff are working with patients to make decisions that would previously simply have been made for them on the assumption that, since they have dementia/schizophrenia, they couldn’t possibly decide on that. We have seen good evidence of use of signs and pictures in learning disability services. Also where interpreters are used it is now sometimes not because they person cannot speak or understand English but that their level of capacity is greater in their mother tongue. The author witnessed a near miraculous transformation of a patient’s level of capacity simply because a Hindi interpreter was introduced to a tribunal hearing. The MCA is a force behind this gradual spread of improved practice.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

The Trust has a policy on advance decisions, a standard format for drawing them up, inclusion of them in introductory training on the MCA. The policy also contains guidance to staff that they should sometimes consider assisting patients in drawing up an advance decision. In Mental Health services use is made of a care planning tool that incorporates elements of advance decisions and advance statements. Despite all of this our experience is that use of advance decisions is low, even amongst patients with chronic conditions who can expect to experience relapse. Where they are used the standard of completion of the advance decision is often poor and would be challenged if it was ever to be put into use. We have seen examples such as: ‘I never want any medication that has side-effects.’ Or advance decisions refusing any basic care or admission to hospital. On occasion we have advised patients to get them re-drawn as they would be disregarded in practice.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

No comment except to say that it has helped and that there is more of such involvement than there once was.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

IMCAs are valuable and to some extent embedded in the culture of services, especially in mental health. The distinctions between IMCAs, IMHAs and generic advocates tend to get lost on many staff. Referrals are often inappropriate e.g. a patient will be referred to an IMCA because an important decision needs to be made even though family and carers are involved in the case. Sometimes it would appear such referrals are accepted, because overall levels of referral to IMCAs are lower than anticipated by contracts. It may be that in fact some of these referrals are in fact passed on to generic advocates within the same advocacy service.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
North East London NHS Trust – Written evidence

Our Trust suffered from a multiplicity of advocacy providers, requiring a complex chart to see who was referred to what service, depending on location, type of advocacy required. Something has recently been done to centralize advocacy provision on a single provider, which has been helpful.

14/ 15 Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals? Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

No comments

Deprivation of Liberty Safeguards

16/17 Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate? Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

In general the level of referrals to DoLs within the Trust has been low, making it difficult to comment. Our general comments on DoLS are as follows:

- we would strongly support the proposals by Richard Jones that DoLS would work better if it was incorporated within the MHA. As our level of referrals is very low it is difficult for us to maintain an efficient system for referrals to DoLS, or to maintain staff expertise. The effect of this is heightened by it being a completely different, parallel legislation. If DoLS was incorporated into the MHA it would become more like S.7 Guardianship: something we also don’t use often but when we do, do so within an Act that we use all of the time. This would make DoLS easier to use and improve practice.

- The above would also enhance safeguards as there would be the minimum requirements for e.g. two medical recommendations and an application before deprivation could begin, the opportunity for a tribunal hearing, including automatic referrals, use of the SOAD system etc. CQC would include both the MHA and DoLS in a single monitoring visit.

- The post-implementation system to support DoLS is clearly inadequate. As an example: there is a requirement for DoLS medical assessors to have regular annual refresher training, as laid down in Regulations. This is in itself completely unnecessary: e.g. S.12 doctors under the MHA are only required to have 5 yearly refresher training, so why the difference? But given that the requirement is in place who is monitoring this? Who accredits the DoLS refresher courses? Who checks whether doctors have attended as required? Is it possible for an ‘Introductory’ and ‘Refresher’ course to be combined, so that a non-DoLS qualified doctor can attend in order to become a DoLS medical assessor? There is simply no system in place to allow these questions to be answered. One suggestion is to broaden the remit of the existing S.12 Approval Boards (who accredit and monitor S.12 Introductory and Refresher courses) to supervise DoLS training. I believe the system for accreditation and refresher training of Best Interests Assessors is better. Would it be possible to extend its remit to DoLS doctors?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
- The CQC has not so far in our experience provided an effective means of monitoring the use of DoLs. It is difficult to see that the system of notifying them of DoLs referrals achieves anything. We have no experience in the 5/6 years since DoLs was implemented of any focused visits by CQC on DoLs. Even where such visits have taken place it is likely the emphasis is on DoLs referrals, but does anyone monitor the failure to refer?

The Court of Protection and the Office of the Public Guardian

18, 20, 21

No comments

19 What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

We have limited experience of LPAs. Few have been experienced within the Trust. Where they are in use it has largely been for finance purposes only. We do have some experience of people abusing or attempting to abuse the system of LPAs:

- claiming to have a health and welfare remit when in fact the LPA is limited to finance. On one occasion the position was clarified with the Public Guardian after a person falsely claiming to have a health and welfare LPA was refusing to allow his mother who had dementia to receive prescribed medication.
- using the LPA as a general excuse and justification for any actions that are seen fit. On one occasion a patient admitted to hospital had possessions removed from her house by relatives who, when challenged, retorted that they had a LPA and could do what they pleased. This was reported to police as an act of theft.

People appear to rely on being able to make bluffs about the existence and power of LPAs. This points towards the need for a robust Public Guardian: our limited experience of the Public Guardian has been good.

Regulation

22

We are not aware that the CQC has risen to the challenge of integrated monitoring of the MCA and the MHA. It is true that in their regular visits to our Trust the MHA Commissioners from CQC will monitor capacity issues in relation to patients they talk to or whose records they inspect. However they only ever interpret their remit as relating to detained patients. They never inspect records relating to informal patients who may lack capacity. Some of the recommendations they have made have a general bearing upon management of people lacking capacity and the Trust has implemented these. In general it
still seems true that the CQC has not extended its role beyond monitoring the care and treatment of detained patients.

23

No comment

Other Legislation

24
It is assumed that this refers to the inter-relationship between the MCA and the MHA. This remains a very complex area where misunderstandings are frequent and perhaps also excusable.

2 September 2013
North Staffordshire Combined Healthcare NHS Trust – Written evidence

Overview and context

The MCA has gone a significant way to achieving its aims and acts to safeguard individuals who lack the capacity to make decisions for themselves. It gives structure and guidance to decisions makers. However, additional powers or guidance may be required around conveyance / transport of people who lack capacity to make decision about admission to hospital or a care home.

Implementation

The initial implementation of the MCA was under resourced, especially considering how fundamental it is to practice. The MCA is accessible to carers, unqualified workers and professionals. However the lack of a defined process has meant that as a Trust we have had to develop a number of MCA related polices and assessment forms. The guidance around this was very limited. The implementation of the MCA has been more difficult in comparison to DOLS and The Mental Health Act amendments, as the MCA has no specialised practitioners with extensive training or practical experience such as AMHP’s, Approved Clinicians or DOLS Best Interest Assessors. The Trust has also developed mandatory training around the MCA to increase understanding amongst practitioners – this has had a positive impact on awareness of the MCA.

Decision Making

The increased understanding of staff, local policy and assessment documentation supports the decision making process. While the MCA and its Code of Practice provide a structure for Best Interests Decisions, the Trusts local policy has developed guidance around Best Interests Decision meetings. Reference to such meetings was largely absent from the Code, however they proved very valuable and positive mechanisms for complex decision making. The Trust has also developed a Policy around advance decisions and has incorporated this into the CPA process. The Trust also has a positive relationship with the local IMCA service and the role appears to provide an additional safeguard for service users who have no one to speak on their behalf. Where they are involved IMCA have usually had significant input into the decision making process. However, further guidance may be required about referral for IMCA, in situations where the Trust and carer’s are in dispute – as suggested in Neary v Hillingdon.

Deprivation of Liberty Safeguards & Court of Protection

The Deprivation of Liberty Safeguards have been successfully implemented within the Trust. The Trust successfully operates a BIA service that undertakes the DOLS assessment function for one of the area’s Local Authority Supervisory Bodies. However, there remains a lack of clarity about what a deprivation of liberty is. Case law has brought clarity to some areas of practice – Use of DOLS in Mental Health Hospitals – GJ v Foundation Trust, but other cases such as Cheshire West & Cheshire Council v P have only confused the issue. The process is also overly bureaucratic and should be simplified, for example number of forms should be reduced. The West Midlands Regional DOLS Leads group have made some positive steps to

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
strengthening the forms, but are unable to reduce the number. The extensive DOLS assessment process and its focus on protection of rights rather than detention are its strengths. However, in reality people who are subject to DOLS have limited options to appeal against their DOLS. The Supervisory Body review process is not independent and review by the court of protection is not easily accessed, can be lengthy and as a consequence can be expensive. In practice representatives (RPRs) do not request reviews via the court or the Supervisory Body. The IMCA Section 39D role should be automatic in the initial stages of a DOLS authorisation. The Trust has extensive experience of the Mental Health Act Tribunal System and believes it to be a robust safeguard of patients rights. Any review of DOLS should consider if the DOLS Appeal / Review procedures should be similar and as accessible as Mental Health Act Tribunals

Other Legislation and Regulation

Practitioners within the Trust have an understanding of the relationship between the MCA / DOLS and the Mental Health Act. The limits of MCA Section 5 and use of restraint (MCA Section 6) are not clearly defined and case law has not clearly identified the factors that indicate a deprivation of liberty. Although there is guidance in all three codes of practice, they are out of date and not clear. The Trust would welcome a single definitive practice guide around this area to inform practitioners and regulators.

2 September 2013
North Yorkshire County Council – Written evidence

Overview and Context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

It is a great first attempt at a vast area of complex decision-making, taking what was good practice and requiring it to be the norm. Its implementation however, remains patchy, inconsistent, and in some sectors undeveloped. Greater clarity is needed in some areas ie who is the decision-maker in certain circumstances, ie self-funders and how does that work in practice? The examples given in the code, do not reflect the complexity of circumstances that can surround many decisions to be made.

2. Which areas of the Act, if any, require amendment; and how?

The Deprivation of Liberty Safeguards need to be clarified, the documentation simplified, and be given more teeth, to be able to achieve its aim of truly being a safeguard for vulnerable people. Opportunities for the person to challenge an authorisation need to be more robust and timely.

Better guidance re self-funders.

More emphasis and guidance on people planning ahead

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

Yes, but given the wide range of people and circumstances they are applied to, these can be in practice, very complex judgements, and are often heavily reliant on the people currently involved in the persons’ life.

Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

Caseload audit shows that capacity assessment, best interests decision-making and looking for the least restrictive option is embedded in every day local authority practice. Practitioners are less likely to record what practical steps they have made to enable the person to make the decision for themselves. Finally the concept of unwise decision-making is only now beginning to be really addressed with any confidence, with little guidance available and a natural tendency for staff to be risk averse.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Initially it was well thought out, supported and changes made. However, as it was aimed to change culture, particularly at a time of huge and constant, organisational and personnel changes, it ended too soon. Measures to inform families re the Mental Capacity Act were less prominent than those aimed at statutory organisations. Whilst some are very aware, it tends to be on a need to know basis rather than in cultural awareness, hence will need ongoing measures for some time to become truly embedded.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

There appears to be a wide variation of knowledge both within specific professional groups, and across the different sectors. Whilst within the local authority it is it is broadly well established, it appears less so in healthcare settings, both hospital and community, with GP’s, and with some housing providers. The banks and financial sector appear to be less well engaged, and local attempts to engage with them have proved ineffective.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance been struck between protection of the carer and protection of the individual lacking capacity?

People have tended to develop their knowledge of it, on a need to know basis.

8. Has the Act ushered in the expected, or any, change in the culture of care?

Yes, the formalised process has led to much more transparency of a standardised process and in decision-making. The starting point of asking can the person make this decision for themselves, has really challenged assumptions in some service areas. The section 44 offences place more accountability upon all carers.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

No evidence of this- although self-funders may be more at risk of poor information sharing and non-compliant MCA decision making.

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

Anecdotally I would think yes, but am unable to evidence that. Nor am I able to comment about the quality of the decision making.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?
Anecdotally there have been only a very small number of advance decisions brought to our attention, within the context of the social care support that we provide. There is no evidence of any increase in awareness or demand, in more recent months/years.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

It has made clear the nature, role and weight of their contributions to decision-making, within the prescribed, hence transparent process. It enables them to hear the views of others, and hence provide opportunity for them to re-evaluate their opinions and enable change and acceptance as appropriate.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

Yes, anecdotal evidence suggests that this can be an effective voice and safeguard, but there is little statistical or other evidence available, from the relevant person or others, to confirm that this is the norm rather than the exception.

14. Has the level of referrals to IMCA’s met expectations? What are the regional variations in the number of referrals?

In relation to changes of accommodation the figures in our area are good and consistent. The level of safeguarding referrals has fluctuated, but is on the increase. Of serious concern, is the very low referral rate for serious medical treatment…a national problem, and those that are referred, are almost exclusively from hospital settings.

15. Are IMCA’s adequately resourced and skilled to assist in supported and substituted decision making for people lacking capacity?

Anecdotally there are many examples of really good practice, and very occasionally a poor response. I feel that sometimes the role suffers from a lack of status in the eyes of professionals, which may contribute to the lack of appropriate referrals, particularly from healthcare professionals.

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

No, given the complexity of the concept and language of the Safeguards, the bureaucracy involved, the vulnerability of the relevant person and likely complexity of their circumstances, it is in danger of being unintelligible and meaningless. It offers a second opinion assessment, by two experienced assessors, and the scrutiny of senior local authority managers, but part 8 reviews are undertaken via the same system, and there is no quick access to the Court of Protection for legal challenge. Urgent assessments can be particularly difficult, especially in hospitals where circumstances can change very rapidly.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The processes for authorisation and review are clear, accessible and timely, although the outcome of assessments, appear to be rarely challenged. Review requests tend to come from the managing authority or a paid Relevant Persons Representative, rather than the person or family members. Only a very small number of cases have been taken to the Court of Protection, and RPR’s appear reluctant to take it down that route. The use of RPR’s as litigation friends, as an alternative to the use of the Official Solicitor, raises questions re the ability, knowledge, skills etc required of RPR’s.

The Court of Protection and the Office of Public Guardian

18. Are the Court of Protection and the Office of Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

Both institutions are seemingly overwhelmed with applications and hence would appear to be understood and accessible. However, changing demographics suggest that more people should be planning ahead than they currently do, and the Court of Protection can involve several months wait before peoples cases can be heard, hence may be viewed ineffective.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

There remains only a few Lasting Powers of Attorney for Health and Welfare, that are brought to our attention. Given the forecast demographic changes, there needs to be a comprehensive public campaign to encourage more people, to plan for their future.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

It would seem that understanding of the MCA has been poor within CQC, hence they have not yet effectively utilised the powers they currently have, hence making a case for additional powers would seem inappropriate at this time. However, as implementation of MCA across services they inspect, remains patchy and inconsistent, they are ideally placed to address that.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Yes, the individual codes underline the values and good practice for each profession, and the Mental Capacity Act by its very nature runs through all of these as a thread. Hence it would be appropriate for sanctions to be used, when practice falls short.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

Again this is very patchy – there are some specific services/people that expertly negotiate the two pieces of legislation, and others, that give little regard to MCA, still believing that they exclusively use the Mental Health Act. Again, the practicalities of the two, can lead to complex situations re the management of care, ie negotiating the end of S17 leave and the commencement of DoL, or understanding why both a DoL and a Guardianship order might be appropriate and the respective processes a person must then be subject.

Devolved administrations and International context

25. Does the implementation of the Mental Capacity Act differ significantly in Wales?

Unable to comment

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

Unable to comment

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

Unable to comment

2 September 2013
Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

Response – Overall the framework has provided a useful process for professionals to follow. However, the MCA aimed to provide a flexible decision making framework for people without capacity, this has been limited due to conflicting court decisions. Especially where there may be conflict with relatives. This has resulted in requests of the court to make best interests determinations where the MCA seemed sufficient provision but organisations have been encouraged to apply to the court. This has not benefited patients in the majority of cases.

2. Which areas of the Act, if any, require amendment; and how?

Response – the IMCA role is very narrow and restricted. A wider referral and involvement criteria would encourage a wider patient centered approach.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

Response – These provide a sound basis of assessment and provision of care and treatment under the MCA.

Implementation

1. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

Response – These have been well received by frontline staff and are useful and applicable in day to day practice. They give a clear overview of what the MCA is about.

2. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

Response – The implementation was led by the Local Authority due to funding allocations and was therefore concentrated in this area of practice. Many healthcare providers designed and implemented their own systems and processes in their organisations including provision of training and monitoring.

The MCA has led to a significant change in practice assisting in putting the patient at the center of decision making.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
3. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?
Response – Knowledge and use of the MCA has been a long process and continues to be ongoing. Our experience is that it is understood to an acceptable level in health and social care but other agencies, such as the Police, continue to have some way to go.

4. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?
Response – There continues to be work necessary with relatives and carers with their understanding of the MCA. At times too much emphasis is given to the views of relatives and carers in determining best interests of a person. At times this almost results in relatives providing consent on the patient’s behalf.

5. Has the Act ushered in the expected, or any, change in the culture of care?
Response – The MCA supports the principle of least restrictive practice which is also in the Mental Health Act 1983, these have complemented each other and have had a significant impact on practice especially where restrictive practice and involvement is concerned.

6. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?
Response – We have not encountered any disproportionality.

**Decision making**

1. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?
Response – The MCA has supported patient centered decision making process and provided a clear framework to do this.

2. What evidence is there that advance decisions to refuse treatment are being made and followed?
Response – Advance decisions continue to be not widely used by patients. They are quite restricted in their application in practice.

3. Has the MCA fostered appropriate involvement of carers and families in decision-making?
Response – Involvement of others has always been an important aspect of mental health and learning disability service provision. The MCA has reinforced this. However, it is an area which requires more detailed guidance as it has produced an ‘over reliance’ on the court to settle disputes.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
4. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

Response – The IMCA role continues to be quite narrow and would benefit from being applicable to all decisions being made in a person’s best interests and also where the person is befriended. This would provide an objective opinion and protect the rights of people. A similar provision to the IMHA role (incapacity in decision making = qualifying for IMCA) may be used. Overall the IMCA has been a useful provision.

5. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

Response – The IMCA referral rate has not been what was originally expected. Patients in the northeast of England are often befriended by a supportive family network or community.

6. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

Response – Yes – in the current service provision.

Deprivation of Liberty Safeguards

1. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?
Response – We feel DoLS do not achieve what they set out to do. This has been mainly due to the conflicting case law since their implementation and the lack of a clear definition. This has left much confusion in health and social care.

2. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?
Response – The process is adequate but the appeals process appears cumbersome and expensive to operate.

The Court of Protection and the Office of the Public Guardian

1. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

Response – There is not a good understanding of these in practice and adequate practice based training is not available. To use the Court of Protection in practice is expensive for organisations to access and use. The process is lengthy and not always timely.

2. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

Response – We have seen little impact of welfare LPA in practice. These don’t seem to be widely used in practice.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
3. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

Response – We are acutely aware of the large costs associated with the Court of Protection. These may be prohibitive in applications in some services.

4. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

**Regulation**

1. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

Response – The CQC do not seem to have a clear role in the monitoring of the MCA.

2. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Response – The CQC seem best placed to carry out this role.

**Other legislation**

1. How well is the relationship with the mental health system and legislation understood in practice?

Response – This is an area which is not widely understood by front line staff and at times other agencies. Mainly this is due to conflicting court decisions in this area.

**Devolved administrations and international context**

1. Does the implementation of the Mental Capacity Act differ significantly in Wales?

Response – We do not have any experience of the use of the mCA in Wales.

2. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

Response – Substituted decision making would seem an appropriate addition to the MCA.

3. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

23 August 2013
1. The Nuffield Council on Bioethics welcomes the House of Lords’ Select Committee’s call for evidence on the Mental Capacity Act 2005. In response, the Nuffield Council would like to draw the Committee’s attention to conclusions drawn in its 2009 report Dementia: ethical issues. To this end, the Council’s response focuses on the MCA in the context of its application to people with dementia. In particular, there are five areas we wish to highlight, four of which are in relation to the Code of Practice which accompanies the Act itself.

Joint decision making for ‘borderline’ cases

[Re. questions 3 and 12]

2. In cases of dementia, a person’s capacity to make decisions will vary; for example, according to the time of day at which they are assessed, or their emotional state when a decision is sought. In such cases, the MCA’s Code of Practice is to be endorsed for its approach in highlighting the need to choose the best time and best circumstances for assessing a person’s capacity.

3. Despite this, any assessment of a person’s capacity is an inexact science, especially in cases where a person has dementia and finds it difficult to communicate clearly. For example, professional opinion may differ as to whether a person does or does not have sufficient understanding to make a particular decision at a certain point in time. In addition, the law takes a binary approach to capacity at present, dictating that a person either does, or does not have, the capacity to make a decision at a particular point in time, and it is difficult to see how else a law could be framed more loosely. This does not, however, mean that this approach to capacity is without issue: for example, in the earlier stages of dementia, very different outcomes may arise from marginal differences in capacity, or indeed in opinions about capacity. We suggest that a way of avoiding these conflicts would be through encouraging the use of joint decision making with trusted family members. This would bridge the gap between the time when a person with dementia is able to make his or her own decisions, and the time when some kind of formal proxy decision making becomes necessary on a regular basis.

4. The use of joint decision making with family members would, of course, depend on heavily on existing family relationships, and levels of trust between the person with dementia and their relatives. However, the ethics framework developed in our report notes that most people do not make autonomous decisions in isolation: rather they come to decisions supported by those close to them and in the light of those relationships. We therefore recommend that the Committee considers amending the MCA’s Code of Practice to emphasise the importance of good communication and supportive relationships with families, so that joint decision making is encouraged where appropriate.

Best interests and decision-making: the relevance of past and present wishes

[Re. questions 3 and 6]

5. When considering what kind of decision a person would have made, if they still had capacity, the MCA refers to both ‘past’ and ‘present’ wishes and feelings. In many cases,
there will be clear continuity between the way people with dementia approach their life now and in the past. However, situations arise where people’s past and present views about a particular question or issue will be very different. The MCA’s Code of Practice approaches this issue by highlighting the importance of strong views in the past, particularly those set down in writing, but emphasising that these would not be the only factor to take into account when considering best interests. However, we recommend that additional guidance should be provided in the Code of Practice on how past and present wishes and preferences should be taken into account where these appear to conflict. This guidance should emphasise that neither past nor present wishes can automatically take precedence, but that the relative strength of the person’s wishes, the degree of importance of the decision, and the amount of distress being caused should all be important factors to consider.

**Interpretation of advance refusals**

[Re. questions 3, 6 and 11]

6. We are concerned about the current lack of consensus as to whether an advance refusal made under the MCA could be invalidated by inconsistent behaviour after capacity to make the decision in question has been lost. Such a lack of clarity adds to the concerns on the part both of those who wish to write binding refusals and of health professionals who have to act upon them. We therefore recommend that additional guidance should be provided in the Code of Practice on whether advance refusals may be invalidated by inconsistent behaviour after a person with dementia has lost legal capacity to make the decision in question.

**Lasting powers of attorney for health and welfare: funding mechanisms**

[Re. questions 19 and 20]

7. We recognise that lasting powers of attorney for health and welfare (hereafter ‘welfare attorneys’) are a very good way of promoting the interests of a person with dementia. For example, they allow decisions to be made in the light of up-to-date knowledge both of the person’s clinical needs and the care options available, thus supporting and facilitating decision making on behalf of people who are inherently vulnerable as a result of their declining capacity. To this end, it is our view that welfare attorneys represent a social good. As such, they should, in principle, be available free of charge for everyone. At the very least, a funding mechanism should be found in order to ensure that when a person is first diagnosed with dementia, they are actively supported in nominating a welfare attorney if they so wish.

**The authority of welfare attorneys**

[Re. questions 19 and 20]

8. We recognise that although welfare attorneys have the legal authority to make decisions on behalf of the person who lacks capacity, they do not have complete freedom of action, as the MCA obliges them to act in the individual’s best interests. While in the vast majority of circumstances the requirement to act in the person’s best interests will not be problematic, conflicts may arise in cases where the welfare attorney and health or social care professionals do not agree about the individual’s best interests. Indeed, in many of the

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difficult decisions that arise in dementia, there will be no single ‘right’ or ‘best’ answer. It is therefore unsurprising that those involved in making a decision on behalf of the person with dementia do not always agree. In light of this, we recommend that the Code of Practice should explicitly address the question of when it is appropriate for professionals to seek to override the decision of a nominated welfare attorney by approaching the Court of Protection. Both professionals and welfare attorneys would then be clear as to their respective conditions. Our view is that significant weight should be placed on the fact that the person on whose behalf the decision is being taken has actively chosen, in the past, to trust the welfare attorney to act on their behalf. This would suggest that others should seek to intervene only if they have grave concerns about the welfare of the incapacitated person, and not simply because they themselves take a different view of best interests.

9. I attach a copy of the report for the Committee’s reference. We are very happy to discuss our recommendations further if required.

28 August 2013
Mary O’Toole – Written evidence

My elder sister has significant learning disabilities and other complex needs; including some mobility impairments, but appears to people who do not know her as much more able as she really is. She has lived in a residential care village run by a voluntary sector provider since age 32. These comments apply to my experience of the application of MCA 2005 for persons with Learning Disabilities.

Changing culture of care For families with significantly learning disabled members, the premise of the Act, that capacity must be assumed, as a starting point, is frequently problematic. The act does not seem to have taken the issues arising from permanent lifelong learning disability into sufficient account. Rather, it seems constructed mainly to prevent inappropriate restrictions placed on persons due to age related conditions like dementia, or due to temporary medical conditions.

The requirement to assume capacity has resulted, in my experience, in provider organisations very frequently failing to consider if a person really has capacity, where it suits the provider not to do this. E.g. It has encouraged staff/providers to assume capacity inappropriately, and exclude families from decision making. If the person is asked, or can be persuaded to agree to a major life decision e.g. moving out of residential care into a supported living environment, staff often just ignore families. If the person can communicate verbally, answer questions etc, too often, they are open to persuasion and manipulation, to deliver the ‘result’ that the provider wishes.

This effect is compounded because most care/support staff are poorly paid and rarely recruited from tertiary educated cohorts. The subtleties of interpretation of the act, and the sophisticated language & reasoning used, are far too complex for the day to day use of the under-educated, over stretched and poorly trained sector staff base.

‘Families get in the way’ comment made by staff member, when family asserted their right to be present in the process of housing selection.

The requirement for time limited and context specific capacity statements greatly increases the administrative and cost burden for families and providers. The Capacity Statement, obtained for a particular purpose is regarded as ‘expired’ even if the original circumstances for its use are still applicable (e.g. lack of capacity to determine accommodation changes)

For these reasons, it is more likely in fact, that the act will be ignored, or its protections under-applied.

2 September 2013
Office of the Public Guardian – Written evidence

Overview and Context

Question 1: To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1. The OPG endorses the general framework of the Act and especially the clarity it has bought about by enshrining the 5 principles in relation to capacity. It also established a clear decision making framework in relation to capacity issues.

2. Prior to the MCA, although there was a Public Guardianship Office there was no statutory role of Public Guardian (PG). The Public Guardianship Office (the fore-runner of the OPG) was the administrative arm of the “old” Court of Protection.

3. The new role, created by the Mental Capacity Act 2005 has a number of functions including (a-d being statutory functions under the MCA):
   a. being the registering authority for Lasting Powers of Attorney (LPAs) and Enduring Powers of Attorney (EPAs);
   b. maintaining registers of LPAs, EPAs and Court-appointed Deputies;
   c. the supervision of Deputies;
   d. the investigation of allegations or concerns as to the conduct of Deputies and Attorneys; and
   e. communicating with the public on matters in respect of adults who lack capacity, and to work with other organisations to support a coherent approach to addressing the potential abuse of vulnerable adults.

4. It is important to draw the distinction between the OPG and the Court of Protection (the Court), as the Act purposefully set up two separate bodies to demarcate the judicial and administrative functions. Previously there had been some blurring of responsibilities with administrative decisions requiring quasi-judicial input and judicial decisions being undertaken by administrative officers. The split also allowed the administrative functions of the Court to be brought within Her Majesty’s Courts and Tribunals Service and hence part of the more formal Courts structure.

5. The split ensures that in the public eye, there is a separate and distinct Public Guardian with specific responsibilities in relation to those who lack capacity; responsibilities that are clearly distinct from those of the Court. It has ensured that this role is filled by a single person who is responsible for this area, has a set of statutory duties and reports directly to the Lord Chancellor. This has allowed the OPG to raise awareness of and develop its business in a more flexible way.

6. Lasting Powers of Attorney (LPA) ensure that mechanisms are in place so that adults are empowered to be able to plan ahead for a time when they may lack capacity to make decisions for themselves. The Mental Capacity Act 2005 has allowed for the opportunity to register an LPA to make provisions in relation to either, or both, an individual’s Property & Finance and Health & Welfare. In the case of Health and Welfare it is the first time people have been able to make provision in this area.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
7. Also by ensuring that LPAs have to be registered with the OPG before use (whereas EPAs only had to be registered if the Donor lost capacity) there is a clearer remit for the Public Guardian to be able to investigate complaints or concerns about the actions of attorneys acting under a registered power.

Question 2: Which areas of the Act, if any, require amendment; and how?

8. Based on the experience to date and the changes that have been made via secondary legislation, the OPG feel that for the most part the Act is working well and does not require significant amendment. However, the OPG is currently undertaking both a digital transformation programme and a fundamental review of the supervisory role of the Public Guardian and cannot rule out at this point that, in order to support these to the fullest extent, that some changes may be required. As a result of the review, the OPG may wish to broaden some of the Public Guardian’s current powers (such as statutory access to financial records to mirror the current statutory access to health records) and to remove some of the restrictions that have become apparent with day to day use of the act (such as the need for the Public Guardian to make LPA severance applications to the Court of Protection rather than the attorney or donor).

9. As part of the digital transformation programme, the OPG is seeking to explore the possibility of introducing a fully digital LPA. In order to take this forward, this would require primary legislation to remove the need for wet signatures. The OPG recognises that there may be concerns around this proposal and are working with stakeholders to explore and discuss these.

Question 3: At the core of the MCA are the principles and definitions of capacity and best interests. Are these appropriate?

10. The Public Guardian considers that these are the key facets of the Act that need to be embedded in practice. They form an appropriate balance between empowerment and protection. There is some debate as to whether best interest decision making is UN compliant. This is based on the view that it is 'substituted decision' making as opposed to 'assisted decision' making. Our view is that best interest decision making needs to be balanced with other principles, one of which is that P should be given all possible assistance to make decisions themselves and have the fullest input into decisions made on behalf where they cannot make those decisions for themselves.

Implementation

Question 4: To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

11. All staff within the OPG, whatever their role, work with the principles of the Act in mind.

12. The five principles of the Act are included on the face of the current LPA form and Attorneys, in signing the LPA forms, agree to act in accordance with the five principles of the Act and best interest decision making.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Office of the Public Guardian – Written evidence

13. As part of the Deputyship Annual Report process, Deputies have to sign the following statement:

'I confirm that I have carried out my duties as a Deputy in accordance with the requirements of the Mental Capacity Act and Code of Practice'.

14. Since October 2007, 135,845 reports have been lodged; the figures include live, terminated and archived cases but moreover show that by signing a statement which refers to the Mental Capacity Act, and stating that they are complying with it, the Deputy is certifying that they are aware of the Act itself, and that they are taking the five principles into account when carrying out their duties as a Deputy.

15. The supervision and investigation functions within the OPG are set up to ensure that there is a balance between enablement and protection and ensuring that decisions are made in the client’s best interest. Court of Protection appointed Visitors, as part of their visit, ensure that Deputies are compliant with the Act and the Code of Practice.

16. The OPG has undertaken some research to determine the level of knowledge of the Act and its implementation in practice. In 2012, a Professional Deputyship Customer Questionnaire was conducted by the OPG. Of the 393 responses a large majority of professional Deputies (271 or 69%) were not only aware of the Act but accessed it as a tool for managing their Deputyship and by so doing putting in place the principles of the Act.

17. During 2012, Deputyship interviews were carried out to obtain a qualitative analysis of the Deputyship service. Of the 14 interviewed 10 (71%) mentioned that they were aware of and had read some parts of the MCA 2005 and Code of Practice.

Question 5: How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

18. The OPG undertook research on levels of awareness and developed an implementation plan to ensure that the key players were aware of the Act and its key provisions. This included working with key stakeholder groups, the 3rd sector and other Government departments such as the Department of Health.

19. The Mental Capacity Implementation Programme (MCIP) was a joint programme between the Ministry of Justice, the Department of Health, the Office of the Public Guardian and the Welsh Assembly Government. MCIP produced a series of specialist booklets264 aimed at specific groups outlining the Act and its main principles and ensuring

264 OPG601 - About your health or finance - who decides if you can’t?

OPG602 - A guide for family, friends and unpaid carers

OPG603 - A guide for people who work in health and social care

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that there was a significant awareness of the Act and its principles before it came into force.

20. The Code of Practice\textsuperscript{265} was published 23 April 2007, before the OPG and the new Court of Protection came into existence to ensure that people had a chance to look at and become familiar with, the Code and its contents before they were called upon to put it into practice, significantly raising awareness of the Act. The Code of Practice is available to purchase but also available free of charge via download\textsuperscript{266}

21. The OPG has also assisted the Law Society with the production of practice notes relating to the provisions of the MCA, so that clear and correct information can be distributed throughout professionals within the Law Society. The OPG’s work with a large number of 3\textsuperscript{rd} sector industries such as the Alzheimer’s Society has been vital in the dissemination of information for families and professionals, to underline this, one of the objectives which the Alzheimer’s Society campaigns for is, ‘Awareness raising for the public and full training for all health and social care professionals in the Mental Capacity Act 2005.’

**Question 6: Is the Act widely known and understood by professionals, required to implement it? How does this differ across different sectors, such as health, social care, banking and others?**

22. The OPG has been aware for some time of confusion around the powers and limits of the role of an attorney acting under financial LPAs and Deputies acting under court orders who have reported difficulties dealing with banks and buildings societies. The OPG has, as a result, been working with financial organisations, including the British Bankers’ Association and Building Societies Association to develop and publish guidance, backed by the Law Society, Age UK, Alzheimers Society and Solicitors for the Elderly. This was published in March 2013\textsuperscript{267}.

23. The OPG has also received anecdotal evidence that the Act is not fully understood in all areas of the Health and Social care sector and is working with the Department of Health to address these issues.

OPG604 - A guide for advice workers

OPG605 - The Mental Capacity Act – Easy read

OPG606 - The Independent Mental Capacity Advocate (IMCA) Service


\textsuperscript{266} http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf

\textsuperscript{267} Guidance for people wanting to manage a bank account for someone else

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Question 7: Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance been struck between protection of the carer and protection of the individual lacking capacity?

24. The Act enables people to plan for the future and record their wishes and make financial arrangements through an LPA. The Code of Practice gives guidance on how Attorneys should undertake their duties using an LPA who are often non-professional carers. The OPG via its supervision function ensures that lay Deputies are carrying out their role in line with the principles of the Act.

Question 8: Has the Act ushered in the expected, or any, change in the culture of care?

25. The OPG has no comment to make on this question.

Question 9: Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

26. Figures taken from the OPG database suggest that, of those with gender specific titles, women are almost twice as likely as men to make provisions for a time when they may lack mental capacity. They are also more likely to have a deputy appointed. This may be a side effect of the fact that women tend to live longer than men. Also those who make LPAs or have a deputy appointed on their behalf tend to be aged 75 and over.

27. The OPG has recently commissioned an extensive research project from Ipsos Mori (‘Lasting Power of Attorney and Deputy Research’) in order to reach and better understand the customer base. The project itself will focus on understanding the customers and will seek to understand the breakdown of ethnic groups at the same time as examining any factors which could inhibit or enhance LPA uptake. As a result of this, the research project will look at what unique barriers and enablers that Black, Asian and ethnic minority (BAME) groups face, if any, at making an LPA. In addition to looking at representation from BAME groups, the research will seek to understand how the provisions of the MCA affect those from different socio-economic groups. The research is due to report in November 2013.

Decision Making

Question 10: Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – general authority, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

28. The OPG has no evidence that the means by which the decision is made impacts on the quality of the decision making.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Questions 11 - 14

29. The OPG has no comment to make on these questions.

Deprivation of Liberty Safeguards

Questions 16 and 17

30. The OPG has no comment to make on these questions.

The Court of Protection and the Office of the Public Guardian

Question 18: Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

31. Since its launch in 2007, the OPG has seen a significant increase in demand for its services.  

32. The OPG regularly reviews its services and how easy they are for our customers to access and to understand. The OPG has started a transformation programme consisting of two key elements:

   a. Digital transformation
   b. Fundamental review of Supervision.

33. As part of this work, the OPG issued a public consultation in 2012: ‘Transforming the Services of the Office of the Public Guardian’ with the aim of making the services offered by the OPG more accessible to all. A number of questions were asked regarding the nature of future LPA forms, especially surrounding the idea of a combined form for those wishing to make an LPA for both Health & Welfare and Property & Finance. The government response was published in January 2012 and bought into force changes such as the reduction in the statutory waiting period from 6 to 4 weeks.

34. Alongside this, the OPG has undertaken stakeholder and user testing in relation to new forms and form design to reduce complexity and error rates. This work has informed the revision and redesign of the forms, and the OPG is hoping to consult on these later this year. The intention is that, should the consultation responses be positive, these forms would come into force in 2014.

35. As a key step in the digital transformation, on 1 July, the beta version of the LPA online tool to allow the completion of LPA forms online went live. Currently, forms have to


269 Transforming the Services of the Office of the Public Guardian, Response to Consultation (CP(R)23/2012), 22 January 2012

270 https://www.gov.uk/lasting-power-of-attorney

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
be downloaded and signed, but the tool allows for a significant reduction in the amount of information that needs entering (due to the automatic completion of the same information in multiple fields).

36. Figures from the first month show that 3,293 users have registered an account, 710 applications have been completed, 187 have been received and 302 online payments have been made. These figures are within our expectations and we would expect the use of the service to grow. As it is a beta release, we have undertaken limited publicity for the tool and once Version 1 is available later in the year and we have a new case management system in early 2014, we will look to actively market the digital tool as a means of completing LPA forms.

37. To make the online digital LPA process more accessible, individuals are able to make use of contextual live guidance which makes reference to the individual section which they are completing at that specific time. To reduce errors, individuals completing the forms are unable to continue to the next part of the digital form if certain information on the previous page has not been completed.

38. The feedback received to date on the digital tool has been positive both from lay and professional users. We are using this and other data to make minor changes to the tool to further iterate and improve it for our customers.

39. The OPG is looking at ways to assist those who wish to make an LPA via the online tool but who cannot do so because they do not have access to the internet or do not feel confident using such a tool. The OPG is working with its existing partners to look at ways in which this support can be provided and hopes to be able to launch some pilots in the near future.

40. The fundamental review of supervision will deliver a new operational model for supervision. It will ensure that this delivers a service that is customer centric and tailored to different types of deputy.

41. A key aim of the review is also to ensure that there is provision of fuller guidance and support which is available earlier in the process to ensure that deputies fully understand their role and the responsibilities they are taking on. The aim is to get the Deputyship off on the right foot ensuring a greater likelihood of compliance.

42. The OPG will be looking to consult on the general principles of the new supervision model later in 2013. This will allow stakeholders, deputies and others to provide fuller input.

**Question 19: What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?**

43. Since the implementation of the MCA on 1 October 2007, the OPG has registered 764,416 LPAs, ensuring that more people have been able to plan for a future where they may lose capacity. Of these, 171,194 have been Health and Welfare LPAs. Before the introduction of the Act, there was no means of planning for the future in this area, so a large number of people have chosen to take up this option now that it is available.

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Question 20: What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

44. The Office of the Public Guardian sets a fee for registering a Lasting Power of Attorney and for supervising deputies. The OPG is fee funded and fees are set at a level to recover the costs of the OPG (minus exemptions and remissions), and these fees have varied since 2007.  

45. Whilst the fees for LPAs were raised to £130 in 2011 in order to fund the current transformation programme, they were still at that point lower than the £150 fee that was payable when LPAs were first introduced in 2007.  

46. The OPG has now laid a statutory instrument to reduce the LPA fees down to £110 from October 1st 2013 (subject to parliamentary passage). This means that the fees will be significantly lower than they were on introduction in 2007 (a fall even more significant when cost of living rises are taken into account).  

47. The key change to supervision fees as a result of the 2011 Fees Consultation was the change from graduated fees dependent on supervision category to a flat fee for all but those cases where there are minimal assets. Under the previous system it was P who had to pay from their estate the cost of an investigation into whether or not they were themselves suffering from abuse or fraud (via Type 1 fees). The OPG felt that this was wrong and that all deputies should pay towards the costs of investigations (as is the case with LPA fees). These changes were brought into force on 1st October 2011.  

48. The OPG is aware that many people who make LPAs choose to employ the services of a solicitor to assist them for a variety of reasons, the OPG continues to make changes to its forms and guidance to ensure it is possible for those who wish to do so to make an LPA without legal assistance whilst recognising that people will wish to retain the choice as to whether to avail themselves of legal or professional advice.  

Question 21: Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

49. The OPG has no comment to make on this question.  

Regulation

Question 22 and 23

50. The OPG has no comment to make on these questions.  

Other Legislation

271 Proposals of Changes to the Office of the Public Guardian Fees, Consultation Paper, Feb 2011

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Question 24

51. The OPG has no comment to make on this question.

Devolved administrations and international context

Question 25: Does the implementation of the Mental Capacity Act differ significantly in Wales?

52. The jurisdiction of the Mental Capacity Act 2005 encompasses England and Wales under the same statutory framework and the OPG covers both jurisdictions.

53. The Welsh Language Act 1993 introduced new responsibilities on all public sector organisations who delivered services in Wales regarding their use of the Welsh language. The primary objective introduced under the Act was to ensure that all public sector organisations developed their own Welsh Language Scheme which must describe how their organisation meets the needs of Welsh speakers using their services. The Act also categorised types of documents and services and gave guidelines on which categories needed to be made available in the Welsh language.

54. The OPG introduced their Welsh Language Scheme in 2007 and have complied with all the additional guidelines contained in the Act. This includes an annual report to the Welsh Commissioner detailing how the office is performing against the objectives in the scheme and recording any complaints regarding the office’s Welsh language provision.

Question 26: What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

55. The OPG regularly meets with other jurisdictions to exchange ideas and also engage more widely in the area of mental capacity. The provisions contained within the MCA are compliant with the recommendations made by the Council of Europe in this area.

56. The OPG is looking at practical tools that are used by the Scottish Public Guardian with a view to possibly using them to better supervise Deputies in England and Wales. The OPG has also engaged with Scotland on the approach to investigations and used that to improve practice.

Question 27: Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

57. The Mental Capacity Act 2005 predates the UN Convention but the empowering ethos of the MCA (autonomy and self-determination for the individual with proportional safeguards) is in line with the Convention. The view is that the supervision regime as currently undertaken by OPG ensures compliance.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

EXAMINATION OF WITNESS

Alan Eccles, Chief Executive, Office of the Public Guardian

Q281 The Chairman: Good morning Mr Eccles. Welcome to this evidence session this morning. We are grateful to you for your written submission, and I have to remind you that the proceedings are being broadcast internally, and also recorded and transcribed. Could I start by asking what impact the creation of the statutory role of Public Guardian has had in practice?

Alan Eccles: Yes, good morning. My Lord Chairman, in relation to that question I think the creation of this statutory role for the first time by the Act has given a real clear focus to the primary responsibilities of the Office, which were around the registration of lasting powers of attorney, the supervision of court-appointed deputies, and the safeguarding investigatory function that we undertake. That focus is evidenced by the fact that year on year the Office of the Public Guardian has seen a significant increase in the workload that has come into the Office, which means that both knowledge of the functions of the Office, and, indeed, demand for the services that we offer are growing significantly.

Lord Turnberg: The Government are consulting on changes to the Office of the Public Guardian. Can you give us any hint about what those changes might entail and what they might mean for the Mental Capacity Act?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Alan Eccles: Yes, we are currently consulting on four main areas. The first area is about trying to simplify the application forms for lasting powers of attorney. There has been an ongoing conversation, debate, about how straightforward they are. On 1 July we launched an online digital tool to assist people in the completion of lasting power of attorney, and during that process we did a lot of customer insight work with applicants who were applying, and out of our learning from that we took the opportunity to review the forms. As you are aware, all the forms are prescribed forms, and therefore we are consulting about making them simpler, more accessible.

Lord Turnberg: Shorter?

Alan Eccles: Shorter—you will be pleased to know that the online tool means you only have to put data in once and it pre-populates all the bits where you need repeated bits of data, and it checks the validity of the information, so we have cut out a lot of the errors that are made by people if they use the online form. We have learned lessons to make the form shorter, and also to try to make some of the language in the forms more accessible to lay people who are making the applications for themselves. We are also consulting about having a joint form so you only have to fill in one application form if you want to make both a property and affairs, and a health and welfare LPA, which again cuts down substantially the amount of information that you have to put on the form, and makes it far more straightforward if you want the same attorneys to act in both capacities.

Secondly, we are consulting about our desire to put our registers online, so they can be electronically searched over the internet. Obviously that would be of great benefit to professionals, who could then gain access to see whether or not there is either a deputyship order or a lasting power of attorney in existence, but we are conscious that always with the work we do there is a balance between access and protection for the vulnerable. One of the things we are consulting about is how much should be accessible in our register publicly, whether there should be intermediate tiers of access for professionals, what information should we make available, and how do we make that information secure for those sorts of searches.

The third area that we are consulting about is, last year we launched a fundamental review of supervision. The number of deputies we are supervising is growing 8% year on year. We are currently supervising 48,000 deputyship orders, and the growth of 8% year on year means we need a sustainable model of supervision to ensure that it is proportionate, but also that we are giving the safeguards that we need to do when we are seeing such a significant growth in numbers. We launched a fundamental review of the supervision regime to ensure that it was sustainable, proportionate, and met the safeguarding aims under the Act and, again, we are asking questions about that.

The final area that we are consulting about is, we have an ambition to eventually enable you to apply for a lasting power of attorney completely online, and we respond to you electronically. We are consulting about the possibility of removing the concept of it being a deed and linked to wet signatures, having to be on paper, and moving to a modern format of being able to deal with you in that way. Again, we are consulting about the balance between access and speedily getting a lasting power of attorney against the safeguards that need to be in place to make sure that it is a secure instrument to be used.

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Q282 Lord Swinfen: People tend to move once they have produced the powers of attorney. Do you have National Health numbers or National Insurance numbers on the form, so that they can be referred to that particular person?

Alan Eccles: No. We do not keep that information at the current moment, and there is a big debate under data protection law. There is no legitimate need for us currently to hold that at the moment, so legally I have been advised that we should not be keeping National Insurance numbers at the moment.

Lord Swinfen: If someone who is elderly goes to live with a relation, and the relation does not know that the power of attorney has been granted, how do they find out?

Alan Eccles: They can make an application to ask to search the register to find out—

Lord Swinfen: Do they?

Alan Eccles: Yes, we have a considerable number of applications. At the moment it is a paper-based application; they ring up usually our contact centre and make a request for a Level 1 search. Normally our experience is that the lasting power of attorney or the deputyship, unless it is held by a professional, is usually held by a family member and these things are well known within the family. It is usually the family who are notifying us that the donor has moved, and then we update our records accordingly.

The Chairman: What is the timescale for this consultation process?

Alan Eccles: The consultation closes on 26 November; then obviously we will be considering all the responses and the hope is that we will publish the response to the consultation in the spring.

Lord Swinfen: Mr Eccles, what would be the practical implications of the changes in governance that resulted from the abolition of the Public Guardian Board?

Alan Eccles: As you are well aware, the Public Guardian Board was created under the Act and was an advisory board to the Lord Chancellor, and sat outside of the Office of the Public Guardian. Its role was to scrutinise the Public Guardian and how the Public Guardian undertook statutory duties. As a result of the board being abolished, the internal governance of the agency has been changed, and we have now appointed an agency board. The construct of it is that we have appointed three non-executive directors to that board through a public appointments process. Therefore, we have brought more external challenge, if I put it that way, into the agency. Three non-executive directors have been appointed: one was appointed because of their background in digital IT development; our second new non-executive director is a clinical neurologist, who deals with capacity assessments in his professional life, and the third non-executive director who was appointed has come with an audit and finance background to challenge us in respect of that.

In addition, I sit on the board, there are four executive members of the board, and a Ministry of Justice nominee is also on the board. We reflect now more normal agency governance, if I can put it that way, in the construct of the board.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Q283 Baroness McIntosh of Hudnall: In the course of taking evidence we have heard quite a number of people say that they feel that the Mental Capacity Act and the matters that flow from it are not well understood by people at large, not even by the people who might really need to know that there are issues that they need to resolve. I wondered about your role in raising awareness about the Act and about the necessity for compliance with it, not just among professionals, but more widely with the general public, and what sort of information and guidance you make available for people. Also—I suppose it is the same question—how do people find out about you? If they are faced with a problem or an issue that might need your help and support, what is their first port of call?

Alan Eccles: Interestingly we have done some of our own research to find out this question, and interestingly, when we were starting to develop our digital suite of tools we wanted to know how many of our customers used the internet or not. In fact, our customer research indicated to us that the vast majority of people who are inquiring about any of our functions, one of the first places they turn to is a Google search, and then—

Baroness McIntosh of Hudnall: What search term would somebody who did not know the words “Public Guardian” put into Google?

Alan Eccles: They quite often put powers of attorney in, because lots of people know about powers of attorney, or they put in mental capacity. Another avenue to us is to search other well known sites. For instance, if they have a relative who has dementia they go to the Alzheimer’s Society. We have a very close working relationship with the Alzheimer’s Society; they have signposting to us on their website. Similarly we have a close working relationship with Age UK. We also have a very good working relationship with the CAB. Each of those three agencies, for instance, is going to partner with us in our assisted digital approach.

We work through a whole network of stakeholders. I have just mentioned the charity sector; we work closely with Solicitors for the Elderly, the Law Society, similarly with accountants’ representative bodies. We have done a lot of work with the British Banking Association and the Building Societies Association to raise our profile amongst the banking sector and to make sure that they have awareness of lasting powers of attorney and deputyship orders, and what they should do. I am painting a big picture of how we work through a network of stakeholders to broadcast what we do and who we are. They will signpost us and what our services are.

Our relationships are good, in that we validate their documentation to ensure it is accurate and they are saying what we can do. Also, lots of people seem to know that the Public Guardian exists because we get all sorts of queries. If you have the title Public Guardian, the public seem to quite often think I can do things I cannot, but, again, they will put that in the search term to find out about us. We have an online presence that gives information; we have also got a lot of written material about the various roles that we are responsible for, we run a contact centre where members of the public can just ring up, and we answer all sorts of queries through our contact centre, which is busy as well.

Baroness McIntosh of Hudnall: Do you think that, in relation to the public information about the Mental Capacity Act and everything related to it, it is primarily your role to be the disseminator of information, or do you think that, for example, it should be Public Health England, or any other body, that has a wide range of responsibilities?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Alan Eccles: Yes. I do not think that I have got the primary responsibility for that; in fact, I have got no statutory responsibility actually to promulgate the MCA at all—that is not one of the things in the list. Clearly I take the view, as Public Guardian, people would expect me—especially in the areas of lasting powers of attorney, deputyship orders, the supervision regime, my investigatory powers—to make sure they are well known, that people will know what services we provide and how to access them. I, and my staff, will take any opportunity we have to publicise them and talk about them, so I am pleased to say that quite regularly now I am invited to speak on “Money Box” on Radio 4, for instance, and we are usually inundated with questions from the public, so there is a big demand out there to know about these issues.

Q284 Baroness Barker: In all the bodies that you pointed out, you did not point out any parts of the NHS, like memory clinics or anything. Should we attribute any significance to that or not?

Alan Eccles: No, I do not think so. It is fair to say that we learn from the complaints that people talk to us about where they are having particular difficulties. Our mailbox and our contact centre have been inundated about complaints about how banks do not respond very favourably or recognise lasting powers of attorney or deputyship orders, so it has been one of our priorities to try to tackle that issue at a headquarters level with the financial institutions to get their commitment to do something about that. We get far fewer complaints about NHS and those sorts of services, although it is fair to say that that is one of the areas on our list to have a conversation about.

We have very good relationships with the Department of Health, and work with officials there to raise the profile of MCA issues with professionals there. I was at a meeting at the department recently where they were talking about how we can raise the profile, and interestingly there was the President of the Royal College of Psychiatry. At the end of the meeting, she came up to me and asked me if I could do a one side of A4 for doctors to explain to them what lasting powers of attorney and deputyship orders actually meant in practice. That is something we will definitely look into and do.

Baroness Barker: Do you think that LPAs are being created in sufficient number and, if they are not, what do you think are the barriers to people taking out LPAs?

Alan Eccles: As I said earlier, we have seen phenomenal growth in the take-up of lasting powers of attorney. As Public Guardian I am never satisfied with the numbers that are being taken up, but I will just give you a feel of the growth: in the first full year of existence of the Office of the Public Guardian, which was 2008/9, we registered just over 49,000 lasting powers of attorney. In the last complete financial year, 2012/13, we registered 228,744, so we are predicting growth rates of 20-25% year on year. This year our predictions at the beginning of the business year were to register 300,000, and we are on target to exceed that.

We anticipate around May of next year, on the register, we will hit the milestone of having 1 million potentially live registered instruments on the register. The growth has been phenomenal, and that has been without us significantly going out and promoting that lasting powers of attorney are here. Part of our transformation programme in the OPG is to
renew our IT systems and to give us the digital tools, so that we can keep up with demand, but we also have the ambition to have the infrastructure whereby we can go out and promote more, because we think there is a latent demand there that has not yet been tapped into.

Currently we are just in the process of Ipsos MORI doing a piece of research for us, specifically on identifying what the barriers may be to take up of LPAs. In other words, to give us some intelligence as to how we may tap into that latent demand. We just had some headlines from that, and we are waiting for the detailed report back, but the indications there are that they interviewed for us a large number of people over 45, and there are a significant number of people who knew nothing about LPAs. We need to tackle that, but when those people were told about LPAs only a third of them thought it was something they would take up, because the issue of lacking capacity they felt was something that would not occur to them. That is a barrier that we are going to need to tackle, but it is going to be an education process, and getting the message out there.

The reassuring thing for me is the headline piece of research is saying that those people who have had some contact with using an LPA, either through using it for a relative or knowing a relative that has needed to use it, have found it to be a very empowering document. They are more likely to take it up, because they have known someone who has used it then those people who have never had any contact with the issue at all.

**Baroness Barker:** Thank you. Maybe when it is possible you might give us the further details of the research. Can I just check with you one thing? You used the term “1 million live registered LPAs”; does that mean LPAs that have been triggered to come into effect, or does it just mean LPAs that have been registered?

**Alan Eccles:** They are LPAs that have been registered. What I mean by that is when we are notified of death or LPAs are revoked we take them off the register, so they are current registered LPAs. I have no way of knowing whether they are being used or not.

**Baroness Barker:** Right. At the time when the legislation was going through, the question of knowing when an LPA had been triggered was a very considerable issue that we discussed. From what you say that has not yet been addressed, but maybe it could be by your—

**Alan Eccles:** In effect, once they are registered with me it is a live instrument, so unless there is a restriction on the instrument that says that it is not to be used unless a trigger event takes place, a property and affairs LPA can be used straightaway. For instance, I have given an LPA to my wife; if tomorrow I decided I did not want to deal with the finances any more, I could say to my wife, “Please deal with these issues for me and go and register my LPA with the bank.” When I say that we do not know whether they are triggered, like mine, mine is live and could be used when it needs to be used, but at the moment I know exactly where it is, it is securely filed away, and at the moment I do not want to burden my wife with dealing with my property and finances. Clearly the health and welfare LPAs do not come into force until there is a lack of capacity.

**Q285 Baroness Barker:** Thank you. That then leads me on to the next question, which is: how do people who are meant to operate their LPAs know about their existence? You
particularly referred to the banks, and the evidence that was given to the Health Select Committee suggested that, while people in the upper tiers of banking are beginning to understand LPAs, front-line staff are still not knowledgeable and comfortable about what to do on a day-to-day basis. Is that your experience?

**Alan Eccles:** To a certain extent yes, but I think it is getting significantly better, if I put it that way. Again, on 1 April of this year we, jointly with the British Banking Association and the Building Societies Association, launched a guide, both for customers of banks but also for bank staff, as to what to do with LPAs and with deputyship orders. We have also been working with certain of the large banks; when we get complaints we take the issues up with them, not on an individual basis, but at a head office basis, to see if we can resolve the issues. Many of the larger banks are now specialising and centralising their resource for dealing with LPAs and deputyship orders, so they have a specialist unit that deals with these things; the instruction at the branch level is that if you get one of these presented, ring us up and we will give you advice about dealing with them. The banks recognise that trying to get that detail of learning down to everybody at counter level can be quite difficult.

They are employing different techniques. We are in discussion with them now as to whether or not we can jointly develop some e-learning for bank staff, so we can disseminate that, again, with the content approved by us as to what bank staff should do. The other thing that I am really pleased about is we have been having some early conversations with the new Financial Conduct Authority, and they have been discussing with me how they can build into their new regulatory framework the sort of issues that customers complain to us about in terms of how banks respond.

**Q286 Baroness McIntosh of Hudnall:** May I just follow that up in respect of LPAs that have been registered by somebody who then suffers a catastrophic event of some kind, like a stroke or an accident? You talked earlier about the anxieties that people feel about being able to access information about LPAs; I was thinking particularly about front-line medical staff. I do not need to describe the situations in which they might need to know this, particularly obviously in respect of resuscitation, but how will your new arrangements for accessing information about LPAs assist those people in feeling confident about what to do where there is an immediate need to take a decision?

**Alan Eccles:** When we develop the online tool, our ambition is to aid that very sort of situation. The idea is that a health professional in Accident & Emergency could 24 hours a day access the register to see whether or not there was an LPA in existence, and what that would say. Our experience quite often is that A&E staff may be faced with a relative who turns up waving a piece of paper, and they want to check quickly whether there is any validity in the piece of paper or not, and whether it is a valid instrument.

Again, at the moment we have a process whereby you can do an urgent search of our register by contacting us, but we are not at the moment a 24-hour service, whereas A&E is. If we can put this online—and again, what we are consulting about is whether or not care professionals like that should have an intermediate ability to search, so, in other words, they have an enhanced ability to search what is on the register, rather than what a general member of the public would be able to find out when they search the register. That is the whole concept that we are looking into.
Baroness Andrews: Is that because of confidentiality or is it because they need other sorts of information?

Alan Eccles: Our view is they would probably need to have slightly more detail than we would give to a general member of the public. Normally a general member of the public would only need to know whether there is an instrument in existence, and where they might locate that instrument if they need it for whatever reason. Whereas, for instance, a health professional may need to know the detail of whether there is a health and welfare LPA and is there a resuscitation provision linked there.

Q287 Baroness Browning: Is the current system of creation and registration of an LPA flexible and responsive enough to respond to changes in a person’s circumstances, such as the death of a donee or family breakdown? Do they have to start all over again and create a new one? Could you remind us what the cost of registering an LPA is?

Alan Eccles: Certainly. If I take that in stages: once the instrument is made and registered with me then it cannot be altered and amended, but that is not to say that there cannot be constructs within it that make it a flexible document. For instance, if you choose to appoint multiple attorneys on a joint and several basis, if one or other of those can no longer act, then the remaining attorneys can continue to act.

Baroness Browning: Do you add a codicil to that if some circumstance changes?

Alan Eccles: No. If they are appointed jointly and severally then if any of them have to drop out for whatever reason the remaining attorneys can continue to act. It is only if you appoint attorneys to act jointly, if one of them ceases to act then none of them can continue to act. Similarly within an LPA you can appoint replacement attorneys, so, again, if an attorney drops out you can specify in the instrument who should take over in those circumstances. There is that degree of flexibility in it, but also, if your circumstances change and you no longer want those attorneys to act, as long as you have mental capacity then it is your right to revoke your lasting power of attorney and to take out a new one with new attorneys. Therefore, it is flexible to that extent, in that you are not tied into it for ever; as long as you retain the mental capacity to revoke it, you can do that.

The cost of registration with me, I am pleased to say, reduced from 1 October, and it is now £110 to register the instrument. That would be £110 for a property and finance, and a second fee for a health and welfare, so if you took both out it would be £220.

Lord Swinfen: How many people can you include in a power of attorney?

Alan Eccles: I am trying to remember whether there is a—there is not a limit.

Lord Swinfen: There is no limit, so you can have half a dozen of your children if you have got half a dozen children?

Alan Eccles: You could do, yes.

Baroness Barker: With the new online registration system that you are hoping to get towards, how will you fraud-proof that?

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Alan Eccles: That is one of the things we are considering at the moment. At the moment our online tool assists you to complete the forms; at the moment you put in your details, you still have to print out the forms, you would then go and get your witnesses to sign it, and you would get the relevant signatures. You then come back into the tool, it will assist you to complete the registration document, you can pay online, and then you can then submit it, and you put it in the post to us. Again, part of us building a sustainable model to deal with the workload is that when we get our new back end system it will just take the details from online, when you press to register, so we do not have to populate our register at the back: it will automatically pull the information through.

We are trying to do that completely digitally, and one of the things we are consulting about is how do we do that digitally and still maintain the safeguards. Our commitment is that it will be as secure, if not more secure, by doing it online. Part of the thing we are consulting about is how we do that. The sort of questions we are asking at the moment are: if you were to register with a third-party identity assurance company, and you had, in effect, an electronic signature that also was linked to the fact that it recognised who you were and your identity was assured, then do you need wet signatures of a witness to go alongside that, or could you dispense with those wet signatures? We would still maintain the certificate provider because the certificate provider similarly can have an assured ID, and can do that part of the process electronically, and the attorneys can also have identity assurance electronically.

The interesting thing at the moment is, in the current system, we do not do ID assurance to that sort of level, so to a certain extent that would be more secure in the case of the ID assurance, but I know lots of people have comfort in a wet signature witness, and we are asking the question, “Well, does that give you as much comfort as you really think it does?” Again, some of our experience would be pop into the neighbour and say, “Please sign this”, and we are wondering whether digitally we can design a system that may add more safeguards as to what is going on in the system. We are exploring it, but the commitment from us is we want to be assured that it is as secure, if not more secure, than the present paper-based system.

The Chairman: Is a witness to the signature not simply an act: that the witness is not expected to know the contents of the document; the witness is only confirming the signature?

Alan Eccles: Exactly.

Q288 Lord Faulks: I would like to turn to supervision and investigation, please. You told us that you are conducting a fundamental review at the moment; you also told us there is an increase—I think you said 8% year on year—of those who are potentially reviewable, as it were, by you. You are going to be asked in due course about how you identify questions of fraud, possible cases of fraud. I would like to ask you first of all what role do you see yourself having in terms of supporting the skills and decision-making of attorneys and deputies? In particular, in terms of the costs that are incurred by them—I should declare an interest, as a barrister who does quite a few cases about serious brain injuries—I have seen something of an arms race in solicitors describing how much it is going to cost for them to act as a deputy for someone who has perhaps quite a large sum of money, taking decisions on a very regular basis, which they justify on the basis that the Mental Capacity Act says that it is a matter of specific decision: every action is specific. Very often I get the impression—

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and I would like your comments please—that the best and most experienced solicitors who act as deputies, are the ones who enable decisions to be made without interfering all the time. By contrast, those who feel it is necessary to ask, and who have been involved in almost every decision, are charging large sums of money and therefore have a particular role in escalating the costs. Sorry, it is a long question, but I would welcome your input.

Alan Eccles: Okay. If I just stick on what we do to assist attorneys and deputies in the first instance, in some ways I am quite pleased that I do not have any supervisory responsibility for attorneys. With the numbers we are dealing with, it would be virtually an impossible task. As far as attorneys are concerned, we issue guidance to them about what their role incurs, and we give them guidance about the principles of the Act, what they are signing up to. In effect, they get written guidance from us, they have online guidance from us, and any attorney can ring up our contact centre if they need specific guidance in a particular case.

We also issue what I call practice notes; I have recently issued practice notes about gifting. Attorneys and deputies get themselves into all sorts of muddles about what they can and cannot gift, so I have recently reviewed guidance about gifting, and that has been issued. As far as deputies are concerned, clearly I have a supervisory function in that, and, as far as lay deputies are concerned, now for around the last 12 months, all lay deputies are contacted by us within eight weeks of their appointment. We allow them to be appointed, they normally get notified and get the order within six weeks, we allow six weeks to settle, and then we contact them by telephone. We have a conversation with all lay appointed deputies to set the scene for who we are, what we do, but we also ask them about how they are getting on with their order; are they comfortable with the order; do they understand the responsibilities that the order places on them; how are they planning to deal with P's assets; are there some big decisions over the next year that need to be made; how are they going to deal with that? We guide them through the process.

As part of the supervision review, one of the things that is coming out of it is we clearly have a view that the first 12 months of appointment—whether they be a new professional who has never acted as a deputy before, or a lay person—is essential to guide people to get them into the right behaviours to manage that order thereafter. As part of the review we are reviewing what our interventions will be in that first 12 months to support them with that process. Then, of course, we have a process of reporting to us; every deputy fills in an annual report to us, and as part of that process we ask them how they have involved P as appropriate in the decision-making process during that year.

Again, we are developing a digital tool, and our ambition would be, in the not-too-distant future, to have a secure online account for every deputy, who then will transact with us electronically, if they so wish, through that electronic route. In particular I would want professionals to deal with us through that electronic route, because it is a fast, straightforward, more cost-effective mechanism to communicate and deal with us in that way.

On your question about professionals and the involvement of P in decision-making, my experience would be it varies considerably, depending on a case-by-case basis, and really depends upon the level of capacity of P, if I can put it that way.

Q289 Lord Faulks: That states the problem, with respect; what I want to know is whether you, in supervising deputies in so far as you can, have any advisory role or control.
of the costs they incur? We have been provided with the hearing before the Justice Committee in 2010, where Mr Thompson and Mr John describe some of the fees of £409 per hour for relatively small decisions being taken. I am wondering whether you feel it is your role to exercise some control over these sorts of costs.

_Alan Eccles_: At the moment I have limited involvement in those costs, because the costs of professionals are controlled by a practice direction issued by the Court of Protection. Under the practice direction professionals can claim either a fixed fee, or, if they want to go beyond the fixed fee, they apply to the Senior Courts Costs Office to have their bill taxed. As part of the review of supervision we have been asking ourselves what involvement we should be having on monitoring professional fees. In fact, only last week we had a stakeholder group of representatives of professional deputies and the representative bodies of the legal profession, and part of that conversation was about what role did they think it was legitimate to have in that. We made some good progress; the view was that it is the Costs Office role to tax the detail once they have been incurred, but the view was that proportionality might be an area that the public guardian could get into. That is an area that I am exploring and am very interested to get involved with.

_Baroness Hollins_: I wonder how long it would take a lay deputy to complete an annual report; do you have any idea? How lengthy is a report?

_Alan Eccles_: It is not that lengthy and, again, why I hesitate is because it depends very much on the circumstances of the estate that they are looking after and how complex it is. At the one extreme, if the assets are small and the basic question for the lay deputy is, “Am I ensuring that P is getting all the benefits that they are entitled to?” the form can be fairly straightforward to fill in, in that they would fill in the income. It is basically income and outgoings, and they summarise the key decisions that they have made during the year. Again, our ambition is to have this online account that, again, will have interactive tools that would assist the lay deputy, and also enable any deputy, if they wished, to fill in the details as they were going along.

One of the things we do find is that quite a lot of people react—like your tax return—they wait until the end of the year, they know the annual report is coming, and then they think about, “Goodness, where are the receipts? What have I done? How can I get this all together?” Whereas, if we could have a more interactive relationship with people, and we make a tool that is very easy for people to use, they can jot down things on their tool as they go along, and then they can just press the button for submit when it comes to the annual report being submitted.

_Q290 Baroness Andrews_: This is the question on fraud: how much of an issue is it for you and how do you identify it? In your fundamental review, when you are looking for a sustainable model, will you be factoring in better ways of dealing with it, different ways?

_Alan Eccles_: The answer to that question is a definite “yes”, but if I could give a bit more detail than the “yes”. On identifying fraud: again, we have to distinguish between attorneys and deputies in this model. For both attorneys and deputies the main way we get alerted to a concern is through some form of whistleblowing; we have a published whistleblowing line that people can ring us up, but we will take referrals on concerns through any avenue, so it could be a telephone call to our contact centre, it could be a letter written in, or quite a few people now e-mail us about their concerns. We get concerns flagged to us from all sorts of
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people: it may be a concerned family member, it could be a neighbour, it could be a social worker; quite often now it is banks that see some strange transaction occurring on an account, and they will flag an issue to us that they have a concern.

The second area for deputies is through supervision, so we have this ongoing supervision with them, and we will pick up things through supervision that will raise concerns. There will be straightforward things, so the annual report may show a discrepancy on balances from year to year that we pick up, because they have to give us a closing and starting balance year to year. They quite often will disclose unusual payments in the gifting box about what they have been spending money on. We will look will look at expenses, because not only do professionals claim expenses, sometimes quite strange expenses are claimed, so we will pick things up from that.

If our fees are not paid, or the bond fee is not paid, or the report is significantly late, that can be a trigger to us to have a concern. Our investigations may start either through an external referral to us, or through something in our internal process. Our hope is—our aim is; it is more definite than a hope—with the development of new back office case management systems and the new digital tools, to make this as robust as possible. We want to have as many automated flags for caseworkers as possible. Our new IT system should be able to identify gifting of a certain level that will raise a flag to a caseworker, because you can imagine, as we have got 48,000 of these cases to monitor, we need as many flags as possible that can draw something to the attention of a caseworker that there is a concern.

Our biggest ambition—I am not saying how quickly we can achieve this—is that with our secure online account when we have developed it, we can be as swift as the banks. I do not know whether you have ever had the experience that I have that when you have made a large payment on the internet, your phone goes within half an hour and the bank says, “Was it you that made that payment?” My ambition would be to have an online account that if something was put on in real time of a large value, a flag would happen to a caseworker; they could then ring up a deputy and say, “We see this transaction has gone through, would you like to explain that?”

Baroness Andrews: In terms of volume, you have 48,000 cases and it is obviously likely to grow exponentially. In terms of capacity, what proportion of that 48,000 have you had to investigate? Your capacity challenge is not obviously going to be met simply by digitalisation; it is going to be met by people and bodies on the ground.

Alan Eccles: Yes, and smart ways of working to make sure we identify what those triggers are, to identify what cases we should be looking at. At the moment I am very pleased to say that considering that we are supervising 48,000 orders and we have got currently around 880,000 LPAs on the register, last full financial year we did 718 investigations. We have far higher safeguarding referrals to us, but again, that comes back to having a description of Public Guardian. We get a lot of safeguarding referrals to us that I have not got jurisdiction to look into. It is not that we ignore those safeguarding referrals, but we would signpost those referrals to other agencies, usually adult social services, that are the lead agency in dealing with the issue that has been raised with us.

I often say, when I am out publicly speaking about the Office and about whether or not LPAs and deputyship orders are successful, while it is a disaster for anybody when it goes wrong, if
Office of the Public Guardian – Oral evidence (QQ 281 – 291)

you weigh up we did 718 investigations out of those large numbers, that is saying to me that the vast majority of LPAs are working well, and that deputyship orders are working as the court intended them to work in the first instance. It is not that I am complacent about that at all, and I am very hot on being strict on those issues, but I think those numbers put it in proportion. Of those 718 a significant number of those we would have investigated and found there was no cause for concern.

Q291 Lord Swinfen: In evidence to the Health Select Committee in 2010, your predecessor suggested that the lack of power to compel third parties to provide financial information could create delays in investigation. He also suggested that the power to delay registration of an LPA, pending an investigation into concerns, would assist your role. Are these still concerns and has there been action to remedy these?

Alan Eccles: Yes, I would say from my position they are both still concerns; there has been no movement on me having statutory access to financial records, so I have access to P’s health records, and to P’s social care records, but I have no access to P’s financial records under the statute, so both of those issues are still outstanding. We now have an agreement and are working with policy colleagues within the Ministry of Justice to work up a policy solution to those areas, and we are looking for the opportunity to find a legislative slot to do something about both of those matters when that occurs. We have now got commitment from the department that that is an issue, and to work on that.

We have also got agreement with policy colleagues that now, having had six years of experience working with the powers as defined under the Act, there are other areas around the margins of my powers that we would like either extended or tidied up, if I put it that way, to assist in that safeguarding role. Again, there is agreement that we will be working up those areas and, again, seeking the necessary legislative capability to be able to do something about those as well.

Lord Swinfen: Have you got any legislation drafted?

Alan Eccles: Not at the moment, no. I have just got the agreement with policy colleagues that that can be worked up and looked at, so we will be working up those propositions and then looking for the legislative opportunity to deal with them.

The Chairman: You say you have just got agreement with policy colleagues; when did you get this agreement?

Alan Eccles: We have been in discussions shortly after I came into post, and probably the agreement to work them up has been within the last six months.

The Chairman: Thank you very much, Mr Eccles, for your useful evidence. We are very grateful to you for coming along today, and that is the end of this formal session.
16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

Answer:

1. I believe that the name Deprivation of Liberty Safeguards is misleading. I say that because it arguably puts the statutory scheme the wrong way round and also gives the impression that it is only contained in Schedule A1 read with Schedule 1A to the Mental Capacity Act 2005 as amended (MCA). The purpose of Schedule A1 is to enable deprivation of liberty in specified circumstances and places to be authorised by administrative means. Further the amendments to the MCA included the insertion of sections 4A, 4B, 16A and 21A as well. It is important to note that a deprivation of liberty is lawful:

   a. if it is to give effect to a decision of the court made by an order under section 16(2)(a) in relation to a matter concerning the person’s welfare;

   b. or if it is authorised under section 4B (deprivation of liberty necessary for life-sustaining treatment), as well as under Schedule A1.

2. Article 5 ECHR provides that:

   a. no person shall be deprived of their liberty save in the following cases and in accordance with a procedure prescribed by law. One of those cases is the lawful detention of persons of unsound mind (Article 5(1)(e));

   b. everyone who is deprived of their liberty by detention shall be entitled to take proceedings by which the lawfulness of their detention shall be decided speedily by a court and their release ordered if the detention is not lawful (Article 5(4));

   c. everyone who has been the victim of detention in contravention of the provisions of Article 5 shall have an enforceable right to compensation (Article 5(5)).

3. But all that begs the question as to when a person is being deprived of their liberty? Section 64 defines “deprivation of liberty” as having the same meaning as in Article 5(1) of the ECHR. Current case law in England and Wales interprets that meaning very narrowly. Those decisions are being appealed to the Supreme Court (hearing starting on 22.10.2013). Currently, however, in light of those decisions, many people

in care homes, supported living\textsuperscript{273} and hospitals, who under earlier case law, might have been thought to be being deprived of their liberty, are now not so treated because of the narrow interpretation of what is a “deprivation of liberty”.

4. This appears to have had an inconsistent “knock on” effect in respect of requests for authorisations under Schedule A1 to the MCA both because (1) the managing authorities of hospitals and care homes take the view, often correctly in light of those decisions, that the person detained, in their hospital or care home, is not detained in circumstances which amount to a deprivation of their liberty, and in consequence take the view that they do not need to request a standard authorisation; and (2) even if the hospital or care home does request a standard authorisation best interests assessors take the view that the person is not a “detained resident” because they are not detained in circumstances which amount to deprivation of liberty, see: paragraphs 16 and 6 of Schedule A1.

5. Subject to that qualification, section 4A(5) of and Schedule A1 to the MCA do provide an administrative scheme for authorising a deprivation of liberty in a hospital or care home, for the purpose of being given care or treatment, and subject to the qualifying requirements (set out in paragraph 12 of Schedule A1) being met by the person who is, or is to be, a detained resident.

6. It appears from research\textsuperscript{274} that (1) restrictions (particularly restraint), (2) the desire of the person detained to leave, or wish of that person’s family or carers that the person should go home, have been used as indicators of a deprivation of liberty. I believe that accords with the experience of my office in respect of section 21A applications – in particular the latter two factors as well as the question of whether or not the person detained “has somewhere to go”\textsuperscript{275}.

\textsuperscript{273} The degree or intensity of restrictions imposed on the person or degree of control over them may be the same whether they are in a small care home or in “supported living” in the next door property which by happenstance (as far as they are concerned) is not a care home. The statutory scheme in Schedules A1 and 1A enabling deprivation of liberty to be authorised by administrative means applies in the latter case but not the former – so it appears that it is often assumed that persons in supported living are necessarily not being deprived of their liberty, when, subject to the narrow interpretation of what is a deprivation of liberty being overturned, they may well be. If a person in supported living were being deprived of their liberty, then that deprivation of liberty could only be authorised by the court under sections 4A(3) and 16(2)(a) MCA. There appears to be no ECtHR decision which would cause a deprivation of liberty in supported living, which was duly authorised under the MCA, to be unlawful under Article 5(1), provided the deprivation of liberty was for a relevant purpose falling with Article 5(1)(e), in other words, for the purpose of being given care or treatment necessitated by their unsoundness of mind.

\textsuperscript{274} “Understanding the interface between the Mental Capacity Act’s deprivation of liberty safeguards and the Mental Health Act”, University of Cambridge, 2013.

\textsuperscript{275} Although in the ECtHR case of Stanev v Bulgaria, the court said at 153: “The Court notes that the applicant was eligible for social assistance as he had no accommodation and was unable to work as a result of his illness. It takes the view that, in certain circumstances, the welfare of a person with mental disorders might be a further factor to take into account, in addition to medical evidence, in assessing whether it is necessary to place the person in an institution. However, the objective need for accommodation and social assistance must not automatically lead to the imposition of measures involving deprivation of liberty. The Court considers that any protective measure should reflect as far as possible the wishes of persons capable of expressing their will. Failure to seek their opinion could give rise to situations of abuse and hamper the exercise of the rights of vulnerable persons. Therefore, any measure taken without prior consultation of the interested person will as a rule require careful scrutiny”.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
7. A new “Bournewood gap” plugged by the inherent jurisdiction: A NHS Trust v Dr A [2013] EWHC 2442 (COP) concerned an application by a NHS Trust for declaratory relief in respect of a man, "Dr. A" who was on hunger strike in the Trust hospital. The relief sought by the Trust were declarations: (i) that he lacked capacity to litigate and to make decisions in respect of his nutrition and hydration; and (ii) that it was lawful for the Trust to administer artificial nutrition and hydration.

8. Baker J held that in all the circumstances, …[the High Court] has the power under its inherent jurisdiction to make a declaration and order authorising the treatment of an incapacitated adult that includes the provision for the deprivation of [a person’s] liberty provided that the order complies with Article 5. Unless and until this court or another court clarifies the interpretation of section 16A of the MCA, it will therefore be necessary, in any case in which a hospital wishes to give treatment to a patient who is ineligible by virtue of Schedule IA and section 16A, for the hospital to apply for an order under the inherent jurisdiction where the treatment (a) is outside the meaning of medical treatment of the MHA 1983 for the purpose of that mental illness and (b) involves the deprivation of a patient’s liberty.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

Answer

9. Others are much better placed to speak of the processes for authorisation and review. I will confine my remarks to “challenge” which I interpret as meaning applications under section 21A MCA which is intended to implement Article 5(4) referred to in paragraph 2(b) above, i.e. where the deprivation of liberty is authorised under Schedule A1.

10. A number of issues have arisen in relation to section 21A MCA. The provision which has been most litigated in section 21A applications, in my experience is that under section 21A(2)(a) the court may determine whether the relevant person meets one or more of the qualifying requirements. Most often the focus is on the “best interests’ requirement” (as to which see paragraphs 12(1) and 16 of Schedule A1). Paragraphs 38-45 govern the best interests’ assessment.

11. The issues are:

   a. that, where there is a challenge to the best interests assessment, the Court of Protection will usually embark from scratch on a full hearing of the merits of whether the detention is in the person’s best interests. This leads to delay.

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276 In GJ v Foundation Trust [2009] EWHC 2972 (Fam), paras 100-101, Charles J stated that his preliminary view was that when the court is considering making an order under section 21A “the Court should reach its own conclusions on the evidence before it rather than take an approach equivalent to either that taken on an appeal from a discretionary decision, or on review of a decision at public law” and that “the court should focus on the position when the case is before it rather than the position when the standard authorisation was granted”. In Re A [2011] EWHC 727(COP), at para 15, the In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
...with expert reports being obtained to inform the court, sometimes from independent social workers and sometimes, (although not favoured by all the judges of the Family Division when sitting as puisne judges nominated as judges of the Court of Protection), by Court of Protection visitors. I had one such case in which there were 3 directions hearings and the hearing of the application itself took place on no less than 6 days (not all on consecutive days).

b. that if the standard authorisation is for too short period, the standard authorisation may cease before the determination of the section 21A application. If in those circumstances the managing body is unwilling to apply for another standard authorisation, or the supervisory body is unwilling to give one, then the continued deprivation of liberty can only be authorised by the court under section 16(2)(a) and section 48. If that happens then the non-means tested legal will be withdrawn on the ground, so I understand, that Article 5(4) only applies where a deprivation of liberty has been authorised by administrative means and it does not apply where the deprivation of liberty has been authorised by a court.

c. in relation to that, Charles J in Re HA [2012] EWHC 1068 (COP), [2012] COPLR 534, attempted to “square the circle” by holding that the application remains one under section 21A notwithstanding the replacement of the standard authorisation by the court’s interim order under sections 16 and 48. But my understanding was that the Legal Services Commission were not persuaded that non-means tested legal aid could continue to be provided after the standard authorisation had been superseded by an order of the court. I am unaware of whether the Legal Aid Agency takes the same view but expect that it would.

d. in a case where the person detained has a dwelling-house, even if they do not have any or a great deal of liquid capital or an income sufficient to fund the litigation, the non-means tested legal aid is withdrawn, and it may be that they will be unable to fund representation.

e. I am certainly not funded to pay for representation in such cases and must withdraw as litigation friend (see below as well). The legal aid position has led to attempts to run some very implausible arguments in efforts to retain non-means tested legal aid, for example that the court has power to extend or itself give a standard authorisation.

18. [Is] the Court of Protection...sufficiently understood and accessible to all? [Is it] operating effectively and successfully?

Answer

President said that where the only person objecting to a n authorisation is the relevant person, “the court cannot simply act as a rubber stamp, however beneficial the arrangements may appear to be for the individual concerned”.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
12. The following should increase understanding of the court if brought into effect. The President of the Court of Protection’s intention to bring about an “immediate and significant change in practice” in relation to the publication of judgments in the Court of Protection and his desire (subject to the outcome of his consultation) to bring about rule changes so that, as in the family courts, the starting point should be that accredited journalists have a right to attend most Court of Protection hearings, unless proper grounds for excluding them can be established on narrowly defined grounds. The current position in the Court of Protection, in contrast to the recently changed position in the family courts, is that the effect of rule 90 means that the media always require the permission of the court to be present. As it is usual for accredited journalists to be authorised under rule 90(3)(a) to attend hearings and then under rule 91(2) to publish specified information, when they apply for such orders, it seems to me that unnecessary costs are incurred in the making, and consideration by the court and the parties, of such applications under the current rules.

13. The President’s proposal, on which he is consulting, to explore ways in which to make “better use of the ‘ticketed’ Court of Protection judges, in particular the Circuit Judges”, as part of a wider project to see whether more Court of Protection work – especially the personal welfare work – cannot be dealt with out of London, if implemented, should make the court more accessible.

14. The greater number of applications for welfare orders, including serious medical treatment cases, than had been the case before the coming into force of the MCA, under the inherent jurisdiction of the High Court, has created resource problems in various parts of the system.

15. A number of other concerns arise. They relate to:

a. the overall level to which costs can easily rise in disputed welfare applications. It would not be unusual for costs to rise well into 5 figures for each party who is represented by solicitors and counsel. This is a particular problem where P has no assets other than say a dwelling-house, the ownership of which means that they are not entitled to legal aid. There may be some read across from the debate about the funding of care costs.

b. I cannot accept appointment where P only has capital such as a dwelling-house. This is on the basis that I cannot fund the litigation until such time, if ever, that I am able to recover the costs I have incurred out of the proceeds of sale. Indeed the proceeds of sale, perhaps because of any equitable interest or prior charge (for example for care costs), may be insufficient for me to recover my costs either at all or in full. Furthermore, where the dispute is as to whether or not P can go home, it would put me in a difficult position, at least presentationally, to be forming a view as to best interests, on the issue of return home or not, when for budgetary reasons I would need the property sold.

c. very often family members in dispute with public bodies are not entitled to legal aid and must act in person.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
d. as last resort litigation friend, my predecessors and I have never sought to, and indeed could not as a matter of law, recover our internal or administrative costs of being last resort litigation friend.

e. I may, and generally do, however, make my consent to act as litigation friend conditional on my costs, of obtaining or providing litigation services, being secured from external sources, except in cases involving medical treatment, where my involvement has long been regarded a matter of necessity, or where I am invited by the court to provide an advocate to the court. Those external sources may be:

(i) the Legal Aid Agency where “P” or the protected party is eligible for public funding;

(ii) P’s or the protected party’s own funds. If P or the protected party lacks capacity to manage their own financial affairs, I will obtain authority in advance from the Court of Protection or from any property and affairs deputy to recover the costs from P or the protected party;

(iii) a Conditional Funding Agreement (e.g. in personal injury claims);

(iv) an undertaking from another party to pay my costs of retaining solicitors to act for P or the protected party;

(v) the funds in dispute where the case involves a trust or estate.

But very difficult funding issues frequently arise and would do so even if I was not the litigation friend but somebody else was, as the litigation services have to be funded from somewhere.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

16. See above for the problems with regard to legal aid in section 21A applications.

17. Capital passporting is abolished. From 1 April 2013, a client who is in receipt of a passported benefit will still automatically qualify in terms of their income but a passported client and any partner will be means tested on their capital. This is for controlled work (so includes legal help) and licensed work.

18. So even if a client is in receipt of a passported benefit, legal aid will be refused if assessed disposable capital exceeds £8,000.

19. Passported benefits are (1) income support, (2) income-based job seeker’s allowance, (3) income-related employment and support allowance, (4) guarantee credit and (5) universal credit (when in force).

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
20. The removal of passporting legal aid has led to P or the protected party being ineligible for public funding to be represented in Court of Protection proceedings where their sole asset is their home or former home. Although there is a capital disregard available this may not prevent the party from becoming ineligible for legal aid.

2 September 2013
TUESDAY 19 NOVEMBER 2013

Members present

Lord Hardie (Chairman)
Lord Alderdice
Baroness Andrews
Baroness Barker
Lord Faulks
Baroness Hollins
Baroness McIntosh of Hudnall
Lord Swinfen
Lord Turnberg

Examination of Witness

Alastair Pitblado, Official Solicitor to the Senior Courts

Q270 The Chairman: Good morning, Mr Pitblado. Welcome to this evidence session and thank you very much for your written submission. I should start by apologising to you, because we mispelt your name in the official earlier papers, but we have now corrected it on the website. Secondly I should remind you, as I am sure you are undoubtedly aware, the proceedings are recorded, broadcast on the parliamentary site and transcribed by Hansard. Could I start with a general question? The reason that the primary legislation was preferred to voluntary codes of practice or government regulations was to provide the prospect of redress against bad practice, but we have heard evidence that the law is frequently not complied with, and non-compliance is rarely prosecuted. Has the use of the statute proved as effective as was expected in changing the practice?

Alastair Pitblado: May I first say that I have got a cold coming on, so if I am snuffling at any stage or my voice goes, that is the reason. I really do not think I am necessarily the right person to speak to this, because my main role is as litigation friend when proceedings have commenced. I am not there in the background in the first instance. Having said that, the criminal offence only relates to ill treating or wilfully neglecting the person without capacity and does not go to whether or not decision-making is properly in accordance with the Act.
The Chairman: Could I then ask a slightly different question, which may come within your experience: since the passing of the Act, has the case law differed significantly as a result of the Act than the approach adopted prior to that?

Alastair Pitblado: In relation to property and affairs applications, although the test is now best interests whereas before it was, to a large extent, substituted judgment, really the outcome is the same in relation to property and affairs applications. I have currently got about 378 of those on. In relation to the healthcare and welfare cases there has been an enormous increase in the number of those. I have got some figures that I will be able to hand to relevant clerks in due course, but by April 2008, which was three or four months after the coming into force of the Act, I had 42 welfare applications on the books. As at 1 October 2007 I had about 70-odd, and I currently have 527. That has gone up April on April; so April 2009, 216; April 2010, 368; April 2011, 438; April 2012, 601. Although we have put away some finished cases—so that reduces the numbers somewhat — it is down to 527 this April.

The issues being determined by the court are much more diverse than the issues being determined under the inherent jurisdiction by the Family Division before the coming into force of the 2005 Act.

The Chairman: You mentioned inherent jurisdiction; was the Act intended to remove that, or do you think the inherent jurisdiction should still exist in such cases?

Alastair Pitblado: The judges certainly have held that the inherent jurisdiction still exists to fill any gaps left by the 2005 Act. I mentioned in my written response the case of A, who was the hunger striker from Iran, and because of the effect of the labyrinthine Schedule 1A, and the fact that the treatment to be given for him did not fall within the Mental Health Act, there was a problem in that his liberty could not be deprived in order to give him the relevant treatment under the Mental Health Act or under the Mental Capacity Act. Mr Justice Baker held that he could deprive A of his liberty under the inherent jurisdiction of the High Court so that he could be given the treatment under the Mental Capacity Act, and Mr Justice Cobb had done something similar but rather more summarily the previous week. It is undoubtedly the case, as the Court of Appeal has held on a number of occasions, that the inherent jurisdiction remains.

Q271 Lord Swinfen: You identify, Mr Pitblado, in your submission that the current interpretation of the deprivation of liberty is a narrow one, and many other submissions to the inquiry have asked for a statutory definition. Is such clarification possible and necessary? Would it address the concerns raised in your submission?

Alastair Pitblado: I do not think it is possible; therefore one does not need to carry on and consider the second question. The reason I do not think it is possible is because the question of whether or not a person is deprived of their liberty is a question that relates to Article 5 of the convention. As long as Article 5 remains in force in this country by virtue of the Human Rights Act, the interpretation of Article 5 by the European Court of Human Rights is the relevant interpretation. The referential definition in the Mental Capacity Act's

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Section 65, I believe, is the only correct one. I say that having been an advisory lawyer in government departments for 20-odd years before I was appointed as Official Solicitor, so I did have some experience of primary legislation and lots of experience of secondary legislation.

One of the problems with the effect of the two judgments of the Court of Appeal is that it does not feel right to the people on the ground that the definition is so narrow. We have not yet had the judgment of the Supreme Court in those two cases; we are waiting anxiously to get the judgments, and it may be said, if the arguments that were being put forward on my instructions are accepted by the Supreme Court, that the definition is too wide. However, I think that the current effect of the judgments of the Court of Appeal is that very few people are being deprived of their liberty even those who are not free to go. Of course, what being “not free to go” means is open to debate. The question is, if somebody is acquiescent—and the European Court of Human Rights has held that acquiescence is not the touchstone, not the bright line—if a person in reality has to be looked after then are they free to go or not free to go? We will see what the Supreme Court rules.

Q272 Lord Faulks: Can I ask you a bit more about that last answer? You quite rightly referred us to Article 5 and the fact that it is the Strasbourg court that gives us guidance as to what constitutes a breach of the convention right. The convention is a living instrument, so does it follow that we cannot freeze the definition of the declaration of liberty, because it would be subject, in any event, to developments in the Strasbourg court?

Alastair Pitblado: That was what I was trying to say.

Lord Faulks: The next question to some extent you have already dealt with, which is the problem about the hunger striker, and the so-called new Bournewood gap. The court decided it on the basis of inherent jurisdiction; is that satisfactory, or do you think that we ought to be advising some legislative change to fill the gap?

Alastair Pitblado: Ideally I think that Schedule 1A should be looked at so that it allows the Court of Protection to deprive P—the relevant person—of their liberty for the reasons that Mr Justice Baker made the order that he did. Although I believe there is a more recent consideration and a judgment in the Upper Tribunal by Mr Justice Charles of the interplay between Schedule 1A and the Mental Health Act, nevertheless it appears possible that Schedule 1A is too tightly drafted and excludes the sort of unusual case where the treatment does not fall within the scope of the Mental Health Act, where there is a deprivation of a liberty, sometimes a double deprivation of liberty, because even when somebody is deprived of their liberty they can nevertheless be further deprived of their liberty—somebody in an ordinary prison is put into solitary confinement, or so on.

In that case, although by the time of the judgment Dr A was sectioned under the Mental Health Act, nevertheless the treatment he was going to be given involved a further deprivation of his liberty. I know this all sounds very arcane, so I think there might be scope for loosening up the provisions of Schedule 1A.

Baroness McIntosh of Hudnall: Just listening to you and not being a lawyer I am trying to get a hold of this, because this seems an obviously rare but significant issue. Is it in your view a deficiency—if deficiency there be—in the Mental Capacity Act that opens up this gap, or is it, in fact, a shortcoming of the Mental Health Act? That is what it is very hard for a
non-lawyer and a non-practitioner to get a handle on. In a way I feel quite surprised, in relation to somebody who is detained under the Mental Health Act in the way that this person was, that the Mental Health Act is so prescriptive about what may or may not be offered as treatment—is that an issue in your view?

**Alastair Pitblado:** I am not an expert on the Mental Health Act; I consider it from time to time, when it is involved in cases where I am acting as litigation friend in the Court of Protection under the Mental Capacity Act. I would not be suggesting that the Mental Health Act requires amendment, because the treatment that can be given under the Mental Health Act is quite wide, but it must be treatment for a mental illness. That is well-established. The problem in this case, and in any similar case, is that Schedule 1A of the Mental Capacity Act, which was inserted by way of amendment into that Act, is just a little bit too tight and excludes by the eligibility requirement: persons who need the assistance of the Court of Protection. It is Schedule 1A that could be and should be, if possible.

**Q273 Baroness Browning:** Apart from Schedule 1A, which you have just elaborated on, are there sufficient protections in the Mental Capacity Act, the Court of Protection and the Office of the Public Guardian to protect those who lack capacity against abuse, whether it is financial or otherwise? Are there any other gaps that you can see now the legislation has been in place for some time that perhaps we should be alerted to?

**Alastair Pitblado:** I have asked my property and affairs lawyers particularly about this question, and what they told me—and I am sure it is correct, because I do not focus as much on that area as on the welfare side—is that since the implementation of the Mental Capacity Act there has been greater scope for property and affairs deputies, previously receivers, to use P’s funds without authority, either through ignorance or intention. Under the old Mental Health Act regime, receivers only had access to income, and not to capital; if they wished to apply P’s capital they needed prior authority of the court, and that was obtained without a great deal of process.

Now the order appointing deputies provides wide general powers—I will not read them out. I know that the Office of the Public Guardian has been providing new written guidance to deputies as to what gifts can be made, and that is backed up by the Code of Practice at Chapter 8. The deputyship order is drafted in such a way that many deputies quite often consider that they can do what they want with P’s money, even to the extent of paying it to themselves or to members of their family. There have been three recent cases, which I imagine the Public Guardian will be telling you about, because he was instrumental in bringing those cases, where the Court of Protection had to look at funds being siphoned off to the wrong place. In answer to your question, some of it is how people behave out there, as it were, in the real world, when they have the powers of a deputyship. As I said earlier, it might be ignorance or it might be criminality that is involved, but it was much tighter before. The rest of the answer must probably come from the Public Guardian.

In terms of protection of people in respect of their welfare decisions, undoubtedly the Act has produced greater protection and a greater emphasis on the rights of those who lack capacity and on proper decision-making, and on trying to take into account their wishes and feelings, and so on, so I think there has been an upside on the welfare.

**Baroness Browning:** Thank you. Could I come back to this question of property, and in that sense something quite material, such as a residence, say—I do not want to get too
much into the legal aid question, because I think you are going to get a question on that later. I noticed in your evidence you said that where somebody retains a property—a dwelling house is specifically mentioned—then you have to withdraw as a litigation friend, because they are deemed then to have this asset, which cannot be liquidated. Is that correct?

Alastair Pitblado: No. I probably did not explain myself very well. My predecessor had more money in his budget, for various reasons. The office was in the practice of saying, “We will fund this litigation out of the budget and when we have a crystallised sum of money”—in other words, the costs have been assessed. “We will place a charge against the property, and then in due course when the property is sold, we will recover the costs.” I cannot do that in this age of austerity.

What I was trying to say was that if I worked on the basis that I was going to get my money out of the house as and when sold—I am postulating a case where the relatives are saying mother, father, whoever, should come home—and if I took the view on the basis of the evidence that it was in the best interests for mother or father to stay in a care home, or nursing home, then the relatives would be saying, “You have got a financial interest in getting this property sold as soon as possible.” That is just a presentational issue; it is not a legal issue. Although it would not be affecting my mind, I could see how people could suggest and could even think that it was affecting my mind as to the best interests of P. That is what I was trying to say there.

The Chairman: Could I go back to Section 44, which we touched on earlier, and you very properly pointed out that this was an offence of ill treatment of someone who lacks capacity, and there has been judicial criticism of the terms of the section, because some judges say it lacks the clarity that one is entitled to expect of a criminal offence. Do you have any views about that?

Alastair Pitblado: No. I do not get involved in criminal cases.

The Chairman: I just wondered from your drafting experience whether you consider that it might be redrafted.

Alastair Pitblado: I was just a humble departmental legal adviser, so I was not parliamentary counsel.

The Chairman: As Lord Advocate I had many humble departmental legal advisers who were very good at drafting, and knew more about it than the Minister, but thank you very much.

Q274 Baroness Hollins: You said at the beginning that, as litigation friend, once proceedings have commenced you are not involved in the background, so I do not know what your response will be to this question. How do people find out about the services of the Official Solicitor? Are you confident that those who need and are eligible for your help are able to access it? Is representation often refused because of a lack of legal aid, or a lack of capacity in your services?

Alastair Pitblado: To answer the second question first, it is a problem for me, my office, and it is one of the reasons why sometimes there is a delay in my accepting cases, or in order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
sometimes I have to refuse to accept cases if there is no funding. Medical cases apart, where traditionally I and my predecessors have always funded the litigation out of our budgets, subject to seeking to recover half the costs from the hospital, which is gaining an advantage. I need money to pay the outside solicitors; I must instruct outside solicitors, because I could not do all the legal work in house, because I do not have enough lawyers.

The question about people ending up with me as their litigation friend is really the other way round. Normally a public body will issue proceedings; the person concerned will be made a party, which I think is more frequent than the policymakers might have expected before the Act was enacted. The court will make P a party, and P therefore requires a litigation friend. If there is no family member, or anybody else who is suitable and willing, then they always look to me, and quite often the family are not suitable—they may be willing, but not suitable, because the dispute that has caused the proceedings to start is between the family and the public body. Therefore they cannot act as litigation friend without an adverse interest, because they have their views about what is in the best interests of their relative, which may, of course, get mixed up with their antagonism towards the public body and vice versa—I am not saying the public body is antagonistic towards relatives, but sometimes there is an unfortunate clash.

It is not a question of the family thinking, “We need help, we will get the Official Solicitor involved”, and it is certainly not a case of P thinking, “I need a litigation friend; who might it be? The Official Solicitor does that”. It is normally the court, especially the Court of Protection.

**Baroness Hollins:** We have heard evidence that obtaining expert reports can add significantly to the cost of delays. Do you agree with that, and if so what solution would you recommend?

**Alastair Pitblado:** I am in favour of obtaining expert reports, because neither I nor my staff, nor the solicitors I retain on behalf of P, are expert social workers. We are not experts in the creation of care plans; in the assessment of whether a care plan is a good care plan; in whether or not it is safe for the person to go home; if they do go home what adjustments are necessary to enable them to go home; whether care home A is good enough, care home B is not good enough—all those issues.

I do not think where one is having a proper assessment of best interests in the context of making a decision on behalf of a person who lacks capacity that you can do without experts—not in every case, but very often you cannot. Section 49 permits the court to ask either the local authority or the Office of the Public Guardian to instruct an expert to report; some judges prefer independent experts if they are going to have experts; others are content with Section 49 reports. I particularly raised that in the context of Section 21A, which is when somebody is deprived of their liberty under a standard authorisation, and I was describing that process. Generally it does increase costs, and I would not be asking for experts unless I thought it was appropriate in that case and necessary for me properly to represent P.

**Q275 Baroness Hollins:** That leads on to my last question, which is about whether the Official Solicitor has the requisite skills to support individuals with significant communication needs, and it may be that you have already answered that by saying that your staff do not have all the skills necessary to make a proper assessment of best interests.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Alastair Pitblado: Well, I think that is correct. We are the litigation friend; that is the service I provide. If a person has communication difficulties then we ensure that that factor is taken into account, and that somebody, an appropriate specialist, is instructed to enable the person to communicate—e.g. a person who can communicate with deaf people; sometimes it is a question of having to have a translator, an interpreter. That is why we look for experts and provide experts to do the entire job. It would not be feasible, I would suggest, for my office to be filled with all the relevant experts who could deal with any given set of facts, as it were.

Baroness Hollins: It leads to additional costs and delays; is there a solution to this?

Alastair Pitblado: I cannot see that there is one. If P is to be properly represented, and one is not simply going to say, “Well, whatever the social workers say is correct”, and one has to communicate with P to the greatest possible extent and try and find out as best as we can their wishes and feelings, their beliefs and values and any other factors which they could be expected to take into account, then we must be able to communicate with them, if not directly, but through the assistance of an appropriate expert.

Baroness Andrews: I was wondering whether the changes in legal aid in general have had an impact on the work.

Alastair Pitblado: I have been told so by my staff, and I have no reason to doubt it, ever since I was appointed, which was seven years ago, and I am thinking more about family cases, when I was a young barrister dwelling homes were excluded from the calculation, and then came a disregard for the first £100,000. There are not that many dwelling homes, certainly in most parts of the country, where that does not have an adverse effect on the eligibility for legal aid. I think I mentioned in my written response the passporting issue, and undoubtedly the quality of some solicitors, not on the whole the ones I use in the Court of Protection, because I have pool of solicitors I use—I am prepared obviously to expand that—but they do it because they want to do it; they regard it as work that redounds to their credit as well as making money out of it. Yes, it does make life more difficult, because, sometimes, as I said, if P is an elderly person with a dwelling house and has been taken into a care home, then they are probably not entitled to legal aid and that causes great difficulties.

Lord Turnberg: It may be a bit obtuse, but is it true that you have had to refuse representation of people because of lack of legal aid?

Alastair Pitblado: Yes.

Lord Turnberg: It is entirely a funding issue?

Alastair Pitblado: Yes. Occasionally people have a lot of spare liquid capital, but not very often. They will normally then have a deputy if they do, or will be getting a deputy. A person may or may not have capacity in relation to a class of decision, although some classes have easy instances or difficult instances, like medical decisions: “Shall I have a flu jab?” is a fairly straightforward decision, “Shall I have a complicated brain operation?” a difficult one, which requires a lot of assessment of risk and understanding what the doctors are saying to you. The person may lack litigation capacity but have financial capacity; I know that sounds odd.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Assuming they do not have financial capacity, I get an order from the court enabling me, if there is money to pay the costs, to get it from them. In the same way that a middle income person in any normal form of litigation will not be entitled to legal aid and will have to fund it themselves, which they may well find very difficult if their main asset is their home. It is not different in that sense, but it does cause me quite a lot of difficulty and some of my staff spend a lot of their time trying to work out how to fund the representation of the person I have been asked to act as litigation friend for.

Baroness Browning: If the dwelling of P is held in a trust for the lifetime interest of P, I assume then that dwelling does not come into the equation in terms of looking at their assets?

Alastair Pitblado: I have to pass on that one. I know that in relation to paying for care that if there is a discretionary trust that was put in place early enough so that it is not a device to avoid paying the care home fees once capacity is lost, then that does work. It is a bit like inheritance tax, avoidance by making gifts seven years before death: if you do it and divest yourself of your assets when you have capacity to do so, it would work. Lots of people are quite reluctant to divest themselves of their capital so that their children can avoid inheritance tax.

Q276 Baroness McIntosh of Hudnall: We have sort of covered what is in this question, but can I just explore with you a little bit more this issue about the relationship between people’s desire to access your services and the things that might impede them from doing so? It sounds to me as though fundamentally the issue is money: that they either have it, in which case they can choose to spend it with you or those who act on their behalf can choose to spend it with you in litigation; or they are eligible for legal aid, in which case the problem is solved that way. Are there other things that would discourage people from coming to you, other than not being able to pay for your services, as it were?

Alastair Pitblado: I need to emphasise that most of the people lacking capacity for whom I act as litigation friend have not come to me. Sometimes they resent the fact that they have a litigation friend, and it is primarily the court that will invite me to act as litigation friend. The main impediment is funding. Sometimes people will assert their own capacity; they will say, “I have got capacity”, and they will do that both in the civil courts, the family courts, and in the Court of Protection. The rules provide that if a person may lack capacity that the proceeding can start; litigation capacity in the other civil courts has to be assessed before they are treated as a protected party and require a litigation friend. There is a bit of after-the-event assessment that goes on in the Court of Protection, which is fine, because people who do lack capacity need protecting. The main problem is sometimes assessing capacity if a person is unwilling to be assessed. But the main problem is money.

Baroness McIntosh of Hudnall: At the moment the Court of Protection seems to be the only route whereby these issues can be resolved when they reach a critical point. Can you imagine any other route that would avoid—sorry to use the word—the paraphernalia of court proceedings followed then by further court proceedings? Is there another way in which some of these matters could be resolved?

Alastair Pitblado: Sometimes, when it is distrust between P’s family and the public body, there must be scope for getting them round a table. Certainly in my property and affairs cases, my lawyers who case manage those will chair meetings between the various family
members who have an interest in the subject of the application to try to narrow issues. I have had serious medical treatment cases of, usually a case of a catastrophic accident with catastrophic injuries. One young man who was shot in the head; his family desperately wanted him treated; the clinicians said it was futile and burdensome. I had an intensivist go in, because there were court proceedings, and he was able to—and he has done it in other cases—persuade the family that really there was not a great deal that could be done, but then he persuaded the clinicians to do a bit more than they were proposing to do, and he was able to mediate between them. I am sure that sometimes families and local authorities could be got together.

Baroness McIntosh of Hudnall: May I just interrupt you, because it is very interesting, and I am sure it is going to go on to be more interesting? Can I stop you on that particular issue, the case you have just described? There are costs involved in your lawyers convening those discussions and then the subsequent interaction with the clinicians and so on. Who meets those costs, and from what budget?

Alastair Pitblado: If we are talking about the property and affairs cases, P.

Baroness McIntosh of Hudnall: You might set up a quasi-mediation, or an informal mediation procedure for which costs are incurred, and those costs would fall on P?

Alastair Pitblado: In property and affairs all the costs fall on P usually.

Baroness McIntosh of Hudnall: By whatever means, yes.

Alastair Pitblado: The person who makes an application; they will normally get costs out of P’s estate; I am appointed to act as litigation friend and solicitor for P; I get my costs out of P’s estate.

Baroness McIntosh of Hudnall: But the medical issues are different.

Alastair Pitblado: In the medical cases the costs of the trust—I keep thinking of them as trusts, I know they are now different; the costs of the hospital—would be met by themselves. Normally the family will not be represented, because very often the family are not entitled to legal aid and, in any event, events are happening so quickly that they will simply be at the hospital talking to the clinicians. Maybe the clinicians are not the best, do not have the best bedside manner; maybe the family is very demanding; maybe there is a mixture of all of that. I will be paying for the expert, the intensivist or whoever I have asked at very short notice to go in. In due course I will be paying for counsel, and then I will seek half of my costs from the hospital.

Q277 Baroness McIntosh of Hudnall: Sorry, if I can just pursue this a little bit further: the budget to which you referred earlier, in one of your earlier answers, which has been, as you implied, significantly reduced—

Alastair Pitblado: No, it has not. I did not say that.

Baroness McIntosh of Hudnall: There are greater calls upon it perhaps.

Alastair Pitblado: Yes.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Baroness McIntosh of Hudnall: Either way, it does not go so far per individual case as once it did, would that be right?

Alastair Pitblado: You are correct. Ten years ago my predecessor had money coming in from various sources, which he then redistributed in various ways within his budget. I do not have that any more, and although my budget has not been cut—the Ministry of Justice has been mindful of the work I do—I nevertheless have no spare budget to fund things that I did not use to fund.

Baroness McIntosh of Hudnall: The budget that you do have would be available to you at your discretion—this is a question—to deploy in cases such as the one you have just described, where there was an immediate need for some legal intervention to break a deadlock or settle an issue that needed immediate attention, such as somebody having suffered a catastrophic injury, as you describe. That fund exists and you are able to access it at your own discretion, is that correct?

Alastair Pitblado: Yes, to pay the experts who have advised, and I personally think are necessary, and counsel—I am acting as solicitor in those cases.

Baroness McIntosh of Hudnall: Yes, okay, thank you—that is very helpful.

The Chairman: That case that you just explained to Baroness McIntosh, and also cases in property and affairs where the family get together and there is some form of mediation: if it is successful the ultimate benefit is that the case does not go down the route of the Court of Protection, and the costs of that are saved. Is that correct?

Alastair Pitblado: Invariably in all these cases there has been an application to the Court of Protection, so the application has been issued—the fee for that has been spent. In the property and affairs cases it would be a family member who would want either a statutory will approved, or a variation of some settlement. In the medical cases it is almost invariably the trust that has brought the proceedings, so that it gets its back covered in relation to the treatment that it probably does not want to give in those sorts of cases. There are proceedings I have been invited to be litigation friend in, usually in those cases I have accepted, because in the property affairs cases there will not be an application unless there is some money, out of which everybody gets their costs—whether that is right or wrong, that is the rule. In the medical cases, I have a budget for that purpose.

The Chairman: Will there be a benefit if the proceedings, although they exist, will not be as protracted as they otherwise would have been, thereby saving the system, if I put it that way?

Alastair Pitblado: Certainly, yes. Sometimes there will be a consent order or a withdrawal. Normally in the property and affairs cases there will be an agreed order that is put to the judge, the judge will look at it, read the report that I put in, and approve it or not—usually approve it. In the medical cases, it may well be that there is practically no dispute left.

Q278 Baroness Barker: You have explained to us this morning the different ways in which your office either can bring about mediation, or by using experts and expert witnesses...
ascertain the wishes and feelings of P. How often does it appear that these have a decisive impact on the outcome of cases?

**Alastair Pitblado:** When I hand my written speaking notes in to the clerk there will be a written answer to this. My first point about that is that the policy behind the Act is that decisions must be made in best interests rather than substituted judgment. If one looks at Section 4, the primary provision is Section 4(2), which says that the person making the determination as to best interests must consider all the relevant circumstances and in particular take the following steps. Then there are the number of steps, including 4(6), which talks about the wishes and feelings, past and present, beliefs and values, and any other factors, and 4(7), which requires the decision maker to take account of what the family believe the wishes and feelings were and would be, beliefs and values, and so on, and also what they think is the best interests of P.

Yes, those are important factors. I know that sometimes it is called the Section 4 checklist; I think it is not really a checklist, because you start off with 4(2), as needing to “consider all the relevant circumstances”, and it is defined in 4(11) what that means. Sometimes it[wishes and feelings past and present] is quite important; certainly in deprivation of liberty cases there has been a tendency to consider very carefully what the person’s wishes and feelings are. If they say they want to go home—I mentioned a case in my written answers, three directions hearings, six days of argument, P refused to unpack her bag despite having been in the care home for months. She said she was “a prisoner”, and the two Court of Protection visitors both said she could go home with a little bit of tweaking in her home. I was arguing that she should go home. This particular judge made the decision that she should not go home, that she should go to a different care home in a part of the country she did not want to be in, near her family. She did not particularly want to be near them as far as we could work out.

**Baroness Barker:** She sounds a wonderful woman.

**Alastair Pitblado:** Having said that, that was the judge’s decision; the president famously said in one of his judgments, “What good is it making someone safer if it merely makes them miserable?” The judge in the case I have just been describing was clearly much more risk-averse, and at one stage asked, “What would I do if it was my mother!” If it was my mother I would send her home; clearly if it was his mother he would not. Wishes and feelings—yes, they are taken into account, but they are not necessarily determinative.

**Baroness Barker:** Throughout our hearings we have talked to different people from different professions about the balance between best interests and safeguarding, so there is a clear perception out there that different professions approach the Act and use it in different ways, so it is interesting to see where the court takes that. Can I ask you, because of that, how frequently do the people appear in the court proceedings, and does that make a difference, given that the court does not yet sit regionally?

**Alastair Pitblado:** It does sit regionally, but not as much as it could. Certainly all the Family Division judges of the High Court will sit in Newcastle, Birmingham, Leeds, Sheffield, Liverpool, Manchester, and in the county courts in the West Country. What the president is going to try and do is have fewer cases heard by High Court judges and more cases heard by the circuit judges who have the ticket, and the district judges who are already doing so. I have now forgotten the question, sorry. In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Baroness Barker: How often do people take part in proceedings, or is it just in the nature of the work that they do not?

Alastair Pitblado: Yes, yes, originally, and certainly under the inherent jurisdiction, although there were cases under the inherent jurisdiction when the judge would see and talk to the person in respect of whom the decision was being made. There was, in my world, a very famous case where Dame Elizabeth Butler-Sloss went to a hospital bed and spoke to the person concerned, and satisfied herself that the person concerned did not want to be treated, and made her decision that she should not be treated, and she was allowed to die. That is happening more and more in the Court of Protection; I do not mean people being allowed to die, but the judges actually seeing P, and I have certainly got it on my agenda to try to facilitate it wherever that is feasible.

The Chairman: Is technology used: remote links?

Alastair Pitblado: Yes, sometimes.

Q279 Baroness Andrews: You may have answered this question, but let me put it to you this way: we have heard quite a lot of evidence that people are concerned about what they see as delays in the system, particularly around financial and property areas. You have already spoken about the huge increase in workload—a tenfold increase—and about the constraining effect of cost. Do you think that the complaint about delay is a matter of perception, given the complexity of the issues that you are dealing with, or do you think these are real issues to do with processes, above and beyond these two major issues of workload and costs, massive though they are?

Alastair Pitblado: I am assured that the property and affairs cases that I deal with are not taking longer than they used to in the old Court of Protection. I cannot speak about some of the newer areas that are dealt with by the Court of Protection, but the statutory wills and settlements being varied, and gifts being made by application to the court: those, I am assured, are really not taking any longer. I do not think the Court of Protection would hesitate to accept that when it first came into being there were delays that have now, on the whole, been remedied.

The outsider’s perception of what is a delay that has been remedied and the courts’, lawyers’ or the judges’ perceptions of what is a delay that has been remedied are probably different, but any piece of litigation is going to take some time. My answer in relation to property and affairs is that I am advised that those cases are not taking longer than they used to in 2005, 2004, and so on. There was a period where they were, and people remember that sort of thing; it colours how they perceive the current process, even if the current process is more efficient.

In relation to welfare cases, I try to get them finished as soon as I can; that is for pragmatic reasons—freeing up my case managers to manage other cases. It is because I do not like to have them hanging around: it is not good for P, it is not good for the families. The only people it is good for are the lawyers, and I am not interested in their welfare. I do try to get those cases sorted, and I do not like to have them hanging on simply because there is some issue that may or may not need considering in six months’ time.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Obviously if you cannot finish the case off, you cannot, but there is a fairly broad spectrum of when you can finish a case off and when you cannot finish a case off, because you can always think of what is going to be happening in six months, what will happen after P has been moved into supported living from the care home, and so on and so forth. I take the view that unless there is currently an issue to be determined we should try and get the case finished. I am not always successful in that, but I try.

**Baroness Andrews:** On the business of comparison with the previous process, I can see that it is clearly to your credit that it is not taking any longer, because circumstances have changed anyway, as we have discussed. Is there an internal review or audit process which looks at the processes of the office, and is there any scope at all for shortening any of the processes, do you think, in an administrative sense?

**Alastair Pitblado:** I spend a part of my time trying to make sure that the case managers put an appropriate level of effort into the case, but do not gold plate it—Rolls-Royce it. That really is not a factor which leads to delay of the progress of the case; it is a factor that increases workload within the office. Although you can say, “Well, right, if they are increasing workload in the office then the caseload will not be processed as quickly”, I believe that the length a case takes will depend upon all the participants, from the court, to the local authorities or hospital, to the family. Yes, experts will add to the length of time, but, as I said, I think they are necessary when I ask for them.

I do look at the internal process, but I do not think that is really a factor in the overall delay of the case; I think it is more a question of internal stress, and case managers having to do what is necessary, rather than what they would possibly like to do.

**Baroness Andrews:** How much was your budget cut?

**Alastair Pitblado:** It has not been.

**The Chairman:** I think that has been answered already. There has not been a budget cut at all; there is an issue about the workload.

**Q280 Lord Faulks:** You have already mentioned the fact in your written submissions that the president of the Family Division has made some suggestions for the changes, including more use of circuit judges rather than High Court judges on circuit, which I think is the current arrangement. They have to be ticketed before they can do that, with generally more publicity for hearings. Do you think that the suite of reforms that look likely are ones that are going to have a beneficial impact on users of the court?

**Alastair Pitblado:** I do. Taking, for example, the press being in court, which is the norm in the family courts, it is the reverse in the Court of Protection. I took two cases to the Court of Appeal in relation to P’s privacy; since then there has been a clear set of rules so that, if the press apply to be allowed in, I never try to stop them going in on the basis that it is still in private, and then they ask the judge to allow them to report X, Y and Z. I am still concerned to protect P’s anonymity, but it would be a lot easier if the press could go in without that process, because I just regard it as something that adds to process, it adds to the costs of the press, it adds to the overall costs, and I do not feel I need to be looking at that. That would be helpful.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
It is very important that judgments are published, and they are largely now. One of the reasons for that is it is quite easy for disgruntled family members to distort the facts, as they do in care cases from time to time. If more and more cases are dealt with close to where the people live, and where the local authority is, that will be to everybody’s benefit. Now that we have had a few years of jurisprudence case decisions in relation to the issues that are dealt with by the Court of Protection, I can see no good reason why it has to be a High Court judge. Yes, I think they will help. Whether they will reduce the average time of a welfare case—and I do not know what the average time of a welfare case is—from, I am just plucking figures out of the air, nine months to six months, I do not know. They might reduce it from nine months to eight months, but I think they will be beneficial.

**Lord Faulks:** I suppose you have got to make sure that there are judges who are appropriately trained, which involves costs, and there may be some reluctance to train up enough?

**Alastair Pitblado:** Next week I am going to the Judicial College to speak to judges who are being ticketed. Of course, when I was a young man, a circuit judge did crime, family and civil, but that is apparently no good any more.

**Lord Faulks:** No.

**The Chairman:** Thank you very much indeed. We are very grateful to you for your evidence, and it has been a very full session. We will now move on to the next evidence session.

**Alastair Pitblado:** Thank you. I am very pleased to have been able to offer some assistance.
The Faculty of Health and Social Care, The Open University – Written evidence

Executive Summary

1. This submission summarises research undertaken by academics at the Open University and the University of Kent regarding the use of the MCA to support decision-making in contraceptive care for women with learning disabilities.

2. The research shows that in the field of contraceptive care for women with learning disabilities, insufficient measures have been taken to ensure that practitioners and families know about and act in accordance with the provisions of the MCA. The research also suggests that the Act may not be widely known and understood by professionals required to implement it in the field of sexual and reproductive healthcare.

3. Michelle McCarthy’s research (2009a and 2009b, 2010) signaled that decision-making processes in relation to contraceptive care for women with learning disabilities are complex and often hidden, with little indication that women themselves are actively involved.

4. Michelle McCarthy’s research (2011) highlighted there was a poor understanding of mental capacity legislation amongst GPs. Many GPs assumed that carers could give proxy consent to treatment. None mentioned the women’s right to confidentiality.

5. Professionals in Boahen’s (2011) study of an integrated learning disability service drew on safeguarding procedures to prevent ‘promiscuous’ sexual relations. One fundamental principle of the MCA - that people should not be prevented from making unwise decisions - was not always adhered to or was sometimes misrepresented and misapplied in professional practice.

6. A recently conducted survey on ‘Contraception: Who decides?’ undertaken by the Open University (Earle et al 2012) echoes concerns from other sources about the degree to which the Mental Capacity Act is being fully implemented in relation to contraceptive decision-making in learning disability, and unease that proxy consent may be over relied upon. It found that only 38% of women with mild or moderate learning disabilities had been involved in a formal assessment of their mental capacity in relation to contraceptive decision-making, with even lower numbers (30%) reported for women with higher support needs.

7. 38% of respondents in the OU survey said that the women themselves had made the final decision about initiating contraception, meaning that 62% of women had not directly chosen to take contraception.

8. Of 21 OU survey responses regarding women described as having severe or profound and multiple learning disabilities, only 36% were reported to have been involved in discussions concerning their choice of contraception compared to 84% of those with mild or moderate disabilities. A key principle of the Mental Capacity Act is
that ‘a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success’. This finding is of concern as it is hard to see how ‘all practicable steps’ (MCA Code of Practice, 2007), for example the introduction of accessible communication or the involvement of people who know the person well, are being taken if the person is excluded from these discussions.

9. The MCA Code of Practice (p.50) states that ‘Capacity should always be reviewed whenever a care plan is being developed or reviewed’ while the time and decision specific principles also imply the need to re-evaluate key medical interventions for learning disability service users. However, there was a worrying lack of contraceptive care review reported amongst the total sample of the Open University survey, suggesting that key decisions about these clinical and social interventions are not being re-visited with women with learning disabilities.

10. The human right to be involved in important decisions about one’s life advanced by the MCA was not realised by a significant proportion of service users in the sample.

Overview

11. This submission summarises work undertaken by the Open University and other selected academics regarding the use of the MCA to support decision-making in contraceptive choices for learning disability service users. In terms of contraceptive decision-making with women with learning disabilities, there are a number of stakeholders who may be involved in the process: the woman herself, her partner or future partner, family members, front line staff, provider managers, GPs, social workers, Independent Mental Capacity Act Advocates (IMCAs) and nurses, to name a few. Primary health care teams and, in particular, General Practitioners (GPs) are typically seen as the most appropriate source of contraceptive advice. Yet numerous recent enquiries have highlighted barriers encountered by people with learning disabilities in accessing healthcare on an equal basis (Michael 2008; Mencap 2012), and little understanding of the MCA by healthcare professionals. This submission provides evidence focused on the implementation of the MCA specifically in relation to supporting contraceptive care for women with learning disabilities.

Implementation

12. Dr Michelle McCarthy’s research (2009b) found that contraception for women with learning disabilities is prescribed at an earlier age and continues later than for non-disabled women, with an over-reliance on carers to communicate with doctors. McCarthy’s research signaled that decision-making processes in relation to contraceptive care for women with learning disabilities are complex and often hidden, with little indication that women themselves are actively involved.

13. McCarthy included a survey of General Practitioners in her research into contraception and reported on the results of this in a paper published in 2011 (McCarthy 2011). The results indicate a low level of awareness of rights under the MCA as opposed to perceived medical needs. 94.1% of service users were accompanied by a carer to consultations about contraception, which was welcomed
by GPs as helping with communication and compliance, but showed little regard for a woman’s right to make decisions without parental or paid carer influence. Depo-Provera (DP) was prescribed to 34% of the sample of women because they were regarded by GPs as unreliable users of the pill or other forms of contraception. This contrasts with only 3% of the wider population choosing DP, and, suggests McCarthy, may indicate a disregard for the side effects of injectable hormonal contraception for women with learning disabilities. Overall, McCarthy’s research highlighted there was a poor understanding of mental capacity legislation, with many GPs assuming that carers could give proxy consent to treatment. None mentioned the women’s right to confidentiality.

14. Studies show that in relation to sexual relations for learning disability service users, the MCA best interest principle is routinely overlooked in practice because of concerns of potential sexual abuse. McCarthy (2009a and 2009b) observed that contraceptive devices are being used as a response to the danger of sexual abuse and rape; the ‘just in case’ approach, justifying contraceptive interventions even amongst women who are not sexually active, on the basis that something might happen to them at a future point. The rationale is not far removed from the case that was being made to sterilize institutionalized women in the so-called ‘Eugenic era’ (Tilley et al., 2012). McCarthy (2009a) also noted an unwarranted and exaggerated fear of the consequences of pregnancy; and that decisions concerning contraception are influenced by convenience for staff in managing women’s periods, a finding echoed in recent research in Taiwan (Chou and Lu, 2011). McCarthy concluded that her interviewees lacked autonomy or knowledge of alternatives, and played a largely passive role in determining whether to use contraception, and the range of choices available. She points out that whereas sterilization is subject to legal oversight, no such safeguards exist for the use of long-term contraception such as Depo-Provera: ‘when a woman ... is put on contraception for most or all of her reproductive life this is arguably a chemical sterilization, yet it has no legal scrutiny’ (2010: 264).

15. More recently, in a 2011 ethnographic study of an integrated learning disability service, Godfred Boahen observed that professionals were reluctant to allow service users to engage in what they deemed as ‘unwise’ sexual relations. With the prevailing view that learning disability service users are ‘vulnerable’ to sexual abuse (Holomotz, 2011), professionals in Boahen’s study drew on safeguarding procedures to prevent ‘promiscuous’ sexual relations. This research shows that one fundamental principle of the MCA - that people should not be prevented from making unwise decisions - is not always adhered to or that it is sometimes misrepresented and misapplied in professional practice.

2. Decision-making

16. A research team from the Faculty of Health and Social Care, the Open University, undertook an on-line survey in 2012 to find out who decides about contraception choices for women with a learning disability. The survey was designed to explore the experiences of family members, advocates and staff. One limitation of the study is that responses from women with learning disabilities themselves were excluded from the first on-line stage of the research due to concerns about access and capacity to consent. A separate study is now being designed to gather the views of women themselves.

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17. The survey was launched in Spring 2012 and ran for three months. 90 replies to 29 questions were received. An overview of all responses is reported here.

18. Using categories of ‘mild’, ‘moderate’, ‘severe’ and ‘profound and multiple’, respondents were asked to describe the degree of learning disability of the person with whom they had been involved in contraceptive decision-making. The rationale for using these labels was the fact that they remain commonly used labels in health and social care services.

19. Aware that the experiences of learning disabled women with higher support needs are particularly under-represented in the literature, a further detailed analysis was undertaken that focused on responses received in relation to 21 people described as having severe or profound and multiple learning disabilities (S/PMLD). Responses from those grouped as S/PMLD were then compared to responses received in relation to people described as mild/moderate to explore any possible differences in patterns of contraceptive use and decision-making practice. The qualitative data received in response to open ended questions was collated and analysed using a six-phase process of systematic thematic analysis. The findings are reported below.

20. 38% of respondents reported that women with mild or moderate learning disabilities had been involved in a formal assessment of their mental capacity in relation to contraceptive decision-making. 30% of respondents reported that women with high support needs had been involved in a formal assessment of their mental capacity in relation to contraceptive decision-making. This finding echoes concerns from other sources about the degree to which the Mental Capacity Act is being fully implemented in relation to contraceptive decision-making (Rowlands 2011; McCarthy 2010) and unease that proxy consent may be over relied upon by those administering contraception. An equally important aspect of this finding is that the human right to be involved in important decisions about one’s life advanced by the MCA was not realised by a significant proportion of service users in the sample.

21. In only a small minority of cases (12%) was the issue of commencing contraception first raised by the woman with learning disabilities. In most cases the subject was initially raised by the person’s mother (20%) or residential support staff (16%). Others reported as frequently introducing the subject of contraception were GPs, learning disability nurses, and social workers. Once the topic of contraception had been introduced, respondents reported that women with learning disabilities were involved in discussions about whether to use contraception and which type of contraception would be most suitable for them. 62% were reported to have been involved in discussing their choice of contraception with 14% of partners also involved. 38% of respondents said that the women themselves had made the final decision to take contraception, meaning that 62% of women had not directly chosen to have contraception.

22. By far the most widely used form of contraception was contraceptive implant, used by 46% of the women in this sample. This was followed by the combined (oestrogen...
and progesterone) contraceptive pill which is used by 24% of the women and the progesterone only contraceptive pill used by 7%. 45% of women in this sample had the final say about what type of contraception they would have, once a decision to introduce contraception had been made.

23. 28% of respondents said that contraception was required because the women concerned were sexually active. In 15% of cases there was an expectation that the women would become sexually active, while a fear of pregnancy (18%) and avoidance of risk of pregnancy (41%) were also cited as key factors. These findings from the Open University study appear to confirm McCarthy’s (2009b) finding that contraception is frequently used by women with learning disabilities ‘just in case’. Together the two pieces of research provoke questions about whether the best interest principle is adhered to: if service users are found to lack capacity, then by implication, they should only be prescribed contraception if it is in their best interest after such an assessment. It is debatable whether the ‘just in case’ approach is in the best interest of service users who may not be sexually active.

24. It is important to review contraceptive use regularly, particularly if long acting contraceptive implants are used. 40% of women had used contraception for between 3-15 years yet in only 20% of cases was contraceptive use regularly reviewed. In cases where changes in contraception were made this was most commonly prompted by the woman experiencing side effects rather than planned review or life cycle changes such as the menopause.

25. In data concerning women with severe or profound and multiple learning disabilities, the main respondents (38%) were mothers followed jointly by paid support workers and independent advocates. Although a smaller sample, responses were also received from a diverse range of people involved in contraceptive decision-making including: siblings, members of learning disability teams, social workers and an owner of a supported living company. In only 5% of this sample was the issue of contraception first identified by women with learning disabilities, perhaps reflecting their degree of disability and cognitive capacities. Instead, contraception was initially raised by residential support staff (29%), mothers (24%), or the GP (10%). Others involved in introducing the subject of contraception were the headmaster and doctor in a special school, learning disability nurses and a social worker.

26. The issue of contraception was raised at an earlier age with this group with 38% reporting that it arose when the woman was under 16. This was in contrast to women with mild or moderate learning disabilities where only 7% reported that the issue first arose when they were under 16. This finding is surprising given that women who are more able could be perceived as being at higher risk of pregnancy given their higher level of independence in the community.

27. Only 36% of women with severe or profound and multiple learning disabilities in the sample were reported to have been involved in discussions concerning their choice of contraception compared to 84% of those with mild or moderate disabilities. A key principle of the Mental Capacity Act is that ‘a person is not to be treated as unable to
make a decision unless all practicable steps to help him to do so have been taken without success’. This finding is of concern as it is hard to see how ‘all practicable steps’ (MCA Code of Practice, 2007), for example the introduction of accessible communication or the involvement of people who know the person well, are being taken if the person is excluded from these discussions.

28. Only 14% of women in the severe or profound and multiple learning disability group were described as making final decisions about the use of contraception. Instead final decisions were most often made by mothers (29%) and GPs (19%). No respondents made any reference to the involvement of Independent Mental Capacity Advocates (IMCAs) or the Court of Protection under the Act although one respondent referred to the use of a best interest decision-making template for guidance. With high levels of final decision-making reported by other parties and low levels of formal Mental Capacity Act assessments these findings raise concerns about the legality of the decision-making processes currently followed. The low rate of formal capacity assessments for women with high support needs may also reflect the finding that contraception may be given earlier to this group. If contraception is prescribed to a person below the age of 16 then, in line with Gillick competency guidance, a parent is legally able to make the decision on their child’s behalf, negating the need for a capacity assessment. At the same time however, the MCA Code of Practice suggests that such decisions should be in the young person’s best interest. There is thus a tension between the legal rights of parents and young people with respect to decision-making. Consequently, further statutory guidance may be required on the interface between the MCA and the 1989 Children Act, especially during care planning for transition to adult services for learning disability service users.

29. Responses submitted to the 2012 Open University research also provide insight into the anxieties and sense of responsibility experienced by parents, primarily mothers, as they tried to act in the best interests of their child. One said:

- I found it very difficult to agree to put my daughter on contraception. I would not take it myself and I do not normally ask anyone to do anything that I am not prepared to do. My daughter had a boyfriend at the time and my doctor told me that she could not stand the risk of pregnancy.

30. Another commented

- At the time there was no easy read/pictorial format [contraceptive information]. Further discussion with internet research was completed by myself and a learning disability occupational therapist to try to ensure she understood and was making the correct decision.

31. Other responses highlighted the interrelated nature of parental concerns regarding protection and avoidance of pregnancy:

- As the mother of this young person I would have preferred her to have been sterilized but was told this was against her human rights as a woman. She will
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32. Responses from residential care staff also indicated concern about their role in contraceptive decision-making:

   o I find it very difficult to have responsibility in making these decisions. It is like playing God.

33. And the sensitivity of broaching the topic of contraception:

   o It is a very difficult subject for most people with learning disabilities particularly if they have a more severe disability and they live with parents who tend not to view their disabled son/daughter as having sexual needs.

34. Contraceptive implants or injections and the combined contraceptive pill were identified as the most common forms of contraception initially used for women with high support needs. In this study, management of menstruation was the most common reason for the introduction of contraception with a third of respondents providing this reason as opposed to 8% amongst women with lower levels of support need. Fear of abuse (19%) and avoidance of pregnancy risk (13%) being the second and third most common reasons respectively. With only 19% of this group described as sexually active when contraception was prescribed, findings indicate that for people with high support needs contraception is often prescribed as a precautionary measure.

35. Responses received from a number of mothers highlighted that the management of menstruation was a key factor in contraceptive usage:

   o She had the contraceptive pill. She needed to have a break from the pill every three months rather than every month as she cannot cope with periods.
   o As our daughter is not sexually active the pill is used not for contraception but for regulation of menstrual cycle.

36. For women with severe or profound and multiple disabilities there was a much higher rate (52%) of change in contraception following its introduction, with only 29% reporting no change being made after initial choice of contraception. 29% of contraception changes for people with higher support needs were reported to be in response to side effects with 14% as a result of regular medication review. A response from a residential support worker described how side effects of 'weight gain and personality changes' for one woman with high support needs led to a change from implant to the contraceptive pill. The change was reportedly made following a discussion between the GP and mother.

37. 19% had been taking contraception for 1-2 years, 14% 3-5 years 19% 6-10 years showing that many people with higher support needs appear to be using contraception on an ongoing basis despite the fact that a relatively small percentage were reported as sexually active.
38. One response provided evidence of shared decision-making to cease the use of contraception when it was not necessary:

- It was decided by all parties that as the girl did not wish to have a sexual relationship she did not require further contraception after the effects of the initial injection had worn off.

39. However, this response raises further questions of how the woman came to be given a contraceptive injection in the first instance. Three respondents also described women with high support needs being switched from the contraceptive pill to implant following a medication review. The reasons for this change were not documented and, as with other survey findings, suggest that contraceptive review with women with high support needs would benefit from further research.

3. Summary and Recommendations

40. The evidence cited in this submission highlights that in the area of contraceptive care for women with learning disabilities, the five principles of the MCA are being implemented to a limited degree only.

41. The 2012 Open University survey (Earle et al 2012) found that only one third of women with learning disabilities had undergone a formal assessment of their capacity in relation to contraceptive decision-making. While this figure is partly explained by some girls receiving contraception under the age of 16, the number of capacity assessments being undertaken is still surprisingly low given nature of the interventions being prescribed.

42. Amongst people with high support needs, we have noted that only one third were involved in the type of contraception being considered, with parents and doctors taking a lead on decision-making in this area.

43. The MCA Code of Practice (p50) states that ‘Capacity should always be reviewed whenever a care plan is being developed or reviewed’ while the time and decision specific principles also imply the need to re-evaluate key medical interventions for learning disability service users. However, there was a worrying lack of contraceptive care review reported amongst the total sample of the Open University survey, suggesting that key decisions about these clinical and social interventions are not being re-visited with women with learning disabilities.

44. Interestingly, no respondents in the Open University survey made reference to the use of IMCAs in these decisions. While the OU survey did not explore whether service users had family and friends, the research found that the issue of contraception was first suggested by care workers for service users in residential accommodation. In these circumstances it would have been advisable for IMCAs to be involved in decision-making about contraception choices.

45. The findings of the research evidence cited here show that some women with learning disabilities are not being involved in decisions about their contraceptive care under the provisions of the MCA. The research suggests that it is hard to see how ‘all practicable steps’ (MCA Code of Practice, 2007), for example the introduction of

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accessible communication or the involvement of people who know the person well, are being taken if the person is excluded from these discussions.

46. The research shows that in the field of contraceptive care for women with learning disabilities, insufficient measures have been taken to ensure that practitioners and families know about and act in accordance with the provisions of the MCA. The research also suggests that the Act may not be widely known and understood by professionals required to implement it in the field of sexual and reproductive healthcare. It also raises questions regarding whether an appropriate balance has been struck between the protection of the carer and protection of the individual lacking capacity.

47. While the research cited here suggests that the involvement of carers and families has been fostered in decision-making about contraceptive care, the views and perspectives of women themselves requires further consideration and active support by professionals working in this field.

48. It is our view that the MCA provides a suitable framework to engage women with learning disabilities in decisions about contraception, but that more needs to be done to support its effective implementation in frontline practice.

Submission by the Faculty of Health and Social Care, the Open University:

Godfred Boahen (PhD student)
Dr Sarah Earle (Senior Lecturer)
Dr Sue Ledger (Visiting Researcher)
Dr Liz Tilley (Lecturer)
Dr Jan Walmsley (Visiting Chair)

September 2013

References

Boahen, G. (forthcoming) 'Ethnicity, learning disability, and the Mental Capacity Act 2005: a constructionist ethnography of an integrated service' (Open University PhD)


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4 September 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Sophia Palmer – Written evidence

Sophia Palmer – Written evidence

As a parent I have had no advice whatsoever, and the following points are for your attention.

Item 5. I was not made aware.

Item 12. Not in my experience.

Items 16 & 17. Not made clear to parents.

Item 20. Far too expensive for me and any in my position as OAP with no other means.

Yrs sincerely,

Sophia Palmer.

31 August 2013
Executive Summary

1. The Parliamentary and Health Service Ombudsman (PHSO) welcomes the opportunity to contribute to this call for evidence. One of our strategic aims is to enable public services to learn from complaints and use them to improve the service they provide to everyone.

2. In our submission we explore the extent to which the five Key Principles of the Mental Capacity Act (2005) (hereafter the Act) have been implemented in frontline practice, providing examples of cases we have received concerning each of the Key Principles.

3. In an examination of our case work, we identified 36 complaints concerning the implementation of the Act during the 2012/13 financial year. Some of the key concerns raised in these complaints are:
   - Decisions about discharge arrangements and where a patient can find accommodation
   - Decisions about a patient’s own care and treatment options
   - Families of patients wishing to be consulted in respect of decisions made in the best interests for, or on behalf of, a patient who lacks capacity

4. To ensure implementation of the Act, we support the recommendations made in The Confidential Inquiry Into Premature Deaths of People with Learning Disabilities (CIPOLD) which was published earlier this year, and included the following recommendations:
   - Advice on the Act should be easily available 24 hours a day via a dedicated phone line staffed by expert advisors in all matters relating to the Act
   - Training on the Act should be mandatory for staff involved in the delivery of health and/or social care
   - All decisions that a patient with learning disabilities is to receive palliative care only should be supported by the framework of the Act and the patient referred to a specialist palliative care team

Introduction

5. PHSO is independent and not part of government or the NHS. To support the use of complaints in the improvement of public services, we investigate complaints that individuals have been treated unfairly or have received poor service from the NHS in England, Government departments and other public organisations, and from which the complainant has yet to receive a satisfactory response. Of the 162,000 NHS

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complaints in 2012-13; 15,944 enquires came to us, either because complainants were dissatisfied with the local outcome, or because they needed our help to understand the complaints process.

6. If our investigations find significant or repeated mistakes, we share this information with service providers, professional regulators, Government departments and others involved in the delivery of public services to help them do their job. Most members of the public who bring their complaint to us, tell us that they are looking for three simple things:

• an explanation of what went wrong
• an apology
• an adequate remedy, with action to be taken so that other people do not have to experience the same poor service

7. But sadly, the public perception of complaining is so poor that research we commissioned in 2012 showed:

• the overwhelming majority (64%) of people who complain do not believe that their complaint will lead to any change
• 39% of those who want to complain about a public service do not make a complaint. Almost 60% of this group told us that their reason for not complaining was that they believed the complaints process would be complex, involve them having to chase a response and that they feared nothing would change as a result of their complaint

8. An effective complaints system is a core part of a well-designed and managed public service. When handled well, complaints make a difference. A good response to a complaint can ensure justice for the individual. Importantly, it can also ensure that learning takes place so that mistakes are not repeated and the quality of service improves for all. However, as detailed by the Francis Report278, the reality is that too often complaints do not make the difference that they should.

9. This is highlighted in our new research279 made in submission to the Clwyd Hart review of NHS hospital complaints, which demonstrates there is a ‘toxic cocktail’ within some NHS hospitals which combines a reluctance by patients, carers and families to complain with a defensiveness by hospitals and staff to hear and address concerns. This results in opportunities to learn and improve services being lost.

10. The research sets out ideas which could lead to a step change in complaint handling from the ward to the Board. Improvements suggested by the research include:


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A fresh focus on putting things right on the ward
- Boards should drive forward an open culture which seeks feedback in order to improve
- Boards should focus on measuring people’s experience of complaining

11. By implementing these recommendations to support changes in NHS complaint handling, concerns regarding the Act could also be addressed to ensure that lessons are learnt and mistakes are put right.

12. In an examination of our case work, we identified 36 complaints concerning the implementation of the Act during the 2012/13 financial year. Some of the key concerns raised in these complaints are regarding:
- Decisions about discharge arrangements and where a patient can find accommodation
- Decisions about a patient’s own care and treatment options
- Families of patients wishing to be consulted in respect of decisions made in the best interests for, or on behalf of, a patient who lacks capacity

Five Key Principles

13. The Act provides vital protection to those who lack capacity to:
- Allow people to make as many decisions as they can for themselves
- Protect those who cannot make decisions
- Provide legal framework for making decisions on their behalf

14. These protections are supported through five key principles, for which we provide illustrative examples from our casework that demonstrate these principles are not always being upheld.

Presumption of capacity

15. The first principle established by the Act is the presumption of capacity, such that every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This therefore means that health and social care professionals cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

16. A relevant case we have investigated concerns a patient, Mr L, who had a history of advanced dementia and chest infections. He was admitted to hospital with increased shortness of breath and diagnosed with aspiration pneumonia and prescribed fluids and antibiotics. The next morning Mr L’s consultant decided to only provide palliative care. When his son (Mr T) was told about that, he had asked to speak to a doctor. After some discussion, the decision was reversed, and Mr L’s antibiotics and fluids were restarted. His condition gradually improved and he was discharged back to his care home. Mr T complained to us about the consultant’s decision, and about the fact that he had not been consulted first.

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17. The Consultant acted in line with the applicable standards when deciding to withdraw active treatment from Mr L. The Consultant said that he acted in accordance with Mr L’s expressed wishes, but we found no evidence that Mr L had expressed any wishes about his care and treatment. There was also no evidence that Mr L’s capacity to consent had been assessed. But on that point, Mr L had advanced dementia, was known to experience confusion, and on the morning in question, he was drowsy and his conscious state was reduced.

18. In the circumstances, it was reasonable to assume that Mr L did not have the capacity to consent to the Consultant’s decision. But in that case, the Consultant should then have checked if Mr L had made a legally binding advance directive, or had an attorney or legal proxy who could have decided which option would be of most benefit to him. He should also have consulted a member of Mr L’s family and members of Mr L’s healthcare team for help in making the decision. The Consultant did none of these things.

Maximising decision-making capacity

19. The second principle established by the Act is for action to be taken to maximise the decision-making capacity of patients. This includes by giving all practicable support before anyone treats them as not being able to make their own decisions. Furthermore, every effort must be made to encourage and support people to make a decision for themselves.

20. Even if lack of capacity is established, the patient should still be involved as far as possible. However we have evidence that even when patients are assessed as not having capacity this principle is in some cases not being upheld.

21. For example, Mr A, who had dementia, spent the last few months of his life in a care home despite Mr A, and his family, expressing repeatedly the wish for Mr A to be able to die at home. While Mr A had chronic physical problems and was assessed as not having capacity, various bodies delayed and deferred making a final decision on whether or not Mr A could be discharged back to the home Mr A and his family had always shared, as they wished.

22. Mr A was never discharged – instead dying in the care home. Staff did not respect or support Mr A’s ability to decide on this matter.

Freedom to make unwise decisions

23. The third principle established by the Act is that people have the right to make decisions that others might regard as unwise. No one must be treated by someone as lacking capacity for this reason. Furthermore, everyone has their own values, beliefs and preferences which may not be the same as those of others.

24. Following on from the previous illustrative example regarding Mr A, who expressed the wish to die at home, concerns were raised by staff that they had received reports that the home the patient lived in was, by some accounts, dirty and untidy, and that they would not be able to deliver a good standard of care in such circumstances.

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25. However, using this line of reasoning to prevent Mr A from being able to die at home, as was his wish, may be considered to be contrary to this principle.

**Best interests**

26. The fourth principle is that any decision made for or on behalf of a patient who lacks mental capacity must be done in their best interests. In consideration of best interests consideration should also be given to whether decision can be delayed; any expressed wishes; and views of carers and others.

27. An example from our case work where this principle was not applied was in our recently published report regarding a decision not to prescribe suitable medication on the basis of cost alone to a patient, Mr H, who had learning difficulties and epilepsy. In April 2011, Mr H’s mother, Ms B asked her GP practice for a repeat prescription of midazolam in liquid form to help her son’s epilepsy. The GP refused her request because it was too expensive and said that he would only prescribe her son suppositories or tablets in future. Ms B advised the GP her son had only been prescribed liquid medicine from a very young age, as his learning disabilities caused him to become very distressed if he had to swallow tablets.

28. Furthermore, when Ms B questioned the GP’s decision, he told her to “find a GP with bigger budgets who would be happy to prescribe the medications”.

29. The investigation found service failure by the practice – and specifically that they failed to consider their obligations under disability discrimination law, and didn’t follow accepted medical guidelines. GMC guidance sets out that when prescribing medicines doctors must ensure that the prescribing is appropriate and responsible and in the patient’s best interests. It also states that doctors should, when appropriate, ‘establish the patient’s priorities, preferences and concerns’ and ‘discuss other treatment options with the patient’.

30. Proper consideration of the patient’s best interests would have meant carrying on this patient’s usual prescription. This case is particularly worrying because the preference and concerns of Mr H’s mother about his medication were ignored, which should be considered in any decision made in the best interests of Mr H.

31. The lack of consideration of the views of carers and others is a common concern that is raised in complaints regarding the Act.

**Least restrictive option**


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32. Before a decision is made on behalf of someone, the patient making the decision should consider whether the decision can be made in a way that interferes less with the patient’s rights and freedoms, or whether a decision is needed at all.

33. Any intervention should be weighed up in the particular circumstances of the case. Furthermore, anything done for someone without capacity must be the least restrictive of their basic rights.

34. Returning to the case regarding Mr A, who wished to die at home, but because their ability to decide on this matter was not respected or supported by staff and led instead to Mr A dying in a care home, it could be considered that Mr A was therefore deprived of their liberty as this was not the least restrictive option.

Conclusion

35. Consistent implementation of the Act is vital to ensure that people who may lack capacity are empowered to be able to make as many decisions as they can for themselves, and protect those who cannot make decisions.

36. To ensure implementation we would support the following recommendations made in The Confidential Inquiry into Premature Deaths of People With Learning Disabilities (CIPOLD), which was published earlier this year281:

- Advice on the Act should be easily available 24 hours a day via a dedicated phone line staffed by expert advisors in all matters relating to the Act
- Training on the Act should be mandatory for staff involved in the delivery of health and/or social care
- All decisions that a patient with learning disabilities is to receive palliative care only should be supported by the framework of the Act and the patient referred to a specialist palliative care team

9 September 2013

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PD – Written evidence

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The MCA appears to have been abused in many situations. The Neary case being a prime example of the way in which authorities have been able to manipulate the act for their own intentions, ignoring the needs and wishes of the individual. Similarly, in the case of Peggy Ross, unsuitable interventions by authority cause stress and aim to restrict the lives of individuals who should be supported rather than targeted.

Additionally, it is clear from contact with other families, that the MCA is being abused by authorities as a means of targeting individuals and families who have complained about or challenged the authority / care provider.

In this sense the MCA has not achieved its aims as it is being used to harass and intimidate people instead of supporting them.

2. Which areas of the Act, if any, require amendment; and how?

Individuals and families need the MCA to provide protection from authorities / care providers who abuse the powers they have gained under the MCA. This protection needs to be of a rapid nature, preventing deprivation of liberty or enforced decisions from occurring without approval of a higher authority such as a court which has heard evidence from all parties. Authorities should not be permitted to use the MCA to deprive people of the liberty at all without application to a court.

It should be noted that individuals and families are currently at risk from Best Interest Assessors who are not independent of the circle of authority which may be a using the MCA. For instance, a Local Authority BIA is unlikely to conclude that a health trust or clinical commissioning group, with which he/she has regular contact, has acted inappropriately or unjustifiably. Such lack of independence creates unacceptable risks for individuals and families.

Additionally, where the BIA is employed by the local authority, the individual and family are at risk from BIA decisions being based on previous contact with the LA, which may have been problematic and / or resulted in a complaint against or dispute with the LA.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

The whole act is inappropriate. It interferes with the right of individuals to make their own choices, removes independence, is open to appalling abuse which has adverse effects on the lives of people subjected to the processes of the act.

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The use of the act in relation to capacity and best interests is highly suspect. People who are inexperienced are allowed to conduct assessments, at times in the most unprofessional manner, assumption of incapacity (contrary to the act) adversely influences assessments and those making best interest decisions are frequently making those decisions based on policy rather than individual need.

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

The lack of enablement and empowerment for the individual is a clear indication that the principles of the MCA are failing. People who were previously able to make their own choices, without interference, have had that right removed.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

No. The act is clearly misunderstood by those implementing it, although this may often be a deliberate misinterpretation in order to progress their own agenda rather than the needs of the individual.

It has been stated to me that nurses do not understand the act, yet they are likely to be the first people to raise issues that result in the act being used. It is also clear that few doctors have any understanding of the act beyond seeing it as a tool to enforce top down imposition of decisions that are not those of the individual they are treating, even when the patient clearly does not lack capacity. It is unacceptable that professionals can have such an extreme effect on people's lives without understanding the act.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

No. The act has not even been heard of by many people who can potentially be affected by it, this includes the carers. There is little protection or reassurance for informal carers who are illegally excluded from proceedings, whose knowledge of the disabled person is ignored, who are treated like criminals when they dare to disagree with professionals and are subjected to unacceptable stress and distress as a result of the way the act is used to bully them.

Additionally there are many people who have not taken the act on board because as they do not lack capacity they believe that the act can not be applied to them. In reality, there are many instances of the act being misused to falsely label people as lacking capacity. Also, in the context of the general public, many people simply do not realise that if they were to become seriously ill or have an accident that interferes with their communication then they would be at risk from the misuse of this act.

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8. Has the Act ushered in the expected, or any, change in the culture of care

The change in the culture of care has been the introduction of a culture of fear in disabled people and their families. It is clear that the abuse and misuse of the MCA can have such drastically adverse impacts on lives, that access to services can become restricted as a result of this culture of fear, that choice is being removed from individuals and that the act being abused in order to exclude carers and families which adversely effects the care the individual receives.

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

Those directly affected by the act are having choice removed by authorities who seek to impose their own opinions instead of empowering the individual. Family members and carers are excluded from decision making processes and prevented from representing the wishes of those they care for.

The quality of decision making is adversely effected by the fact that decisions are being made by people who have little knowledge of the individual. Decisions are more likely to be based on budgetary constraints and tick box services than individual need.

12. Has the MCA fostered appropriate involvement of carers and families in decision making?

No. Carers and families are routinely excluded from decision making. More worryingly the individuals concerned are routinely excluded from decision making. This applies both to those who lack capacity and those who are falsely labelled as lacking capacity.

For example: my daughter does not lack capacity, however, whilst she was in an intensive care unit she needed a surgical procedure. I arrived at the unit to be seen by two consultants who asked me to sign a form stating that she lacked capacity. I refused to sign the form because she does not lack capacity. I was then told that she was ventilated and sedated so agreed to sign the form with the addition of a statement that the lack of capacity was related to this situation only. I then went into the unit to find her wide awake! On checking with the nurse I discovered that my daughter had not been sedated when the surgeon had been in to see her and that he had made no attempt to discuss the procedure with her or gain her consent.

This man had simply observed her existing physical disability and assumed, lack of capacity which is contrary to the act.

The completion of forms for deprivation of liberty have been incorrectly completed by authorities, with the forms stating that the individual lacks capacity when that is not the case and has nobody else to consult with when it is clear that carers and families could and should have been consulted.
13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

The independence of the IMCA has to be questioned. Contracts for this service are lucrative and the service is at risk of being forced to agree with the authority paying for the service regardless of the needs and wishes of the individual concerned. It has been clear that the IMCA will not always support the individual when the agenda of the commissioning authority differs from the individual's choice.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

See question 13.

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

No. The widespread misuse of the MCA reveals that the safeguards are far from adequate.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

No. The act is misunderstood and abused by those implementing it. No individual, carer or family should have to be forced into the process of challenging events under the act. If authorities were not allowed to act without court approval then individuals carers and families would be part of that process and enabled to have their views heard independently. As things stand, families, carers and individuals are being placed under intolerable pressure without the processes of the act being fully explained or opportunity to object to the processes being offered.

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

No. They are not understood and accessible to all. Authorities use the Court of Protection as a threat to make individuals, carers and families obey the orders of the authority involved instead of doing what is right for the individual. It is, all too often, a case of 'do as we say or we'll take you to court', despite the fact that the actions of the individual, carers and families are clearly in the best interest of the individual. We have been threatened in this way on more than one occasion, whilst my daughter does not lack capacity the MCA is still used to threaten and bully us.

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

As it is little known that the CQC has any inspection role on MCA standards there is clearly a case for additional powers. These powers should be widely

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advertised and the CQC should take urgent referrals from individuals, carers and families who are effected by the actions of others in relation to the MCA.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area

A completely independent regulatory body needs to be formed if the use of this act continues. This body needs to include a significant number of disabled people and carers as these groups are the only people with sufficient experience to understand the issues surrounding the use and abuse of the MCA.

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA

Clearly the MCA is being abused to override and ignore the rights of disabled people. Many forms of disability, where capacity is not affected, are used as a reason to assume lack of capacity which is contrary to the intentions of the act. In this sense it is impossible for the act to be compliant with the CRPD.

2 September 2013

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In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Pembrokeshire People First – Written evidence

The following document details the responses of Pembrokeshire People First members, advocacy partners and advocates to consultation about the Mental Capacity Act, 2005.

The methodology involved introducing the Act (see the Appendix for the background document used for the introductory script. This was used in all cases so that there was consistency in approach) and then asking set questions. This was done with a consultation group of five people and with seven randomly selected advocacy-partners where there were individual sessions. The age range of those consulted is about 25 to 55. There were 7 females and 5 males. All of those consulted have learning disabilities and all have some experience of their capacity being questioned and assessed; many have a dual diagnosis of mental health difficulties and have previously been subject to section under the mental health act.

The consultation took place in late August/early September, 2013.

The following document lists the questions asked and underneath them are the direct responses of the people consulted. It comes in two sections: the individual responses followed by the consultation group responses. The advocates’ response follows on.

For those people who responded individually letters (a, b, c…) identify the people so that responses to the questions can be tracked and compared. Otherwise, obviously, all responses are anonymous. Blanks indicate that the individuals had no response to that particular question.

There has been no attempt to generalise the responses or draw conclusions – the responses speak for themselves.

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**Mental Capacity Act – Individual Responses**

1. **What do you think about people like social workers making assessments about what you can and cannot do?**
   
a) Sometimes it annoys me a bit – I usually make my own decisions. I think people make snap decisions without seeing me day to day, what I’m like when I get out of bed in the morning or when I go to bed at the end of the day.
   
b) Social people are a waste of space. It was not until I had Sheila and PPF (advocates) that they did start listening to me. They listened to me after.
   
c) I think they (social workers) suffer from the condition themselves and they are judging other people. I think social workers predominantly think about themselves. We are just products to them, not people. You could probably go so far as to say that we are just cattle being herded.
   
d) I can’t get out of bed on my own and I can’t do the bath myself. I need people to make assessments.
   
e) It depends on who it is. I don’t generally get along with most people. Only some people understand me and I lack trust. I’d know as soon as I saw the person I’d be able to make my mind up about them. If it was someone I knew and liked I’d be happy with the assessment. For someone to do the assessment, they’d have to know me well otherwise it would go totally to pot.
   
g) It’s wrong. I’ve got capacity to do things. Nobody should have the right to make decisions for me. From now on, I call the tune; it’s time people listened to me.

2. **Has that happened to you?**

a) People have made decisions like when I had my breakdown and they said I had to go to hospital. But the medicine kind of thing wasn’t done without kind of letting me know.

b) In the past – it made me pissed off.

c) Of course I’ve been assessed many times. I thought it was a load of b.s.. I thought they were judging me. They were treating me like how they felt they wanted to treat me.

d) It might have happened to me.

e) They got told: do not tell me what I can and cannot do. I try to do what my dad taught me. People wind me up telling me what to do. I just want peace.

3. **Have other people told you that you are not capable of deciding something?**

a) Not that I know of.

b) I can’t remember about that. I don’t think anyone ever told me what I can and can’t do.

c) They may have.

d) Yes, in (supported) houses. It’s mostly staff. They don’t think I’m as capable… they think I’m really disabled and can’t do much for myself when I really can do most things myself.

e) I’m being treated like a disabled person not an able-bodied person.
4. Have you experience of someone making decisions for you?

a) Yes, they've tried to but I've usually given them a mouthful.

b) Not really. I've always done everything myself.

c) (For example) I'm not allowed to go for a walk by myself. It's only because she (the manager of a supported group home) doesn't want anything to happen to me. But I think I'm perfectly capable of going for a walk on my own.

d) Yes, when I was wrongfully sectioned. I think it's horrific how people treat people with disabilities. We're always given the worst of it.

e) Mum has over the years. Someone has to do that but I want to make my own decisions.

f) They have done. I don't like it.

g) At my family member's funeral, other people made decisions for me.

5. Are you always supported to make your own decisions?

a) Not always, no. Even when I've had a problem I've had to sort it out myself. Apart from PPF (advocates) I've never had any help off anyone else.

b) Most of the time I don't have anybody. I just do it by myself… My husband always helped me when he was alive. Now I just have to cope on my own unless I have Sheila (advocate) or someone like that that.

c) I've been supported by advocates. I'm being supported by my mum. Other than that, no.

d) I don't know about that. I would like more support. When I move I'll have to stick up for myself… I'm happy to stick up for myself.

e) Most of the time but sometimes they choose for me. It depends who it is. If they choose for me it makes me really cross and angry. I don't like them making up my mind for me.

Mental Capacity Act – Group Responses

1. What do you think about people like social workers making assessments about what you can and cannot do?

It's okay. She (the psychologist) means well; she's doing that for me so I can have more freedom. But I would be annoyed if someone told me what to do.

Say I'd got a timetable what to do they (social workers) tell me what to do, not what I want to do. You ought to make your own decisions.

So long as you're with your social worker and you are involved, it's alright. If someone's doing an assessment without you (there), that's annoying.

That's where Person Centred Planning comes in so you can have your own voice to speak up for yourself. It's all about preparing beforehand and always involving the person.

2. Has that happened to you?

[Four out of five said they had experience of this. There was only one additional comment.]
My social worker, doctor and nurses (did that) but your assessment should be about you doing it.

3. **Have other people told you that you are not capable of deciding something?**

4. **Have you experience of someone making decisions for you?**

[Note: questions 3 and 4 were taken together.]

Yes. I say I make my own decisions myself but I’m not listened to.

Yes. I said to them I can look after myself but other people made decisions. I had no choice. I argued and argued but they said I had no choice. I thought I’d like to get out of there because I wasn’t listened to.

The only person who can make decisions for you is you, yourself.

5. **Are you always supported to make your own decisions?**

[Four out of the five said ‘no’. Additional comments follow.]

There’s always someone from social services you’re not happy with.

If you’re capable of making decisions on your own, you do. On my own experience, I’m not going down the social services route because they’re awful.

Sometimes it’s good, sometimes it’s not. It all depends on what it (the decision) is about.

Sometimes support workers make decisions for me but I’d like to make my own decisions. Because I’m in supported living it’s difficult for me to make my own decisions.
Mental Capacity Act – Advocate Responses

It should be noted that all the people consulted here are certainly capable – albeit sometimes with support – of speaking for themselves. Future research should involve those people less able to speak for themselves and who, it is likely, are much more routinely subject to capacity assessments (and, arguably, communication skills determine at least a perception of capacity – or lack of it – in wider spheres). An example of this is of someone who uses facilitated typing rather than speech. Because ‘professionals’ doubted the validity of the chosen method of communication, they doubted the validity of this person’s choices (and capacity) even though these choices were routinely and clearly expressed.

The general observation is that capacity assessments tend to be not very robust. It’s almost as if there is a presumption that “if you agree with me then you have capacity; if you don’t agree with me then I doubt your capacity”.

There is also some anecdotal evidence that capacity assessments are sometimes, perversely, done as a defensive measure designed to protect the ‘professional’ and their organisation rather than the supposedly vulnerable person. Sometimes capacity assessments are used, ex post facto: to justify a decision already made. Sometimes capacity and the Mental Capacity Act are only invoked when advocates challenge a decision made about an advocacy-partner. An example of that is of an advocacy-partner who was the sole beneficiary of his family estate. His capacity to handle his finances was doubted and social services regularly discussed his ‘best interests’. It was only after his advocate pressed the issue that a formal capacity assessment was done – by a doctor chosen by a solicitor referred to by the local authority. The assessment result was that there was a lack of capacity. This caused great distress to the advocacy-partner who decided to challenge the assessment. Eventually the original assessment was overturned and it was agreed that, indeed, the advocacy-partner was able, with some support, to manage his own finances. It should be said that the original assessor did not have adequate knowledge about the person and the advocacy-partner was so extremely anxious about meeting a doctor and about the whole process that he was unable to fully express himself. It took advocacy support for rights to be explained, for people and processes to be challenged and for the eventual agreement that this person did – as he claimed all along – have the capacity to make his own decisions. The MCA system worked in this case but only because there was an independent advocate to explain rights and support the challenge: the availability of independent advocacy may be key to the successful implementation of the Act and holding ‘professionals’ to the spirit of the Act.

It is evident from the individual and group responses here that people are often referring to their ordinary experience rather than to the Mental Capacity Act as such. This reflects a general lack of knowledge of the Act (only one respondent said they had heard of it – although we know that many respondents have had capacity questioned, if not formally assessed.) From that it is clear that, in their daily lives, people with learning disabilities often have people making decisions for them. An example of that is of a young female advocacy-partner who suddenly had to have staff present when she was meeting her boyfriend. She did not know why this was; staff told her it had to happen. It turned out that staff had presumed that she lacked the capacity to decide whether to or how to progress the relationship. No assessment had been carried out. No support had been given to help the decision making.

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Support workers, ‘professionals’, family and others in a position of control therefore often do not presume capacity and do not allow people to make unwise decisions. On the other hand they presume they can make ‘best interest’ decisions. Support workers are routinely defensive, perhaps not unnaturally when they are seen as being ‘carers’ and feel that they have a duty to protect.

Arguably, the jargon has trickled down but the ethos and spirit of the Mental Capacity Act is still often absent from the daily experience of many people with learning disabilities.

Overall, the advocate experience and the general consultation response here reflects that of Williams et al\textsuperscript{282} that the principles of the MCA contrast with actual practice and that the attitude of those in positions of power and control are often a barrier to independent decision-taking and choice-making by people with learning disabilities.

A final point is that those people who seek to challenge decisions can often be labelled as having challenging behaviour. Although this is not a proper psychiatric diagnosis it can often lead to the presumption of mental ill health which then, in turn, feeds the assumption that capacity is lacking.

Appendix: Introduction to the Consultation

Mental Capacity Act Consultation

In 2005 the Government passed a law “The Mental Capacity Act”. The law is now being reviewed by one of Parliament’s Select Committees. The Committee wants evidence about how the act works. The British Institute of Human Rights wants your views. It may be that basic human rights are not always respected – because we all have a right to take part in decisions that affect us.

This law is designed to protect vulnerable people when there is doubt about their ability to make decisions.

‘Mental capacity’ is the ability to make a decision. It includes the ability to make a decision that affects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions. It also refers to a person’s ability to make a decision that may have legal consequences – for them or others. Examples include agreeing to have medical treatment, buying goods, handling money, deciding where to live or making a will. It may even include the ability to decide who can visit you.

If it is decided that someone lacks capacity then a decision will be made for them on the basis of their ‘best interests’. The best interest decision will be made by professionals such as social workers.


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The Mental Capacity Act is based on five core principles:

**Presumption of capacity**

**Maximising decision making capacity**

**Right to make unwise decisions**

**Best interests**

**Least restrictive option**

The British Institute of Human Rights is very keen to hear from people who may have been affected by the Mental Capacity Act. They want some examples of how this has been used.

The Select Committee has 27 broad questions. These cover parts of questions 3 & 4

- What do you think about people like social workers making assessments about what you can and cannot do?
- Has that happened to you?
- Have other people told you that you are not capable of deciding something?
- Have you experience of someone making decisions for you?
- Are you always supported to make your own decisions?

5 September 2013
PJ Care – Written evidence

Key areas covered in this submission by PJ Care to the House of Lords Mental Capacity Act committee are to convey:

- How one of the UK’s leading providers of neurological care and treatment centres has worked with residents affected by the Mental Capacity Act.
- How the Mental Capacity Act impacts upon staff and people requiring care and treatment for neurological conditions, including those with Young-onset Dementia, Brain Injury and progressive neurological conditions such as Motor Neurone Disease.
- Why PJ Care believes equal clinical rigour should apply to making Mental Capacity assessments under the Mental Capacity Act to that for compulsory detention and treatment under the Mental Health Act. PJ Care feels this would be in the ‘Best Interests’ of people affected by the Mental Capacity Act.
- Why there needs to be more objectivity and uniformity in Mental Capacity and Best Interest assessments under the Mental Capacity Act.
- That the Department of Health needs to take more ownership and responsibility for the Mental Capacity Act, as in the Mental Health Act.
- How PJ Care staff have found that applying Deprivation of Liberty (DoLs) as part of the Mental Capacity Act has not always been consistently applied or supervised nationally
- How PJ Care staff have found that working with residents’ families and friends when agreeing residents’ “Best Interests” has run smoothly and effectively

Part One

1. PJ Care and the Mental Capacity Act

1.1 PJ Care is an independent provider of specialised neurological care and treatment centres for people with traumatic and acquired brain injuries, spinal injuries and all progressive neurological conditions.

1.2 PJ Care was founded in 2000 by Jan Flawn, a registered nurse and former senior manager within the Department of Health.

1.3 PJ Care’s service portfolio includes Eagle Wood Neurological Care Centre in Peterborough. Launched in 2012, Eagle Wood is the UK’s first specialised neurological care centre providing onsite care and treatment for the full range of recognised neurological incidents and conditions. PJ Care runs two other neurological care and treatment centres in Milton Keynes.

1.4 PJ Care offers 180 beds in its three neurological care and treatment Centres. Employing 385 clinical and healthcare professionals, including consultants in Psychiatry, Psychology, Neuro-Rehabilitation and Brain Injury. Registered Nurses,
Physiotherapists and Occupational Therapists, Speech and Language therapists and Care and Support workers.

1.5 Around 50% of PJ Care’s residents are affected by the Mental Capacity Act, and require either or both a Mental Capacity or Best Interest assessment under the Mental Capacity Act.

**Part Two**

**Key areas for PJ Care**

**A: Increased clinical rigour should be applied when conducting Mental Capacity assessments**

1.6 The Mental Capacity Act Code of Conduct states as follows:

“If a doctor or healthcare professional proposes treatment or an examination, they must assess the person’s capacity to consent.

Ultimately, it is up to the professional responsible for the person’s treatment to make sure that capacity has been assessed

“More complex decisions are likely to need more formal assessments. A professional opinion on the person’s capacity might be necessary. This could be done, for example, from a psychiatrist, psychologist, a speech and language therapist, occupational therapist or social worker.

“But the final decision about a person’s capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity, not the professional who is there to advise.

1.7 There are immense human-right implications when someone is assessed not to have Mental Capacity under the Act. At present, functional and diagnostic capacity tests can be made by any “doctor or healthcare professional” (see above) This can include a non-specialist general nurse or even a dentist.

1.8 This opens up two undesired consequences. Firstly, that a doctor with no suitable experience or training in assessing a person’s Mental Capacity can conduct assessments under the Act. Secondly an unsuitably qualified healthcare professional – perhaps a general ward nurse, or an inexperienced psychiatric nurse – can conduct such assessments. In nursing homes, for example, a general nurse, with little or no mental health experience or training, has the power and authority to conduct such Capacity Assessments.

1.9 PJ Care’s view is that only a suitably qualified Consultant Psychiatrist (as is required, for example, under the Mental Health Act) should make any such Mental Capacity assessments on residents, especially considering the significant human-right implications riding on such assessments. We believe such added rigour would be an additional – and required - safety net for all vulnerable people, including those with various forms of neurological conditions.

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2.0 Such a tightening up on the criteria for who can implement the Mental Capacity Act and undertake assessments would bring the Mental Capacity Act more into line with the Mental Health Act.

2.1 Under the Mental Health Act, medical recommendations for detention or compulsory treatment must be made by at least a (i) Section 12-approved doctor or Consultant Psychiatrist, plus an (ii) approved social worker. There is no such requirement under the Mental Capacity Act. PJ Care would urge the committee to examine this issue.

2.2 PJ Care believes so strongly in the above that, as a provider, we only allow Consultant Psychiatrists to make such formal mental capacity assessments. This would also mean that experienced Consultant Psychiatrists take more ownership of the implementation of the Mental Health Act.

2.3 For reasons outlined above, PJ Care questions whether the implementation of the Mental Capacity Act has actually protected the vulnerable people it was aimed at protecting.

2.4 PJ Care urges a review of the Mental Capacity Act to see if its clinical rigour can be improved to either reflect the rigour of the Mental Health Act, or for it to be integrated into the Mental Health Act.

2.5 Anecdote – inappropriate Mental Capacity assessment?

One of PJ Care’s residents was repeatedly self-harming. When admitted to a hospital accident and emergency unit as a result of an extremely serious self-harm episode, a psychiatric nurse conducted a capacity assessment on this resident, and judged that the person had capacity and therefore could be returned to our care. This resident was judged to be of sound mind and with full Mental Capacity to attempt to take his own life.

PJ Care’s own Consultant Psychiatrist disagreed, and felt a suitably-qualified Consultant Psychiatrist should see the resident and make a full Mental Capacity assessment. No such assessment was made by the PCT’s psychiatrist, and it was emphasised to us that a psychiatric nurse had suitably conducted the Mental Capacity assessment. PJ Care made a formal complaint. Following this complaint the resident was detained under Section 3 of the Mental Health Act and admitted to an acute psychiatric unit where he received appropriate treatment.

B. Increase objectivity and uniformity in Mental Capacity and Best Interest assessments

2.6 There is no consistency in the implementation or the paperwork being used in relation to the Mental Capacity Act. Social workers, acting on behalf of local authorities, present their judgments to PJ Care on the implementation of the Mental Capacity Act using different criteria. This leaves healthcare providers such as PJ Care trying to adopt Act processes and implementations which are unnecessarily inconsistent.

2.7 All PJ Care residents assessed not to have Mental Capacity in relation to any nursing interventions will have this stated in their care plan. Then how this person’s Best Interests are being met will also be detailed in the care plan.

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2.8 Our experience is that while some commissioners give only a cursory examination of how residents’ best interests are being met, others will have particular focus on such aspects of care, and require reams of paperwork to demonstrate how a best interest decision was reached. PJ Care would like to see clear guidelines and criteria with standardised implementation and paperwork for every part of the Mental Capacity Act. This would build in more objectivity into Mental Capacity and Best Interest assessments, and ensure the implementation of the Mental Capacity Act works as efficiently and coherently as the Mental Health Act and. PJ Care believes this would be in the best clinical interests of people affected by The Mental Capacity Act.

2.9 P J Care have found that applying Deprivation of Liberty (DoLs) as part of the Mental Capacity Act has also not always been consistently applied or supervised nationally.

C: Other points

3.0 PJ Care staff have found that working in partnership with a resident’s family and friends in agreeing the Best Interests of people lacking capacity has run smoothly and effectively.

3.1 We note that many people with either progressive (e.g. Motor Neurone Disease) or acute (e.g. brain injury) neurological conditions will have a firm body of family and friend advocates. This is less the case for people with learning disabilities, where IMCAs may be more likely to be called upon. The Court of Protection has rarely been required for PJ Care residents.

3.2 From our experience, we note that training on how to implement and work with the Mental Capacity Act is dependent upon the seniority and expertise of staff. Training has to be tailored to that staff sector, whether it be senior service management or support workers.

2 September 2013
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POhWER – Written evidence

**Overview and Context:**

1. The MCA has provided a much needed legal framework for the protection of people who lack capacity to make certain decisions themselves. However, understanding of the Act and application of its intentions is still varied across different disciplines. More work needs to be undertaken to emphasise principles 1 – 3 of the Act. However, one clear benefit of the Act is that where a case has gone wrong it provides a framework for reflection and learning.

2. Further clarity on the balance between best interests and resources would be useful. At a time of cuts to services and funding, resource issues should be considered. Departments are implementing processes to manage cuts to resources and sometimes this appears to be without regard to how this will impact upon the ability of all parties to work within the MCA framework.

3. The Act seems to work well on the whole for those who do not have capacity to make decisions at the time they need to be made. However, the principles of attempting to enable a person to make their own decision prior to deeming them as lacking capacity are not always followed.

**Implementation:**

4. The second principle is not always given enough attention in terms of implementation. Too often people are deemed unable to make a decision themselves based on one or two conversations, rather than exploring the practicable steps that could be taken to increase a person’s capacity. Where a person is unable to make the decision at the time it needs to be made, this can often be seen as final. Too often insufficient consideration is given to implementing care plans that could help the person gain an understanding and capacity in the future. The same care and attention that is given to care planning for personal care etc should be given to planning support to empower a person to make their own decisions. In effect, it seems professionals sometimes start at principle 4 rather than ensuring steps 1 – 3 are fully considered. The spirit of the Act is rooted in empowerment and it is difficult to assess how the Act is being implemented in most cases as raw data is patchy. We can report on how many IMCA referrals there have been; we can audit a hospital within a given time to assess whether everyone who met the criteria for an IMCA was referred. However there is no duty to do this. In other areas relating to the Act there is an even greater difficulty in monitoring outcomes, for example, ensuring people have been supported to make their own decision prior to being assessed as lacking capacity. There also seems to be some misunderstanding of the ‘least restrictive option’, for example, thinking the least restrictive option must be chosen without regard to other determining factors. There is also uncertainty over whether the least restrictive option must be chosen if this is more expensive than what otherwise would be considered. Clarification around this will be useful.

5. The MCA seems to have been generally well implemented, but there is evidence that application across the different disciplines is somewhat uneven. Some areas seem able

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to understand and implement the Act well, whereas others seem to have only a general overview. Whilst we can measure take up of provisions such as LPA it is difficult to assess whether the public understand the principles of the Act and how to apply them. Our experience in representing people who have family / friends suggests that most people do not know of the Act, or do not understand it well. Training on the MCA was widely available when the Act was first introduced but that availability is patchy now. The quality of training can also vary hugely. Accredited, approved and in-depth training may now be useful. In providing that training thought needs to be given to moving away from basic training around what the MCA and its principles are and instead provision should focus more on the implementation of the Act and how to overcome common issues and problems.

6. Not all professionals are aware of the Act, especially within the Health sector, although once made aware they usually embrace it. There still appears to be some confusion regarding consent within the Health profession, for example, thinking an adult can consent on behalf of another adult when there is no Attorney or Deputy in situ. Understanding in Social Care varies from professional to professional. Whilst training is provided often this does not always seem to be monitored to see whether it has been understood and is being implemented appropriately. Some professionals still seem to think that family members are the decision makers, or IMCAs are the decision maker where there is no family, or there is a disagreement within the family. Where a family are in dispute with the professionals, or are difficult to engage with, they are often deemed inappropriate to consult which seems to go against the spirit of the Act. Families may be labelled as inappropriate to consult for one issue and this label sticks causing them to be ruled out of future decisions where they would in fact be appropriate to consult. There are still cases within Health where a person’s capacity is only questioned when they are resistive to treatment. There still seems to be a culture of ‘presumed consent’ in certain cases.

7. When applied correctly the Act does seem to have the correct balance. However, there is the risk that informal carers are ruled out of processes as ‘being inappropriate to consult’ merely because they disagree with decision makers.

8. The Act is resulting in a culture change, but there is still further work to be completed to ensure it is implemented across all disciplines and is sustainable.

**Decision Making:**

9. On the whole the Act does seem to have given more autonomy to people with capacity issues, but there is still some way to go. Capacity assessments can often be decided on one or two conversations. Often not enough weight is given to principle 2. Where a decision is required urgently there often is no thought to on going work which can be completed with the person to increase their capacity in the future. Professionals often seem to start at principle 4 without enough regard to principles 1 – 3. Further education is required regarding LPAs in terms of professionals sometimes assuming an LPA can make all decisions without checking what is or is not included in that LPA. Similarly we have come across cases where a professional thinks they can over-rule an LPA because they do not agree with them without regard to due process.

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10. In-depth formal guidance would be welcomed for ‘advanced decisions’ to increase likelihood of written statements being valid. There is a risk that people think they have protected their wishes, but later their statements are considered not specific enough and therefore invalid. More work can be done around advanced statements to empower people to keep control of their own decisions at times of crisis.

11. The MCA does promote inclusion of family members and friends when implemented correctly. Prior to the Act there was often a focus on only consulting Next of Kin and extreme caution of who can be consulted in terms of confidentiality. s4(7) of the Act has ensured wider consultation which is, in the majority, of benefit to the person and the process.

12. The IMCA service can be invaluable in certain cases and we know from feedback we have received from clients, family members and professionals that in some cases the best outcome for the client would not have been reached had we not been involved. However, the IMCA service is reliant on professionals referring all qualifying persons to our service. Auditing and monitoring of departments to ensure they are referring to IMCA when they should would be welcomed. The use of IMCAs in safeguarding proceedings is variable, indicating that the duty to ‘consider’ referring to IMCA may not always be followed. Where IMCAs are instructed for safeguarding cases a key benefit is the IMCA ensuring the client remains at the centre of the decision making process, capacity is considered for every issue, due process is followed, risk aversion avoided, and above all, the client’s voice is heard throughout the process. Some comparative research on referral rates per 100k of population or 100 hospital beds might be instructive as to the application of the Act across England and the various disciplines.

13. It is difficult to state with certainty whether referrals are low in certain areas or for certain issues without audit of departments to check whether they are referring to IMCA when the criteria are met. Some professionals still think referring to IMCA is a choice. Within Health some professionals seem to think there is no need to involve an IMCA if there is a certain option with is (assumed to be) in the person’s best interests. This is particularly true of medical treatment decisions. From our experience the vast majority of care review instructions are where the person is already known to the IMCA service, for example, because IMCA represented them in the initial change of accommodation decision, or because the IMCA has suggested the care review. Awareness needs to be raised among professionals so referral to IMCA for care review is considered in all cases and referred where appropriate. For example, a person may have lived in a care home for a number of years, but their health and social needs are changing and significant decisions need to be made on that person’s behalf. s.39C referrals seem very low, but this may be due to the Managing Authority / unpaid representative not informing the supervisory body of when the representative is no longer able to carry out the role.

14. Resource of IMCA services will always be difficult as there is no control over when referrals will be received. Therefore IMCA services need internal processes to manage when referral rates are very high as this can impact on the time available for each client. In a lot of areas IMCA services are consistently busy and working above commissioned targets. There is a general feel that a lot of people are still not referred to IMCA when they should be. This implies that should everyone who

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
qualifies for an IMCA be referred to the services there would not be enough resources available. Timing of referrals can be problematic: where referrals are received too late this has a negative impact upon the work an IMCA is able to complete prior to their representations being submitted. A national quality performance mark or qualification for IMCAs would be welcome. At present qualifications and performance marks are determined by contractual agreements with commissioners. This is a vital professional role within the MCA and should be treated as such in terms of accountability, performance checks, continual professional development and so on.

**Deprivation of Liberty Safeguards (DoLS):**

15. Application of DoLS is varied across authorities as evidenced in statistics. However, the hard data does not really inform in terms of whether the legislation is being applied appropriately. Where someone has restrictions in place but these are deemed to fall short of a DoL there seems to be a lack of services and support for them, especially where these people fund their own care. Case law can sometimes cause practices to change such as the Cheshire case resulting in less authorisations being granted in certain areas. However, the paucity of case law to date means that it is difficult to build a ‘big picture’ and for each piece of case law to sit in context. There is a risk that emerging case law can have a detrimental effect if taken in isolation, especially where that case law is being, or may be challenged. Language used in case law can appear discriminatory, for example where the judgement refers to certain circumstances being ‘normal’ for someone with that condition. The MCA makes it very clear that decisions cannot be made purely around someone’s disability, yet the labels imposed in case law can sometimes carry the risk that assumptions are made that this is normal and the situation cannot be improved with careful care planning and implementation. Sometimes DoLS can be misused in terms of authorising poor care when misunderstood and inappropriately applied. However, one must not lose sight of where DoLS has had a very positive impact which could not have been achieved without the DoLS process, such as that of Steven Neary. In general we feel the legislation is very welcomed and needed, although any simplification of its processes without jeopardising the safeguards will be welcomed.

16. We have found that some people may have an authorisation as they are actively resisting and trying to leave a particular location. However, after some time they stop resisting and therefore the authorisation is rescinded. There seems to be too much emphasis on whether a person is resisting or not rather than whether the circumstances amount to a deprivation of that person’s liberty. If someone has been resistive for a long time to no effect they may stop resisting but this does not necessarily mean they feel any differently or are any less restricted. The timescales for assessment when an urgent authorisation is in situ cause many difficulties and in some ways appear contrary to the values of the MCA. Assessments can be rushed and there is little or no time to implement principle 2 and empower the person to gain an understanding and potentially capacity. Similarly where an IMCA is required this often is not realised on day one; the supervisory body then needs to process a referral to the IMCA service that in turn have to process the referral internally. This can leave the IMCA with one or two days to complete all casework causing frustrations of not adequately supporting and representing the person due to time constraints.

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17. The terminology of processes can be confusing for people under an authorisation and their family. For example, an authorisation being lifted as 'the best interest element is not met' can be interpreted to mean what is happening is not in the person's best interests when it actually means the restrictions no longer amount to a DoL. The large volumes of paperwork can also be difficult to understand and navigate for the general public and managing authorities. Many people who have moved from residential care to supported living are experiencing the same restrictions as previously yet they can only access DoLS via the court of protection. It does appear that there are people in supported living who are not being referred to the court. Finally, access to appeal being limited to the Court of Protection only does make the appeal process time consuming, resource expensive and off-putting for some. Many s.21A appeals venture into welfare decisions which can have cost implications for the person / applicant. We have supported unpaid representatives when acting as s.39D IMCAs where the representative has withdrawn their intention of appealing through the court due to worries over costs. Clearer guidance on what people deprived of their liberty and their family / representatives can expect from taking a case to court would be welcome. A review of whether there is a simpler appeals process such as the Mental Health Act Tribunals process would also be welcome. A DoLS appeal only goes to court if the responsible body, relevant person, their representative or an IMCA pursues this. Otherwise the authorisation is only scrutinised at review by the same body that authorised it in the first place. A relevant person may be unable to express a desire to appeal or understand this right and therefore is reliant on others for initiating scrutiny.

The Court of Protection and the Office of the Public Guardian:

18. There still seems to be confusion amongst different departments about when a case should or should not be referred to the Court. A lack of in depth understanding from the decision maker can also result in them receiving incorrect legal advice as they have not explained the situation correctly to the solicitor. There is a fine balance between exploring alternative courses of action or whether an application should be submitted immediately in some cases. For a relevant person the court is only accessible if they are able to express a desire to take their case to court, or where another person sees the need and takes it on their behalf. The MCA is intended to put those who lack capacity on an equal footing to those who have capacity, yet this part of the system seems to fall short of this. The MCA code of practice makes it clear that capacity assessments should be completed by the most appropriate person, yet the courts insist on a COP3 being completed by a psychiatrist, which again does not seem to fit well with the spirit of the Act.

19. As an IMCA service we ask the decision maker whether there is an LPA, deputy or advanced decision / statement in place and in some cases the decision maker has not even considered this let alone checked. For urgent best interest decisions the decision can be made and implemented by the time the OPG has responded about whether there is an LPA in place. Where LPA’s are in place these can be invaluable in empowering people to keep control over their own lives once they have lost capacity for certain decisions.
20. The LPA forms can be repetitive which can put people off applying. There have also been instances where GPs have been asked to complete the capacity section but the GP has not heard of an LPA and does not understand the MCA. The costs can also be a barrier and discriminate against people who cannot afford it. In order for LPAs to be in line with the spirit of how the Act was intended it should be accessible to all. Case law published by the courts can be confusing as different cases can disagree on which aspects of the Act are the most important, for example, a person’s wishes compared to what is deemed to be in their best interests.

21. While s.21A appeals are not means-tested, welfare decisions are and often s.21A appeals spill over into welfare decisions. This is prohibitive for some people when considering accessing the Court.

30 August 2013
Marie Poole, Professor Julian Hughes, Professor John Bond, Dr Helen Greener, Dr Stephen J. Louw, Professor Louise Robinson and Charlotte Emmett – Written evidence

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

Submission to be found under Professor Julian Hughes in Volume 1.
David Rees – Written evidence

Status: I am a barrister in independent who specialises in Court of Protection work (primarily property and affairs cases). I was a member of the group that advised on the drafting of the Court of Protection Rules 2007. I am currently a member of the Court of Protection Court Users Group and I am General Editor of Heywood & Massey’s Court of Protection Practice, a practitioner’s textbook on Court of Protection work.

This evidence is submitted on my own account

Summary

In this evidence I look at the Mental Capacity Act 2005 from my experience as a barrister dealing with the legal issues raised by the Act on a daily basis. In particular, I address a number of technical issues which, if there is the possibility of primary legislation to amend the Act, I would suggest should be considered. I have sought to confine my evidence to reasonable length, although if the committee were interested I can identify other technical issues which might merit further consideration.

Question 2 - Which areas of the Act, if any require amendment; and how?

(1) Sections 1 and 2

The opening words of these sections “The following principles apply for the purposes of this Act...”; “For the purposes of this Act...” limits the scope of the general principles and the definition of lack of capacity to the purposes of the Act. The intention behind this appears to have been a wish not to alter common law tests of capacity. The Code of Practice states at para 4.33

“The Act’s new definition of capacity is in line with the existing common law tests, and the Act does not replace them. When cases come before the court on the above issues[283], judges can adopt the new definition it they think it is appropriate.”

However, the consequence of this has been a degree of confusion where courts (other than the Court of Protection) have been hearing cases which are not brought under the MCA 2005 and in the course of those proceedings have been asked to consider whether a person had capacity to carry out an act. Does the Court apply the statutory test[284] or the common

[283]The issues listed are, capacity to make a will; capacity to make gifts; capacity to contract; capacity to litigate; and capacity to marry (Code of Practice para 4.32).

[284]See Perrins v Holland [2009] EWHC 1945 (Ch) at para [40]
I would suggest that this is an issue that requires clarification. If (for example) a person wishes to make a will, then a solicitor who is advising him will need to have regard to sections 1-4 MCA 2005 in order to ensure that he takes all practicable steps to ensure that the client (if he has capacity) is assisted in making the will. I would suggest that any subsequent retrospective assessment of capacity should be conducted by reference to the same statutory criteria, and that the statutory test of capacity should be expressed to apply for all purposes.

A further point upon which clarification would be of assistance is whether a transaction entered into by someone lacking capacity is void or voidable. The law on this point is unclear.

(2) Schedule 2 para 8

This paragraph prevents the ademption of gifts in wills in certain circumstances. If a person lacking capacity has made a will containing a gift of specific property, and that property is then sold during the person’s lifetime under an order of the Court of Protection made under section 18 MCA 2005, then the gift in the will takes effect as a gift of the proceeds of sale of the property. Without such a provision the gift would be adeemed (ie not take effect). Whilst this provision prevents a person’s interest under a will from be accidentally adeemed an act of the Court of Protection it has several problems associated with it.

(a) It leaves it unclear (unless the Court gives directions) as to how in practice the proceeds of sale are to be traced into the estate of the person lacking capacity;

(b) It does not assist where the sale is effected by an attorney under an EPA or LPA. Nor does it assist where the sale takes place pursuant to an order of the Court made under its powers to give directions to attorneys (section 23 MCA 2005 for LPAs and Sch 4 para 16 MCA 2005 for EPAs).

I have encountered a case where there was a dispute after the death of a person who had lacked capacity as to whether a sale of property by his attorney had been authorised by the Court under Sch 4 para 16 MCA 2005 (in which case the gift would have adeemed) or under section 18 MCA 2005 (in which case it would have not). Although the application process and the issues to be considered by the Court in either case is identical, the effect of the order is fundamentally different. I would suggest that the distinction is unwarranted and that either Sch 2 para 8 is repealed, or it is amended so that it also protects property sold by attorneys from ademption.


286See Re MM (an adult) [2007] EWHC 2003 (Fam) para [79] to [80].

287Sutton v Sutton [2009] EWHC 2576 (Ch)

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(3) **Schedule 3.**

Schedule 3 which deals with the recognition and enforcement of international orders in relation to incapacitated adults was not an issue considered by the Law Commission in *Mental Incapacity*, but was added when the Bill came before Parliament to take into account the 2000 Hague Convention. I appeared as counsel for the Applicant in *Re MN [2010] COPLR Con Vol 893*, the first reported decision on the provisions of this Schedule.

The first point I would wish to make is that although the UK has signed the 2000 Hague Convention, it is currently only in force as regards Scotland. This should be remedied and the Convention brought into effect in England and Wales.

More generally, whilst I agree with the main thrust of Sch 3 (which is that decisions relating to the affairs of adults lacking capacity should be taken by the courts of the jurisdiction where the person is habitually resident) the drafting of the Schedule is complex and there are a number of ways in which the drafting of the Schedule could be improved. I would suggest that the Schedule needs a comprehensive review. However some specific points which I have identified include:

(a) Including specific provisions for the mutual recognition of powers of attorney and the mutual recognition and enforcement of orders between the various jurisdictions within the UK and the British Islands (cf Family Law Act 1986 in relation to the mutual recognition and enforcement of orders regarding children).

(b) Clarifying the extent (if any) to which the Court of Protection may go behind a foreign power of attorney. If a foreign form power has been registered in the jurisdiction where P is habitually resident, it is permissible in proceedings in England and Wales for the Court of Protection to consider the underlying validity of that power?

(c) By making clear the extent of the Court of Protection’s jurisdiction to deal with property situated in England and Wales that belongs to a child under 16 who is habitually resident outside England and Wales where it is likely that the child will continue to lack capacity when they attain 18. The Court of Protection’s jurisdiction under section 16 MCA 2005 extends to dealing with the property and affairs of children under 16 if it is likely that they will continue to lack capacity when they attain 18 (MCA 2005 section 18(3)). Where the Court of Protection becomes involved in the affairs of such a person, it is usually because they are the recipient of a large damages award requiring professional management.

However Sch 3 (and in particular Sch 3 para 7 which sets out the geographical extent of the Court’s jurisdiction) deals only with the jurisdiction as it applies to “adults” as defined by Sch 3 para 4. The current provisions mean that there is no basis upon which the Court of Protection can recognise and enforce a decision of a court from another jurisdiction in relation to the property of a child who is likely to continue to lack capacity on attaining 18. I have recently been involved in a case where such a child was habitually resident outside England and Wales. She owned a house in the jurisdiction in which she was habitually resident, but also had a large damages award held in England and Wales. The foreign equivalent of a deputy was required to hold the overseas property (as the Court of Protection has no jurisdiction to deal with overseas property of a person habitually resident outside England and Wales). However an English deputy was needed too, as the Court of Protection was unable to recognise the foreign deputyship order under Sch 3 as P was not yet 16. Amending Sch 3 to provide for mutual recognition in such circumstances would

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avoid the duplication of costs involved in having two deputyships in two different jurisdictions.

(4) Sch 4 Para 2

Subsequent to the enactment of the MCA 2005, but before it came into force, a further form of EPA was prescribed (by the Enduring Powers of Attorney (Welsh Language Prescribed Form) Regulations 2005 (SI 2005/3125). These should have been added to the list of prescribed forms in Sch 4 para 2(2), but have not been.

(5) Sch 4 para 16.

Under Sch 4 para 16(2)(b) the Court of Protection may give directions with respect to the management or disposal by an attorney of the property and affairs of the donor under a registered EPA. This provision simply re-enacted the equivalent provisions of the Enduring Powers of Attorney Act 1985. However, an EPA becomes registrable with the Public Guardian once the donor “is or is becoming” mentally incapable (Sch 4 para 4(1)). This means that an EPA may be registered even though the donor thereof may retain capacity to make various decisions for himself. I would suggest that Sch 4 para 16 should be amended to make clear that the Court of Protection cannot make a direction under Sch 4 para 16 where a donor retains capacity to make the relevant decision for himself.

Question 20

There is clearly a tension between making the Court of Protection a responsive tribunal where matters can be decided quickly and without incurring significant legal costs and having a set of court procedures which are fair and respect individual’s rights under Art 6 ECHR. There is however a risk that procedures which are put in place are so cumbersome that it becomes too expensive for an individual to incur the risks of litigation.

My experience is primarily in property and affairs applications where decisions regarding significant sums of money belonging to incapacitated persons may need to be taken, although I have been involved in a number of welfare applications as well. I have found that in general the property and affairs applications tend to be dealt with at a lower judicial level (even where very substantial sums are at stake) than welfare cases, and frequently are disposed of with fewer and shorter hearings. Whilst I accept that some welfare cases involve complex factual or legal issues, I consider that there is also an element of the two types of case continuing to adopt the cultures of the two different courts which heard them prior to October 2007 (welfare cases being heard in the Family Division of the High Court; property and affairs cases in the old Court of Protection). Although the Court of Protection Rules 2007 provided for a single set of rules for both types of application, in practice many differences remain, and this is perhaps something which will need to be looked at further in the forthcoming review of the Court of Protection Rules 2007.

One key point on costs are the default rules which currently apply. In welfare cases, the starting point is that each part bears their own costs regardless of the outcome (r157). In property and affairs cases the starting point is that the costs of all parties are met from P’s estate (r156). Again this reflects the rules that applied prior to October 2007. The advantage of the property and affairs rule is that if a person who has a concern about an incapacitated person may raise it with the Court of Protection without running the risk of an
adverse costs order. On the other hand it also enables persons to pursue self-interested litigation (such as statutory gift and will applications) without any real risk of an adverse costs order. Again I would suggest that these problems are best looked at in the context of the review of the Court’s rules.

2 September 2013.
REF – Written evidence

SUMMARY

The underpinning ethos of the Mental Capacity Act 2005 is one of protecting vulnerable people from abuse, and to enhance opportunities to control their own destiny.

This case study exemplifies that in G’s instance the Act has failed in that intent. As a result of all the systemic failures G has endured abuse [detailed in Appendix One] beyond the pale; not by us, but by the very authorities that purport to work in his ‘best interests’.

G does not have any protection in law. Lasting Powers of Attorney cannot be had for such as G, for permission has to be given by the individual in the first place. If someone cannot give informed consent, then he/she cannot give that initial authority.

Thus the individual becomes more vulnerable, not less; and prone to the vagaries of authorities who seek to justify their own existence on the backs of those who cannot speak up for themselves.

Despite all historical reports confirming G’s levels of capacity, that capacity has been little understood with authorities choosing for their own reasons either to ignore validity of the evidence presented to them, by some very eminent linguistics experts; or simply not to recognize the difficulties.

The concept of ‘best interests’ then becomes a bit like ‘knitting fog’; so too, that of ‘choice making’. In practice, this idea is often used as a means of justifying nothing short of poor professional practice, and that constitutes the most insidious kind of abuse – Institutionalised. But who has the tenacity, and the means, of bringing to account those guilty of such malpractice?

In G’s case, the Court of Protection has been misled by, and may itself be guilty of, such malpractice. Indeed the judicial system as whole needs to be much more savvy in the needs of those with communication disorders, and autism. Only then will the aspirations within the Mental Capacity Act 2005 be achieved on behalf of those who have such complex difficulties.

The ideal of Deputyships must be revisited; parents are not the devils in disguise. The power of authorities must be curbed, or we will be living in a police state; and the Court of Protection must be more proactive in establishing an arbitration route, administered by the Public Guardian.

INTRODUCTION

1. This case study reflects an overview of our experiences in the process of caring for our son ‘G’. Although G is now 43 years of age, his life has been blighted by ignorance of his conditions.

2. These consist of, in order of priority, Specific Language Disorders (now Pragmatic Language Disorders); Childhood Autism [not formally diagnosed until 2007]; Learning
Disabilities; Cerebral Palsy; and associated mental health difficulties. Each of these is designated as singular and complex disabilities in their own right, thus demanding treatment and provision in their own right. Collectively they become even more complex with the need for careful and clear assessment in order to provide for needs.

3. That complexity cannot be overemphasised; it is only by living with and constantly observing his efforts at communication - which to an outsider, may appear quite articulate but which in fact, are distorted, leading to serious misunderstandings, and misrepresentations - in close proximity, can the realities be appreciated, understood, and accepted.

Background

4. G’s education career was a tumultuous affair; constant fighting, arguing, and challenging against all the then legislative background, finally resulted in the correct provision (at 15) - in a specialist residential school where his difficulties could be observed on a 24-hr., 5 day week basis, giving consistency, continuity, and expertise in provision.

5. On leaving school in 1989 at the age of 19, G’s ‘capacities’ were recorded as ‘Semantic Pragmatic Disorders; and mentally subnormal bordering on the moderate to severe; with an IQ of between 55-56’.

6. He transferred into a residential placement run by the charity Scope, in [Town A]; being supposedly sponsored by [Council B], where we lived at the time. When Community Care legislation came into force in 1993 [Council B] were requested to undertake a CCA/Care Plan, but did not attempt to do so until following the events of 1994 (sexual assault). That CCA was never implemented.

7. The residential placement closed in 2005; because there had been no forward planning, G was effectively rendered homeless. It was by our own efforts that a local housing trust bungalow [in Town A] was obtained on G’s behalf; where he now lives happily within the bounds of his disabilities. I [REF] took responsibility for the tenancy under the terms of a then Receivership.

8. By virtue of this G become an ordinary resident of [Town A]; although it was not until 2007 that [Council A] finally recognised its legal responsibility for provision of G’s care arrangements. Again, those arrangements were never clarified through appropriate care planning processes.

9. During this transitional arrangement [Council A] had decided to keep in place the arrangements as instigated by [Council B], but those arrangements had been put in on a temporary emergency basis pending the changeover. Essentially they were on a domiciliary care basis only, and not the specialist help required for those with complex needs. The arrangement broke down due to a physical assault by the carer, within six weeks [May
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

10. [Council A] then failed to complete the necessary S47 Community Care Assessment; specifically in line with good practice for those with communication disorders and autism.

11. We sought legal advice with a view to effecting a judicial review.

IN CONTEXT OF THE MENTAL CAPACITY ACT 2005

12. In 2003 G’s capacities were reaffirmed by the psychiatrist attached to the local team [Council A] for those with learning disabilities; as ‘not having capacity under the Mental Health Act 1983. This was party to legal proceedings for negligence against Scope in having allowed G to get into the situation of being raped - on the pretext that, despite all previous records as to his capacities - ‘it was G’s choice’.

13. In 2009, having submitted all relevant information - including the above confirmation, along with support from the G.P. - and undertaken all the preliminary work ourselves, we applied for both the Welfare and Financial Deputyships; they were awarded in July of that year.

14. The speech therapist and the psychologist attached to that same team, also confirmed G’s levels of capacity, giving support for the application [under the MCA].

15. During this time there was no effective social work input.

16. There was still no appropriate CCA and Care Plan; G’s care arrangements remaining on an emergency temporary basis. These matters were confirmed in the Report of an Independent Social Worker commissioned as part of the proceedings. The author recommended that both Authorities apologise for the systemic failures; they failed to do so.

17. Having taken independent advice from his own sources, the author further re-emphasised G’s levels of capacities, and recommended the necessary type of care plans needed to provide for G’s needs. The Authority ignored, and failed to act on, those recommendations.

18. It subsequently transpired that that emergency temporary arrangement had been converted into a permanent contract [May 2008] without our knowledge, and without proper authority via an assessment; importantly without G’s knowledge and understanding.

19. In September 2009 G’s case was finally allocated a social worker; but as was to become self-evident, this individual did not have a clue as to the realities of communication disorders, autism, cerebral palsy, and OCD; and least of all did she appreciate the complexities of everything combined. In this she failed in her professional duty.

20. Moreover, she failed in her professional duty to investigate the background to the
case in a proper manner; she failed to acquire appropriate knowledge - in particular G’s communication and language disorders - to allow her to investigate matters thoroughly, and with intent.

21. She did not appear to be sufficiently aware of either the assault of rape, and the criminal process that had gone with it; or the later physical assault, and the criminal process that had gone with that.

22. She further failed in her professional and legal duty to ensure G’s access to appropriate communication resources as required by both the Disability Discrimination Act 1995, and the Autism Act 2009. As a result she failed to appreciate, understand, and represent G’s best interests in a manner applicable to good professional practice.

23. From then on her involvement in G’s case became one of personal prejudice against ourselves; with a perfunctory, arbitrary, and predetermined agenda; based not on objective reasoning but on clear bias.

Court of Protection

24. Party to our potential judicial proceedings, following the submission of the Report of the Independent Social Worker, the Authority’s worker was required to conduct a ‘thorough assessment’; instead, as it transpired, she was doing no such thing. Rather she was instigating a Safeguarding procedure - as said, on false and vindictive information from the temporary non-specialist agency.

25. Resulting from this, in March 2010 we received a Court [COP] summons, requiring us to appear in Court a few days later; although we managed to get this deferred until we had the opportunity to obtain legal advice. The allegations were that:

- We had supposedly been starving G.
- We were controlling him.
- We were not allowing him to exercise his right to his own choices.
- We were restricting him from going where he wanted to go.
- We were not allowing him sufficient funds for his weekly activities. And that:
- We had been embezzling his overall financial resources.

26. All of which had been taken at face value from the care agency engaged on the emergency temporary basis; but who had never been made aware G’s conditions; least of all understand them. No preliminary investigations on an informed basis had ever taken place.

27. Resulting from those unsubstantiated assumptions the Authority had originally applied for an Order ex parte to have G taken into respite care without our knowledge, with restricted contract, and to have us excluded from our son’s life. Fortunately, that request was denied. [We have to assume that this was a Deprivation of Liberty Order [DOL].]

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28. The Authority had expressly stated that ‘we were concocting the complexity of G's difficulties; and that I [REF] should undergo psychiatric evaluation (inferring Muncheusen’s Proxy Syndrome)’. This I refused to do, as all our actions had been substantiated by relevant professional input; which should have been evident from the files.

29. By Order of the COP the Authority was, as recommended by the Independent Social Worker, required to produce a CCA; thus supporting the contention that there had never been an informed one; which in turn might suggest that the COP process was unnecessary.

30. If an informed Assessment had been carried out originally, and an appropriate agency appointed on a needs-led basis, then all the above allegations would not have arisen - for the very reason that the things we were being accused of would have been recognised as legitimate practice [on record] for those with such complex difficulties as G's.

31. Whilst the Authority did ultimately submit an Assessment to the Court, it was not in line with the Statutory Guidelines required of the Autism Bill 2009; nor was it conducted under the prequisite person-centred planning. The end result did not, therefore, represent a true, accurate, and thereby lawful reflection of G’s needs.

32. An Official Solicitor had been appointed on behalf of G, but again, it became self-evident that she did not have sufficient understanding of communication disorders, and autism, to be able to question the information presented by the social work department; thus she too failed to represent G’s best interests.

33. Central to all of this had been the presumption that, even though reports from his educational career proved otherwise ‘G had full capacity to conduct his own affairs’. Two independent professionals - a psychiatrist, and a psychologist - were appointed as experts on behalf of the Court. G’s functional levels of capacity were re-affirmed during this process; i.e. that his levels of understanding remained at around the 55-56 IQ level; that his ability to make complex life decisions [as within the spirit of the MCA] was limited to that of around a 7-8 yr old level; essentially he functioned little differently from when he left school.

34. At the same time, the local speech therapist who had conducted a further major assessment [instigated by ourselves] of G’s difficulties in 2001, supporting G’s historical school reports; along with the psychologist involved with the local team, both of whom, as said, had supported our original application for the Deputyships, affirmed that G’s difficulties remained more or less as they had always been - little understood. She had re-emphasised the complexity of G’s difficulties, stressing the need for others - that would include the Official Solicitor - to be able to validate information.

35. They confirmed too, that it would be very difficult for outsiders - such as the Official Solicitor, and the independent experts - to be able to confirm the realities of G’s disorders without the specialist language knowledge, and the opportunity to digest the realities;
otherwise conclusions drawn would likely be flawed.

36. The experts had been asked to express whether or the Deputyships were actually needed. In their opinion the Welfare Deputyship should not be needed, as the best interests principle should apply; but that had been a pre-loaded question by an authority that did not understand what it was dealing with.

37. In respect of the Financial Deputyship it had been agreed that G did not have the capacity to handle his own financial affairs, and that if the Court was satisfied that there had been no financial impropriety, there was no reason as to why the Deputyship should not remain with us.

38. We had been responsible for this for two years, receiving exemplary reports from the Public Guardian’s office.

39. The original concerns of the Authority had been done so not on reasoned analysis of facts at the time - that is, the non-existence of a Community Care Assessment along with appropriate paperwork authorizing financial processes – but on predetermined ideas as to the circumstances there and then.

Evidence has now emerged to the effect that the lack of paperwork was resulting in the lack of bills for care being sent out, with money accumulating when it should not have done so. That was the responsibility of the authority, not ours.

40. At the same time the Authority applied to have the Welfare Deputyship awarded to themselves; which was at odds with rational thinking, since it was they who had doubted the validity of G’s capacities, in the first place. However, this application was refused on the basis that ‘decisions should be taken in the person’s best interests’.

But ‘best interests’ is a moveable feast.

41. We were led to believe by the legal representatives that for whatever reason the Deputyships should not have been awarded in the first place; in other words the awarding judge had got it wrong.

But that seems at odds with the spirit of the Mental Capacity Act.

42. As a result then, of all the bullying and harassment we felt we had no option but to voluntarily rescind the Deputyships; at least until we could prove matters outside of the Court arena, since we could not afford continuing legal fees.

43. Orders had been made from the hearings, but those Orders were in themselves flawed since the information presented by the Authority to the judge was biased, arbitrary and predetermined.

44. As further evidence has emerged, then, we are now faced with the possibility of
having to re-apply to the COP to have those Orders superceded on the basis that ‘the judge was misled by false and misrepresented information’.

We are pleased to report that G now – only two months ago - has a care package by a specific agency specializing in provision for autism, and communication disorders.

Ad that has been only by our own persistence – at a heavy price.

What a waste of a very treasured human life.

Appendix One - Schedule of abuse.

1. In 1994, whilst in residential care, G was subject to an incident of rape (we will not defer from disguising that term) by a member of his local church. He was allowed to get into the situation on the pretext of it being ‘his choice as an adult’. The authorities (Council B and Council A) failed to address the matter; nothing was done to report to the police; nothing was done to obtain appropriate aftercare.

2. In 1998, G suffered a major mental health episode. Following protracted proceedings the issues ultimately reached Professor in 2001. Professor recommended that G be moved from the immediate area as a matter of urgency. The authorities failed to act on this recommendation.

3. Resulting directly from the lack of appropriate care planning (which is of itself an abuse) G suffered ongoing malpractice by carers – often itinerant foreign workers - who were simply not equipped to deal with complex disabilities. (This included G being made to walk beyond his capabilities; being shouted at; and being financially manipulated.) Both authorities failed to deal with the issues. A formal complaint was made in 2009, to (Council A) [coincidentally around the time that the social worker instigating the Safeguarding process became involved] Council A failed to act appropriately on this complaint.

4. Resulting from the failure of (Council A) to complete a S47 Assessment following transfer of responsibility, G was physically assaulted by a coloured worker whose command of English – least of all, understanding of autism - was negligible. [How logical is it to put someone in who could hardly understand the English language, with someone (G) who has a severe and complex language disorder?] The authorities failed to deal with this appropriately. While the matter was reported to the police, with a resultant criminal process that process was cut short by lack of persistence on the part of the authority (Council A). Despite physical evidence the team manager at the time stated that he believed the incident had not happened; G had fantasised about the event.

5. Complaints were made to (Council A) about the nature of the agency appointed on the emergency temporary basis; again they were not equipped to deal with G’s difficulties. The authority (Council A) suggested within the COP proceedings that this agency was the best thing since sliced bread.

G now [June 23rd 2013] has a new agency, specializing in these types of disabilities; why?
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Claud Regnard FRCP (Consultant in Palliative Care Medicine, St Oswald’s Hospice) – Written evidence

Responses

This feedback is restricted to the application of the MCA in clinical practice based on experience working in adult palliative care, paediatric palliative care and learning disability services.

All weblinks checked before submission.

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?
Response: The MCA has yet to be embedded into clinical medical and nursing practice. This is despite the Act and the Code of Practice creating the foundation for a solid clinical decision framework.

2. Which areas of the Act, if any, require amendment; and how?
Response: Further advice and clarification are needed on

a) Assessing the ability to use or weigh up issues in the capacity test. While this part of the capacity test is straightforward in most situations, there are occasions where this is challenging. Advice, even a requirement to have a second opinion, would be helpful.

b) The Act and the Code suggest there is a hierarchy of advance decisions with the recollection of a verbal advance decision at one end and a written, valid and applicable ADRT at the other. Clarification or advice on this would be helpful.

c) The nine point checklist of the best interests decision-making process described in the Code is proving to be an excellent clinical framework and its components are in the Act. However, it is unclear if the decision of a correctly formulated and documented best interests process has legal authority, such that it cannot be changed if circumstances and information are unchanged.

d) The Code and the Act make clear that a LPA must act in the individual’s best interests. However it is unclear if this means that they are subject to the nine point checklist of the best interests process.

e) The decisions of 16 or 17 year old have less protection under the Act than those of an 18 year old or a 16 year old under the Adults with Incapacity Act in Scotland. The decisions of a young person with capacity below 16 years have no legal protection apart from case law that long predates the Act. This legal and geographical inequality needs clarification.

Implementation

- The Code of Practice is an excellent resource written in plain English with many illustrative case studies. Not surprisingly it is widely used by clinicians as the main source of information for the Act. It is therefore of concern that the Code sometimes implies certainty when this is not reflected in the Act. A court judge who is very familiar with the Act recently advised (in external advice outside of court proceedings) that clinicians should ‘not rely solely on the Code of Practice.’ (personal communication). Since the Code is
much more understandable to clinicians than the Act, this is a potential source of confusion. Updating the Code would be helpful.

- Centrally, there a surprising lack of recognition of the key role of the Act. For example:


  c) The following **DH key policies** make no mention of the Act:


  d) NHS England draft **Transforming Participation in Health and Care** (August 2013) is a policy in development that includes a section on legal issues, but makes no mention of the MCA.

  e) Winterbourne: Ian Winter (Chair of the Winterbourne Review Improvement Programme) acknowledged on the 17th June 2013 that, "the lack of specific mention of the MCA in the Transforming Care and Concordat documents leaves an important gap." but he added that they would correct this omission (personal communication).

  f) GMC: the current **Good Medical Practice 2013** does not mention the Act, best interests or testing for capacity (see [http://www.gmc-uk.org/guidance/good_medical_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp))

  g) Neuberger panel on the Liverpool Care Pathway **Less Pathway More Care** (July 2013): recommendation 32 states that everyone who lacks capacity should have an 'independent advocate' but makes no mention of compliance with existing capacity legislation in the UK.

- The **Care Quality Commission** is aware that safeguarding aspects of the Act are not well understood. (see [http://www.cqc.org.uk/media/cqc-finds-mental-capacity-act-not-well-understood-across-all-sectors-and-calls-more-work-provi](http://www.cqc.org.uk/media/cqc-finds-mental-capacity-act-not-well-understood-across-all-sectors-and-calls-more-work-provi)) In the north east the CQC have recently checked compliance with other aspects of the Act but their website has no reports on compliance on non-DoLS aspects of the Act.

- **NHS sources**: the only guidance that has the Act at its core is on Advance Care Planning, see:

[http://www.endoflifecare.nhs.uk/assets/downloads/pubs_Advance_Care_Planning_guide.pdf](http://www.endoflifecare.nhs.uk/assets/downloads/pubs_Advance_Care_Planning_guide.pdf). Other sources such as NHS Choices have some guidance on the Act but this information is difficult to find, spread over many different sections and does not explain the key role of the Act.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Only one **Do Not Attempt Cardiopulmonary Resuscitation** form in England and Wales is currently concordant with the Act (see [http://www.cnne.org.uk/end-of-life-care--the-clinical-network/decidingright](http://www.cnne.org.uk/end-of-life-care--the-clinical-network/decidingright) and click on regional forms).

Personal experience suggests that mental health services and social work professionals tend to have the best understanding of the Act but surprising knowledge gaps exist in some individuals. Most NHS health Trusts have incorporated the Act in policy and training and appointed MCA leads but other care organisations, especially care and residential homes, appear to have a low level of compliance with the Act. Overall, the Act has yet to be embedded into clinical practice.

**Decision making**

- Compliance with the Act empowers
  - the individual with capacity to make advance decisions to whatever level of authority they wish
  - the individual who lacks capacity to have decisions made that are individualised to their needs
  - the care professionals to ensure that the decision-making process empowers the individual patient

However, individuals are unaware of the choices they can make and care professionals are often unaware of their duties under the Act.

In the north east and Cumbria a region-wide initiative called **Deciding right** has been adopted by all health care organisations which has the MCA at its core. See: [http://www.cnne.org.uk/end-of-life-care---the-clinical-network/decidingright](http://www.cnne.org.uk/end-of-life-care---the-clinical-network/decidingright).

- The term 'best interests' is probably the most abused and misunderstood phrase in health and social care. It has too often been the vehicle for poor decision-making as described in many of the cases in Mencap's **Death by Indifference** reports (see [http://www.mencap.org.uk/campaigns/take-action/death-indifference](http://www.mencap.org.uk/campaigns/take-action/death-indifference).

  See also the comment regarding regulatory and professional bodies on page 4.

- Shared decision-making is a helpful approach in the dialogue between patient and professional (see [http://www.rightcare.nhs.uk/index.php/shared-decision-making/](http://www.rightcare.nhs.uk/index.php/shared-decision-making/) ) but is restricted to patients with capacity. There is no recognition that this approach has value in the best interests process for individuals who lack capacity.

- Personal experience with IMCAs in the north east has shown them to be an excellent and skilled resource. They are able to ask searching questions of everyone, including care professionals, and often help with clarifying the process. However, they are underused by care professionals and organisations.

**The Court of Protection and the Office of the Public Guardian**

1. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

   *Response:* The Office of the Public Guardian have changed the wording of the Act in two situations:

   - LPA for Personal Welfare has been changed by the OPG to **Health and Welfare** LPA
   - the OPG do not use the MCA term 'advance statement' but instead have a section for 'Guidance' in their forms which appears to be the same as an advance statement.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Both changes in terminology are causing confusion for patients and professionals. For example, individuals applying for the OPG’s Health and Welfare LPA through can find no mention of this term in the Act or Code.

2. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

Response: in the north east one charity has been established to give free advice on the Act and related issues to people on low incomes (see http://www.legacare.org/). Personal experience of speaking to the one regional law society demonstrated a surprising lack of knowledge of the Act amongst solicitors.
Regulation

1. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

Response: the CQC’s recent emphasis on checking compliance with the MCA is very welcome but they need to widen their remit beyond DoLS into making and documenting both capacity and best interests decisions. Additional powers would not be required if non-compliance was exposed and it was made clear how and why this breaches current legislation.

2. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Response: the GMC, DH, CQC, Royal colleges and medical defence organisations should all be emphasising

- the central role of the Act in decision-making
- the importance of defining ‘best interests’ by the Act and not what a professional thinks is best
- that compliance with the Act is a requirement of practice and employment

Rather than doing this separately with advice that sometimes changes the meaning of the Act it would be better if they simply used an updated version of the Code.

28 August 2013
Rehabilitation Education and Community Homes Limited – Written evidence

1) To what extent has the MCA 2005 achieved its aims?

The act has confirmed in legislation that it should be assumed that any adult has full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to make a decisions. To ascertain capacity, assessments need to be carried out that are decision specific. The Act has also enabled and promoted the use of multi-disciplinary meetings along with advocates and IMCAs again being decision specific, and working in the best interest of the individual.

2) Which areas of the act if any require amendment and how?

Not necessarily changes to the Act, but more impetus needs to be given to how we support families to understand this and other pieces key legislation which impacts on their disabled family members lives.

3) At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

Yes the principles and definitions are appropriate, as they outline what is required by multi-disciplinary teams acting in the best interest of the individual. Also, for those who are deemed to have capacity ensures that the decisions they make are followed and supported.

4) To what extent have the five principles of the MCA been implemented in front line practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

Within our provision the company along with managers, care managers, social workers, families, guardians all follow the five principles of the MCA

By completing Mental Capacity Assessments, holding best interest meetings, having discussions at residents’ review meetings, identifying risks or further review of known risks. Other evidence would be DOLs applications, authorisations and extended authorisations, Safeguarding Alerts and outcomes.

By involving all relevant parties, a good balance between enablement and protection is achieved.

5) How effective was the government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provision of the MCA? Has it led to sustainable change?

As professional Home Managers, we are able to access more information and training, as we have to implement and follow this government legislation and it is a CQC requirement, along with operating within the best interest of the individuals we support.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
We feel that family/guardians require our support to understand the MCA. For families not being in the professional environment, information is not as easily obtainable, and can be difficult for them to understand when MCA is discussed in review meetings; we also have to be aware that not all families/guardians have access to the internet to research.

6) Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors such as Health, social care, banking and others.

As Home Managers supporting individuals with learning disabilities a common problem is that when review meetings and monitoring visits are taking place and individuals are supported by their local authority, there have many occasions when we as Home Managers have had to explain that MCA can only be carried out for an individual decision not as a general capacity assessment. So there are times when within the social care sector the Act is not understood by all who are required to use and implement it.

Local authorities may also come to meetings or requested meetings, with their own agenda, which can be to make placement decisions which may not always be in the best interest of the individual.

8) Has the act ushered in the expected, or any, change in the culture of care?

We think that there has been a change in the culture of care, in relation to individual needs, wants and wishes being seen as important and relevant to the individual. These decisions being interpreted and understood and every effort made to bring them to fruition. Decisions are not able to take place unless supporting documentation is completed and in place.

10) Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made- general authority, lasting power of attorney, deputyship. Court of protection, affect the quality of decision making?

We feel that individuals are supported to a greater extent to make decisions for themselves than in the past.

The means by which the decisions is made supports all concerned., however time frame can be an issue if there are changes which need to be made quickly to an initial agreement.

12) Has the MCA fostered appropriate involvement of carers and families in decision making?

It has to an extent, but through our experience shows that families/guardians need support with understanding the Act in more detail and how it can effect and support their disabled family members.

13) Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no one to speak on their behalf?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
This continues to be decision specific, for those life changing issues. However from a residential provision there are times when IMCA do not have the relationship or knowledge to make and informal decision, as the meetings can be few and far between and may only happen once when the needs of the individual warrant a more in depth assessment.

In relation to safeguarding their input has been valuable and important.

16) Are Safeguards in the Deprivation of Liberty Safeguards adequate?

Yes, as the Safeguards exist to provide a proper legal process and suitable protection for the individual where Deprivation of Liberty appears to be unavoidable and in a person’s own Best Interest.

They should be implemented for no longer than necessary.

17) Are the processes for authorisation, review and challenge of Dols sufficiently clear, accessible and timely?

Yes, experience has proven that all DoLS applications for standard, urgent and extension of authorisations are clear, accessible and timely. Authorisation may be applied for in a non-DoLS situation and refused, and feedback is always given to allow care providers to understand their decision and how they came to it.

Reminders are always sent if extensions are required and re-assessments take place.

8 August 2013
Rescare (The Society for Children and Adults with Learning Disabilities and their Families) – Written evidence

On behalf of Rescare I should like to submit evidence to the Committee. Rescare is a small charity which promotes the role of families in the care of the learning disabled.

Rescare Committee members did give evidence to the Joint Committee on the Mental Capacity Bill, so Rescare can call upon a significant amount of experience. In addition, Rescare runs a helpline which gives advice to members, so it has been able to use evidence from carers to frame its response to a number of the questions, as follows:

Question 1

1.1 Rescare has always understood that the purpose of the Mental Capacity Act (Act), was to protect individuals, who cannot make decisions for themselves. In order to do this, it is necessary to recognise the role of families and empower them, whilst protecting individual rights.

Question 7

7.1 Rescare’s experience is that many non-professional carers do not understand the Act. There is too much uncertainty about the role of informal carers, which contrasts with the duties and responsibilities of deputies. Rescare believes that the duties and responsibilities of deputies do strike the right balance between protection of the carer and protection of the individual, who lacks capacity, but there is a lack of clarity for informal carers.

Question 10

10.1 The Act does provide the means to enable and support decision making, by the introduction of Lasting Powers of Attorney, deputyship and the Court of Protection, but Rescare believes that the reality is different. Appointment of deputies can improve decision making.

Question 12

12.1 The Act does provide the mechanism to involve carers and families in decision making. There are clearly defined roles and responsibilities for deputies and attorneys, but the number of court appointed deputies is extremely low in proportion to the number of people with a learning disability. As there is considerable statutory control over the way deputies operate, Rescare thinks that it is desirable to encourage applications. Statutory control includes Section 16(8) of the Act, which gives the Court of Protection control over the way a deputy behaves and enables the Court to revoke an appointment, or vary the powers. Section 20 also imposes restrictions upon the powers of deputies and the Code of Practice sets out a list of duties which a deputy should follow.

12.2 In addition the Office of the Public Guardian has various functions in relation to deputies, as well as donees of lasting powers of attorney and Court of Protection Visitors can support deputies and donees.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Rescare (The Society for Children and Adults with Learning Disabilities and their Families) –
Written evidence

12.3 Rescare believes that if a family member is prepared to undertake the responsibilities associated with deputyship, including supervision by the Court, the Public Guardian and Visitors, the system should encourage them to do so.

Question 13

13.1 Independent Mental Capacity Advocates have a role, but only in the specific circumstances which the Act provides, namely on medical treatment matters and accommodation by the NHS, or a local authority.

Question 14

14.1 If IMCAs had an extended role, then the number of referrals might increase, but there would need to be a campaign to increase public awareness of the IMCA’s role.

Question 18

18.1 Rescare does not believe that the public understands the roles of the Court of Protection and the Office of the Public Guardian. Rescare is concerned about recent press reports about the way the Court makes decisions, sometimes on the basis of a telephone call. Whilst urgent decisions are necessary on issues like administration of life saving treatment, there is statutory protection for medical professionals, to enable them to carry out treatment pending a Court decision. These provisions should allow the Court to make properly considered decisions.

Question 20

20.1 Rescare frequently receives complaints from members about the costs of making applications to the Court of Protection. Rescare believes that the costs discourage applications, particularly as many people might require professional help with applications, because of the complicated process.

Question 21

21.1 Rescare shares the concerns expressed by the Law Society and the Bar about the impact reforms to legal aid will have on access to justice. The reforms will have a detrimental effect on the learning disabled, who have already been adversely affected by welfare reform.

Question 22

22.1 The Care Quality Commission (CQC), could extend their role. They recently published a report on Deprivation of Liberty Safeguards, which they already monitor. The report referred to widespread misunderstanding of the Act and called for more work to ensure both better understanding of the Act and better implementation. The CQC could play a role in ensuring better implementation.

Question 23

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
23.1 Rescare thinks that it is better to have one body, the CQC, to oversee the Act, rather than diversify functions amongst a number of different bodies. The CQC would then be fully accountable.

**Question 26**

26.1 Rescare believes that the procedures for Guardianship and Intervention Orders, under the Adults with Incapacity (Scotland) Act 2000, could be usefully applied. An intervention order is for a single decision and a guardianship order is for the long term. It is possible to apply for an order if you are already an attorney, or if someone else is. The applicant has to specify the powers that they require, and there are restrictions on the powers. The local Sheriff’s Court has jurisdiction, which improves accessibility for the public.

I hope that the above comments will assist the Committee in its deliberations. They are submitted on a corporate basis, for and on behalf of Rescare.

27 August 2013
Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?
   It should have created a huge change in the care of people who have problems with decisions making both to protect them in making their own decisions and guiding staff on how to make decisions etc. As a trainer to health and social care staff (and CQC MHA commissioner) I am concerned at the continued lack of awareness and basic knowledge of the Act however and this impedes what the Act should have achieved.

2. Which areas of the Act, if any, require amendment; and how?

   The Code should be slimmed down – for busy health and social care staff it is simply too imposing. It is well written but if staff see it as too big they don’t even open it.

   Training – health staff in particular have failed to connect the MCA with consent. I regularly train doctors and nurses on the Act and although they have had training on it before and heard of it they have not connected the fact the Act is effectively the law on consent to treatment for people unable to give consent (because they lack capacity to make a decision). I do not believe the professional bodies have made that clear and neither have NHS Trusts and the NHS generally. It seems many health staff think the act is for ‘mental people’ (hence the title) and therefore not something they need to use every day.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

   Yes – the principles and assessment of capacity and best interests are clear and straightforward and the courts have shown they are robust and work.

Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

I think a great deal of training funded by the Department failed to communicate the key message about the MCA and its connection to consent. The Cipold report and the latest Parliamentary & Health Service Ombudsman report (Ms B) both highlight the complete failure to apply the Act in situations where it clearly should have been used. The Act is good but if staff don’t realise (or feel the need) to use it then it has no impact. However, over time and unfortunately

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
with more court cases against Trusts and doctors the importance of the Act will become more obvious however this may mean the Act is only seen in a negative light by health staff and for complex cases.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

I train health and social care staff of all levels. I find the Act is least understood by GPs and hospital staff. I often train hospital staff who are shocked to learn the MCA relates directly to the ability to give consent. They understand consent but have never in training or other guidance been told about its connection to consent to care/treatment. They have also not understood the need to record the use of the Act and show evidence of its use. A simple example is that many DNAR forms (hospital or GP versions) make no mention of the MCA. However, some Trusts are more developed than others in their understanding and use of the Act but this can be patchy within a Trust so the wards providing care to older people have an understanding but staff in other specialities have little appreciation of its use. I have inspected a large general hospital with CQC and found no evidence of the Act being used for older people who were clearly confused and not able to consent to the care they were receiving.

I don’t believe the NHS has integrated the Act (DNAR forms a single simple example) into its daily practice – staff often see the Act as a separate add-on rather than integrated to normal procedures. I will often say to staff don’t create separate forms for assessing capacity and best interests as they should be built into your normal/existing consent to care/assessment forms.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

8. Has the Act ushered in the expected, or any, change in the culture of care?

No – this is evidenced in numerous reports – CIPOLD, CQC annual reports on both MHA and DOLS, Ombudsman reports. But in some areas it has led to considerable changes and this relates to the effective and determined implementation by an organisation. I find that many Local Authorities have taken on board the impact of the Act and have trained all levels of staff and integrated the Act into assessments and other processes.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does
the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

I believe they are but this will relate to individual areas (which local authority) and types of decisions (health or social care etc). Having worked as an advocate with people with dementia on mental health hospital wards before the Act was introduced it has created a huge change. It was not uncommon before the Act that a person with dementia would be defined as lacking capacity to all decisions and no one would question this.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

I don’t know there is evidence as there is no central register for them. My fear is that many health staff don’t understand the rules and procedures for Advance Decisions in terms of recognising them and their authority or enabling patients to make them. I have spoken to several teams of palliative care staff and they tell me about end-of-life care planning policies (DoH). I ask them if they cover Advance Decisions and LPAs with patients as part of this and they respond ‘No’. It seems some policies/strategies are being given priority over legislation and this may because the DoH is not clearly stating and re-stating the importance of the Act and integrating it into policies.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

It should have but I am concerned that many health service staff still talk about next of kin which is not part of the Act and leads to other family member or interested parties being effectively excluded from consultation.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

I believe the variation in use of IMCAs applies to the knowledge of staff in an area about the triggers that lead to the need to an IMCA. I trained a local authority manager recently with responsibility over reviews of care for those in residential care and they were not aware of the ability to request and IMCA for annual care reviews where a person had no other person to consult. In this area therefore no IMCAs were being requested in relation to this part of the Act. One question seems – the statistics are available (from IMCA organisations and the DoH) but what is being done and by whom to question and challenge areas that have low IMCA referrals?

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
I don’t believe they are as over time the number of referrals is going up (reflecting gradual improvement of knowledge by the NHS and local authorities of the Act) but I am not sure the funding is reflecting this.

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

Clearly DoLS is the area of the Act that has come in for most criticism. I am concerned though that people think anything else will provide an answer. The courts have shown that deprivation of liberty is a very difficult concept in relation to care in care homes and other care environments. Over time with more cases this will be clarified.

People criticise DoLS for its patchy use across the country. This is the case, but if change is needed then this applies to the Mental Health Act as well. The CQC annual report on the MHA has shown CTOs are being used with wide variation across Trusts and Guardianship under the MHA has shown wide regional variation for over 20 years.

Just as some local authorities have very rarely used Guardianship in the last 20 years it seems some are also not using DoLS. The CQC should be inspecting these areas to address the issue.

I think all Representatives should be automatically referred to an IMCA rather than being opted in by the Local Authority. Case law (Neary) shows how important the IMCA is in relation to DoLS.

As a trainer to Best Interests Assessors I believe they need the same level of training of AMHPs under the Mental Health Act which is 3 days every year. There is no minimum level for BIAs at present but the role is often more complex and challenging than that of an AMHP (because of the complexities of defining deprivation of liberty and because many BIAs are only doing assessments a few times a year as opposed to AMHPs who do them far for regularly under the MHA and the case law is numerous).

Forms – it will sound very simplistic but having worked as an MHA administrator in a mental health hospital forms are oddly important to staff. The DoLS forms are unnecessarily complex and could be simplified and brought together. Just compare the standard DoLS forms to the forms and evidence needed to detain a person under Section 3 of the MHA.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

The Court of Protection is viewed as very slow in making its decisions. A person under DoLS will get a quick initial hearing but the case can then drag on. I think this is a difficult area as the Court show it looks at each case in considerable depth and has the ability to make wide ranging decisions. In comparison the Mental Health Tribunal system is very quick but (depending on your view) but it
does not look in the same detail at cases (hearings last 3 hours generally) and its scope is very limited legally. Effectively does the person meet the criteria for detention under the Act.

The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

Staff and local authorities are very concerned about the time and cost involved in using the Court of Protection. This is deterring local authorities from accessing the court for decisions.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

People are deterred from registering an LPA because of the cost although I find many people do not realise that those on low income/benefits can apply for a waiver of costs. This needs to be integral to the LPA form – at present you have to request/complete a separate form for a waiver of fees.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

Any reduction in legal aid in this area affecting the most vulnerable of people is very concerning and will have a negative impact in enabling people to challenge local authorities and the NHS. A great deal of case law has shown problems with how the NHS or local authorities make decisions under the Act. The courts have protected the rights of families to challenge ‘best interests’ decisions but relies on an accessible appeal process.

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

I believe the CQC should have a clear unambiguous legal duty to inspect on the MCA. At present it inspects the MCA based on the Health & Social Care Act regulations but I think this is confusing and right to inspect on all parts of the MCA would be helpful and standalone as reason to challenge care providers.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Yes – the MCA is fundamentally about the ability of people to make care decisions (consent) and through best interests provides a minimum legal standard of how decisions should be made for those not able to make a
decision/give consent. CIPOLD, the recent Ombudsman report and case law show the failure to use the Act effectively leads to poor care.

Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

In my experience is it not well understood but over time this is changing. Oddly social services seem much more developed in their understanding compared to NHS staff. It is taking time for staff to understand the much wide scope and significance of the MCA compared to the MHA which they have worked with for so long. I find staff in mental health have not fully appreciated the meaning of use/weigh in the assessment of capacity, take compliance from a patient as consent rather than if they have capacity to consent,

16 August 2013
This evidence is submitted on an individual basis
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Rotherham Doncaster and South Humber NHS Foundation Trust – Written evidence

I write in relation to the above. I wish to comment specifically on the Deprivation of Liberty Safeguards (DoLS), particularly on the subject of mental health assessors. The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 (Part 2, Regulation 4) stipulate who is eligible to carry out a Mental Health Assessment for the purposes of DoLS. It is very loose, and it is basically left to the supervisory body to determine whether someone is eligible to be an assessor. This contrasts starkly with the approval of doctors under Section 12(2) of the Mental Health Act 1983 and approved clinicians under Section 145(1) of the same Act, both of which functions are carried out in accordance with detailed Instructions from the Secretary of State and are subject to rigorous governance processes.

When DoLS was first introduced, Section 12 offices were asked to keep lists of Mental Health Assessors, however, in most areas this has broken down. This has come about for a variety of reasons, not least because different supervisory bodies were interpreting the training requirements differently, thus rendering any list kept by a Section 12 Office useless. The requirement for annual training for assessors was (and is) also perceived as being problematic (in comparison, registered medical practitioners approved under Section 12(2) of the Mental Health Act 1983 are only required by the Secretary of State to undertake one day’s training every five years).

Local Authorities do not have the expertise to approve and regulate Mental Health Assessors, as they do not have appropriate governance procedures and structures in place for dealing with doctors, and it would perhaps be better if this sat with Section 12 services, and if clear training requirements etc. were developed – at present, references are not even sought for Mental Health Assessors, which is a concern. Equally, there is no evidence that Local Authorities are carrying out checks to ensure that Mental Health Assessors are Registered Medical Practitioners by checking their registration with the General Medical Council.

I am also aware that many areas of the country seem to have a shortage of Mental Health assessors, which must be causing problems for the safe and efficient operation of the Safeguards.

I am happy to discuss further.

23 August 2013
Royal Borough of Greenwich, Best Interests Assessors Forum – Written evidence

I) To what extent has the Mental Capacity Act MCA) 2005 achieved its aims?

The Mental Capacity Act has provided a legal structure for assessing capacity and decision making for those who suffer from a mentally disordered, or a learning disability.

The decision specific aspect of the Act ensures that those affected, are allowed to have as much autonomy as possible over areas of their lives in which they retain the capacity to make decisions. Recent case law has reinforced the appropriate use of this piece of legislation, particularly in regards to a person’s ability to understand the ‘salient points’ of a required decision.

Overall the MCA when applied appropriately has improved the practice of social workers and other professionals involved in the care of service users.

2) Which Areas of the Act if any require amendment and how?

There is a lack of clarity in the Act and/or the code of practice as to when a conflict between service users /families and professionals should move from mediation to the Court of Protection.

There should be more guidance in the code of practice to encourage greater usage of best interest decision-making procedures by medical professionals.

Informally admitted patients, who lack capacity, continue to exist in a legal vacuum, as there is no independent scrutiny of their admission, under the MCA DoLS or the Mental Health Act.

The Act does not make clear provision in regards to conveyance from a person’s home to hospital, or a care home. In cases where police assistance is required, the attending officers often request that a warrant is sought under the Mental Health Act.

3) At the core of the Mental Capacity Act are its principles, definitions of capacity and best interest. Are these appropriate?

The MCA is clearly laid out and it’s principles and definitions of capacity and best interests easily understood.

Implementation

4) To what extent have the five principles of the MCA been implemented in frontline practice.

The placing of the principles of the Act at the beginning of the legislation ensures clarity as to the purpose of the statute. Social Care staff frequently quote the principles in their assessments and at multi-disciplinary meetings.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
5) How effective was the Government's implementation plan?

There needs to be a targeted campaign to raise awareness among health professionals in regards to MCA and MCA DoLS. Many doctors consider that their education and experience allows them to know what is in patient’s best interests, when it comes to making decisions in regards to the most appropriate treatment.

6) Is the Act widely known and understood by professionals required to implement it.

The majority of health and social care professionals do have knowledge of the Act, however the degree of understanding varies between professional bodies and also within the various professional groups. Social Care staff appear to have the greatest understanding of the legislation, as evidenced by the number of Mental Capacity Assessments undertaken and Best Interest decision meetings.

7) Is the Act widely known and understood by those directly affected by the legislation, or by their carers?

There remains an absence of understanding in regards to the Mental Capacity Act and MCA DoLS by those directly affected by the legislation and their carers. This has resulted in increased anxiety for families at times of crisis, as they are unclear of their role in the Best Interest decision making process.

8) Has the Act ushered in the expected or any change in the culture of care?

The culture of care has changed with the implementation of the act, as it has encouraged practitioners to question and justify their decisions and actions. It has also allowed professionals to support positive risk taking and enabled service users to retain greater autonomy.

9) Is there any evidence that the provision of the MCA affect some Groups disproportionately?

Language and communication difficulties and issues of race and class continue to impede many services users from achieving their rights under this legislation. This is evidenced in by the low numbers of ethnic minorities and working class service users and their families, who apply to register for Lasting Power of Attorney and who seek redress through the Court of Protection.

Young Adults over the age of 16 are unaware of the legislation and children services rarely consider this legislation when making decision for those in their care.

Decision Making

10) Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than would have been in the past?

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The Act has improved practice of professionals by introducing the need to rationalize decision making and creating a level of scrutiny. There is a greater need to evidence working in partnership with service users and their families when making best interest decisions.

11) What evidence is there that advanced decisions to refuse treatment are being made and followed.

This section of the act is more evident in healthcare settings. It is more likely to be considered by those with chronic health conditions particularly in regards to resuscitation. When a person is admitted to hospital in a crisis it may be difficult for health staff to locate this information. Care homes are increasingly attempting to work with service users and their families in regards to planning their end of life care. However this remains a difficult policy to implement due to concerns regarding possible legal or ethical challenge.

12) Has the MCA fostered appropriate involvement of carers and families in decision making?

Carers and families are much more part of the decision making process, however there remains confusion in regards to who is the decision maker and the degree of influence families or professionals should have over any decision.

13) Has the role of the Independent Mental Capacity Act Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse?

The development of IMCAs has had a positive impact for those who have been in receipt of their service. However the remit of IMCA under the legislation is too restrictive, as it only offers a service to those who are 'unbefriended' unless they are the subject of a Safeguarding investigation. Access to IMCA services should be extended to all MCA DoLS cases and to those who may have family or friends but would still benefit from advocacy support. (for example, families who live far away, or who have support needs of their own.)

14) Has the levels of referrals to IMCAs met expectations?

During the initial stages of implementation of the Act, referrals to IMCA services met expectations; this may have been due to the accompanying awareness campaign. Since then figures have declined particularly in regards to medical treatment. The Royal Borough of Greenwich has commissioned our IMCA service provider to raise awareness of their work with the various health and social care teams, in order to encourage more referrals to their service.

15) Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

We are satisfied with the skills of the commissioned IMCA service in the Royal Borough of Greenwich. There are currently no issues in regards to availability of IMCAs, or funding. However we would like to see higher levels of referrals to their service than is currently the case. We would like to be confident that funding would be available if the remit of the IMCA service was extended to all DoLS cases and in certain circumstances to those who are befriended.

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Deprivation of Liberty Safeguards

16) Are the Deprivation of Liberty Safeguards DoLS adequate?

DoLS has been effective in balancing the safety and rights of those assessed and detained under this legislation. However there needs to be greater clarity in regards to whom the act should apply, as evidenced by the disparity between local authorities in regards to the number of authorizations and recent Court of Protection decisions.

The independent scrutiny of placement decisions by the DoLS process has allowed service users on occasion to return home; for others it has led to improvements in care and community access.

17) Are the processes for authorization, review and challenge of DoLS sufficiently clear, accessible and timely?

The DoLS process is overly bureaucratic. There are approximately 38 forms to support the assessment, authorization and review of a DoLS application, many of which request duplicate information.

The timescales to manage and undertake a DOLS authorization does not take into account that the process is managed by services operating within office based hours. Therefore DoLS applications received over Bank Holiday periods are difficult to process within current time restraints.

Court of Protection and the Office of Public Guardian

18) Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all?

The CoP and OPG are easily accessible by phone, and their intranet site is user friendly. However the process of application is time consuming and the backlog in cases, causes anxiety for families, service users and professionals, which may strain relationships. Referral to the Court of protection has an intimidating effect on service users and their families, even if the outcome is likely to be to their benefit.

It is also very expensive for local Authorities to bring cases to the CoP causing a drain on resources. It is also unclear at what point a case should be referred to the CoP, or whether mediation with the family, or between professionals should continue. It would be helpful if another tier of decision making could be introduced, such as a review panel, which would scrutinise decisions and advise if a referral should be made to the Court of Protection.

19) What has been the impact of the introduction of Lasting Powers of Attorney (LPA)?

There remains confusion by both professionals and the general public in regards to the process of applying for a LPA and the remit of the legislation.
20 & 21) What concerns, if any are there regarding the costs associated with registering an LPA or in making an application to the Court of Protection? Is Legal Aid Available or sufficient?

The costs for LPA and applications to the CoP are prohibitively expensive. Many applicants believe that the process requires the assistance of a solicitor. The changes to the legal aid system mean that it is less available to many people, unless a case of abuse can be substantiated. Cases brought to CoP by the Local Authority do not require individuals to find a solicitor as they will be assigned legal representation by the court.

Regulation

22 & 23) Is the role of the Care Quality Commission (CQC) in inspecting MCA standards adequate, or appropriate. Should other regulatory bodies such as health and social care have a role?

The CQC by making enquiries in regards to MCA and MCA DoLS processes when undertaking inspection visits has given this legislation significance. However many CQC inspectors lack in depth knowledge of the Act and in particular MCA DoLS?

It would be helpful if the Mental Health Act Commission had a greater role in examining the implementation of MCA on psychiatric wards.

Local Authority commissioning teams are gradually taking on a greater role in ensuring care providers understand and apply MCA and MCA DoLS legislation. In Greenwich free training is provided to the private and voluntary organization on MCA and MCA DoLS.

Other Legislation

24) How well is the relationship with the mental health system and legislation understood in practice?

There appears to be significant misunderstanding by many Mental Health professionals regarding MCA particularly in relation to inpatient care.

The interface between the two pieces of legislation in which the Mental Health Act has primacy has led to situations in which service users may be ineligible to be detained under either the MCA or the Mental Health Act.

Informal patients who lack capacity continue to remain outside of any process of independent scrutiny, in terms of their admission.

Devolved Administrations and International Context

(25, 26, & 27) Devolved administrations and international context?

This is not an area of expertise by the Best Interest Forum in Greenwich, therefore we cannot comment on this section.

2 September 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Royal College of General Practitioners – Written evidence

The RCGP welcomes the opportunity to submit evidence to the House of Lords Select Committee on the Mental Capacity Act 2005.

We believe it is vitally important for GPs to deliver high quality care to vulnerable patients and that involving their families and carers is a fundamental part of the process. We understand that issues have been raised with the committee around the ability and willingness of GPs to implement the principles of the Act. While we recognise that there are individual cases where GPs may not be in line with best practice there is a lack of evidence around how the Act is being implemented. It is our view that the vast majority of GPs provide sensitive and timely care to their vulnerable patients, and that more research must be undertaken before conclusions can be drawn regarding the extent of any problems that may exist and how these can best be tackled.

The RCGP is not a regulator and consequently we do not have the power to track what happens in general practice. However, we play a very active role in supporting GPs to understand and implement the Mental Capacity Act by ensuring that an understanding of the legislation forms a core part of GP training and revalidation. Our core curriculum and membership exam include details of the Mental Capacity Act along with clinical issues associated with patients with impaired cognition and how these might be addressed in practice.

In addition, the RCGP has developed proposals to extend and enhance GP training which, if implemented, will ensure that future GPs are even better equipped to comply with the provisions of the Act. Part of this programme would involve specific measures to help train GPs to effectively communicate with patients with communication difficulties; involve carers, relatives and friends within the bounds of confidentiality; develop long term care planning; and specifically identify and address issues around a lack of capacity. The educational case for extended and enhanced training has been accepted by Health Education England and they have asked their Local Education Training Boards to embark on local options planning to ensure that training is flexible and affordable. Meanwhile, the Government is reviewing the financial implications. We consider that the introduction of enhanced and extended training would have an extremely beneficial effect in further embedding and reinforcing the provisions of the Act and we would like to ask the Committee to reflect this in its recommendations.

To help GPs implement the principles of the Act once in practice we have produced the ‘RCGP Mental Capacity Act Toolkit for Adults in England and Wales’ for use by GPs within their surgeries. This includes a user friendly overview of the Act; a flowchart and a checklist for use by individual GPs when assessing patients; a form for GPs to follow to ensure they have consulted all the relevant parties; and a checklist to enable GPs to ensure that all decisions are in a patient’s best interests.

In addition, although the annual NHS healthcheck does not formally include a mental capacity check we believe it should form an important part of this process. As such, we encourage our members to incorporate it by including it in our ‘step by step guide’ and ‘summary of process for the annual healthcheck’ for use by individual GPs.

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We would like to draw attention to the fact that identifying a lack of capacity and determining how to respond to this situation is a complex process, which requires long consultation times and more time for individual GPs to process their caseload. However, many GPs are currently suffering from an unsustainable workload. The number of GP consultations rose by 75% between 1995 and 2008, without an equivalent increase in funding or workforce. According to recent polling conducted for the RCGP by Research Now, 56% of GPs said that they have between 40 and 60 patient contacts in the space of a single day. Therefore increased capacity in general practice is likely to be a key enabler for achieving better adherence to the principles set out in the Mental Capacity Act.

Long term care planning- taking into account any legal advanced decisions which have been made by the patient- is an important part of the implementation of the Mental Capacity Act as a method by which health professionals can ensure that patient’s wishes are respected. RCGP has consistently championed embedding care planning within general practice.

It is our understanding that concerns have been raised during the course of the inquiry concerning the ability and willingness of GPs to identify carers. We fully support the idea that GPs must involve carers in decisions around the care of those for whom they are responsible. However, as with the concerns which have been raised around the implementation of the Act, we believe that more comprehensive research is required before conclusions can be drawn regarding the extend of any problem.

The College has created a number of resources to help GPs identify carers and involve them in the treatment of the people they are caring for. These include;

a) The ‘Supporting Carers Action Guide’ produced with the Princess Royal Trust for Carers. This is designed to help GPs identify carers in their communities, support their health and wellbeing and involve them in the decisions about the person they are caring for.

b) A ‘Commissioning for Carers Guide’ which helps GPs as commissioners to take into account the complex needs of carers when commissioning services.

c) Training resources for GPs and practice staff, such as a training DVD with over 1500 copies already in use, and the Supporting Carers e-Learning Programme.

d) The Caring for Carers Awards, which aim to highlight and reward best practice within GP surgeries. These are awarded annually in conjunction with the Carer’s Trust and Carers UK. Patients and carers who feel that they have been helped and supported by their GP or GP practice are encouraged to nominate.

We believe that these resources should provide a suitable support structure to enable GPs to both identify and support carers in their community.

We look forward to discussing these issues in more detail with the Committee. We would of course be happy to assist you with any further information you may require in the coming weeks as you formulate the conclusions of your inquiry.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Royal College of General Practitioners – Written evidence

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council

14 October 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Royal College of Nursing – Written evidence

1.0 With a membership of more than 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.1 The RCN welcomes the opportunity to respond to the committee on this important inquiry. The submission adheres to the committee’s terms of reference and structure, answering questions which are relevant to the RCN and the nursing profession.

Executive summary

1.2 Overall, the RCN supports the intentions of the Mental Capacity Act (MCA) and believes that when it is used appropriately it can be beneficial to both the patient and health professional. However, in light of this parliamentary review, it is timely to express action which the RCN believes could improve implementation of the Act across the health sector.

1.3 It is the RCN’s understanding that the MCA is not widely understood by nurses and other health professionals. The RCN would welcome further input from employers to support and train staff to learn more about the Act and their professional role within it. This could be achieved with better or protected allocated time for continuing professional development.

1.4 Education of the principles, assessment and enactment of MCA at pre and post education stages for nurses could be improved. This would both develop awareness and expand the knowledge of nurses throughout different stages.

1.5 When using or enacting the MCA, multi-disciplinary working is to be encouraged so that the best decisions are made for the patient and that all health professionals involved in care are fully aware.

To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1.6 The MCA has gone some way to address the issue of health professionals dealing with mental capacity. The MCA has provided a useful legal framework for health professionals, patients, families and carers to work within when mental capacity issues become apparent within health and social care settings. The RCN believes that the MCA is a positive piece of legislation for both staff and patients, as it provides a formal process to refer to. However, we remain concerned that awareness amongst many health professionals is not what it should be. There is concern that many nurses are not clear about the content and use of MCA, particularly in relation to Advanced Decisions to Refuse Treatment and Best Interests. The RCN also notes that the real challenge will be to mainstream awareness of MCA into all
Royal College of Nursing – Written evidence

health and social care settings and across all disciplines including health care support workers, nurses and advanced practitioners.
Staff understanding of the MCA is crucial to providing the appropriate care to a patient, and it is essential that the MCA is not used as a barrier for treatment but as an opportunity to improve resources and general understanding of services.

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

1.7 The five principles of the MCA are referred to throughout guidance provided to nurses by the RCN. Of particular note is the guidance published this year on shared decision making which was produced by a senior learning disability nurse in partnership with the RCN. Making it work: shared decision-making and people with learning disabilities288 is aimed at nurses who work with learning disability patients, who often face issues of determining mental capacity.

1.8 The RCN is aware that where learning disability nurses are practising, there is an increased likelihood of structured best interest decision making and the MCA being undertaken as it should. An example of this is the work of consultant learning disability nurse Jim Blair, who raises awareness of the patient’s needs to all health professionals involved in care, throughout the care journey of the patient289. The RCN highlighted the important role of learning disability nurses at RCN Congress in 2012 through a film showcasing the beneficial impact of when learning disability nurses are involved.290

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

1.9 Within health and social care settings, the RCN has evidence that nurses on the frontline are not fully aware of the MCA. In 2012, the RCN held a series of workshops across the UK and at our annual Congress on the topic of end of life care. These were attended by approximately 300 nurses. Due to its critical place in end of life care, mental capacity and awareness of the MCA was discussed at length as part of these workshops. It became clear in those workshops that understanding of the MCA amongst the nurses in attendance was seemingly low. The RCN is continuing to run awareness events such as these.

2.0 As the professional body for registered nurses and health care support workers (HCSWs), the RCN informs and raises awareness of a number of issues, including mental capacity, amongst our members. The issue of mental capacity falls within many different


289 http://www.theguardian.com/society/2012/feb/14/jim-blair-nurse-people-learning-disabilities

290 https://www.rcn.org.uk/development/practice/social_inclusion/learning_disabilities/pledge_your_support_for_learning_disability_nursing

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
aspects of nursing including community, learning disability, mental health, dementia and care home nursing, to name but a few. In addition to the guidance set out above, the RCN also provides guidance to nurses on the mental capacity act within the publication *Mental health nursing of adults with learning disabilities*. The guidance provides a useful point of reference for nurses who are unclear about the MCA and when and how it should be enacted. This document is currently being updated to reflect recent changes.

2.1 The RCN is currently working with the Mental Health Foundation and other organisations to promote awareness of the MCA. This collaborative work will bring organisations together to develop and deliver key messages to increase awareness and understanding of mental capacity and the MCA as they relate to their patients, service users, customers and clients, staff, membership, audiences and networks. The RCN very much welcomes the work of the Mental Health Foundation and will continue to support the current funding bids for its work on the MCA. Cross-sector collaboration such as this is necessary to achieve the desired awareness of the MCA across health professionals, employers, patients and carers.

2.2 It is important to also consider the role of health care support workers who are an integral part of the nursing team. Although not necessarily formal decision makers in relation to the MCA, HCSWs carry out roles under the supervision of nurses, and are often tasked with assisting nutrition or adhering to patients’ requests. In these instances, it is important that HCSWs are aware of mental capacity issues. The RCN is currently providing information to HCSWs on mental capacity through our publication and forum channels.

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

2.3 The RCN does not believe that the services provided by the Court of Protection and the Office of the Public Guardian are widely understood or known by those who may need to access them. Anecdotally, the RCN’s experience is that families and health professionals are not largely aware of these services. Information about these services could be better embedded in training for health professionals and in hospital and community settings to provide health professionals with better ability to signpost patients, families and carers to the services which they need. If nurses are better equipped with knowledge of these services, they are then able to advise patients on the best way forward.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

2.4 Given the central role which nurses play in a person’s care, particularly at the end of life, nurses often offer advice to patients who are considering appointing a LPA. It is therefore important that they are knowledgeable of the process and feel supported by their managers, team members and employers to effectively provide assistance in this matter.


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2.5 The RCN welcomes the LPA, yet does have concerns at the length of time it can take to resolve. The RCN is aware that the previous process, Enduring Powers of Attorney, was achieved much quicker and at less cost to the patient. However, since the process for this has altered to LPA it has become increasingly complex. In some instances, nurses have found it to be a long and drawn out procedure for patients, their families, advocates and the medical and nursing teams. The administrative delay of appointing a LPA can cause additional stress on potentially very ill patients and it can be difficult for health professionals to work effectively whilst this process is ongoing. The delay can result in medical decisions, such as prescription of medicines, being postponed until the LPA is appointed, possibly leading to deterioration in condition of the patient.

22. Is the roles of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

2.6 The RCN believe that the CQC could do more within their inspection routines to examine the scope of how the MCA is used by health professionals. It would be beneficial if CQC could inspect how effective employers are at providing support to staff so that they are appropriately informed on MCA. This would be hugely beneficial in raising awareness amongst health professionals.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

2.7 The RCN believes that the Nursing and Midwifery Council codes of conduct sufficiently address the issue of mental capacity within the professional practice of nursing.

28 August 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Royal College of Psychiatrists – Written evidence

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

Introduction

The Royal College of Psychiatrists welcomes the opportunity to provide evidence to the Lords Select Committee. This submission has been collated from the views of the College’s Mental Health Law Lead (Dr Julie Chalmers) and representatives from the following College sub-groupings:

The Faculty of Child and Adolescent Psychiatry
The Faculty of the Psychiatry of Intellectual Disability
The Faculty of the Psychiatry of Old Age
The Section of Eating Disorders Psychiatry
The Scottish Division
The Northern Irish Division

General comments and sub-group specific comments are distinguished in the text.

1. To what extent has the MCA achieved its aims?

General comment

The MCA is an important piece of legislation as it places people at the heart of decision making and promotes the enhancement of fundamental rights by outlining a framework for decision making on behalf of those who lack the capacity to do so for themselves.

Comment from the Faculty of Child and Adolescent Psychiatry

The MCA has largely done what it set out to do for young people aged 16-18. It has been useful to put existing common law principles onto a statutory footing. Although it does not apply to younger children, it provides a useful framework and principles for thinking about capacity at that age.

Comment from the Faculty of the Psychiatry of Old Age

The MCA has achieved its aims to some extent but is underused. The DoLs legislation has been sidelined.

Comment from the Section of Eating Disorders Psychiatry

The MCA has succeeded in its aim of raising the profile of capacity issues.

Comment from the Faculty of the Psychiatry of Intellectual Disability

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The MCA and its spin-offs have been a tremendous stimulus to a greater focus on mental capacity and its assessment. The Faculty is very positive about the MCA - it has brought much needed clarity to proxy decision making for people who lack capacity. It has also been successful in terms of helping people with learning disabilities get what they want (within reason) and from an NHS point of view, what they need.

2. Which areas of the Act, if any, require amendment; and how?

Comment from the Faculty of the Psychiatry of Old Age

DoLs – if this is to work then it needs simplification and systems that are fit for purpose.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

General Comment

The College suggests that the Committee consider the arguments made in a paper by Hope et al about the extant best interests checklist in the Code of Practice, which suggest possible extra weighted considerations. For the purposes of this submission, the College takes a neutral position on the arguments presented in this article.

The College fully supports the principle that individuals, if they have capacity, may make unwise decisions and understands that this was partly the reason behind s2 of the MCA.

The College would retain the so called diagnostic threshold and would reject the view that this promotes a subtle shift towards a status approach to capacity determination and, as some have argued, over medicalisation. The requirement that there be a disorder or disability of mind or brain is extremely wide and not necessarily linked to formal diagnostic criteria, and could therefore, depending on the circumstances, apply to us all.

Where a specific disorder is present it may provide pointers to possible deficits that could be otherwise overlooked and the person labelled as having capacity when in fact subtle but significant impairments may be present. eg frontal lobe syndromes where small individual decisions can be made but there is an impairment of overall executive ability.

Comment from the Faculty of the Psychiatry of Old Age

The capacity definition is appropriate and well used. DoLs however are less clearly defined.

The principles of the MCA have been very helpful in making good decisions for people who lack capacity eg those with dementia. They have also been very helpful in sharing decisions with patients and respecting individual’s right to decline care that if available.

Comment from the Section of Eating Disorders Psychiatry


In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Capacity is decision specific, and there is no consensus as to what level of decision one is expected to record/establish capacity for, and how often it needs to be repeated.

Comment from the Faculty of the Psychiatry of Intellectual Disability

The black or white 'has Capacity' or 'lacks Capacity' is simplistic; there are many people with intellectual disabilities who have limited or fluctuating capacity or can participate a bit in best interest decisions but not completely. Some pragmatic guidance with commonsense examples rather than new laws would help.

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

General Comment

Anecdotal evidence would suggest that psychiatrists are generally familiar with the test of capacity and the concept of best interests however some practitioners are still, on occasions, making reference to the common law.

Factors that may contribute to this variation may be:
- Generational - medical students and younger doctors appear more aware of the MCA and less likely to refer to the common law.
- Contextual - psychiatrists working with older adults or those with Intellectual Disability are more likely to be conversant with the details of the MCA.
- Cultural – where there is an MCA lead / trust expert there may be greater awareness of the Act.

Comment from the Faculty of the Psychiatry of Intellectual Disability

The Faculty is not aware of any major problems in its implementation regarding people with intellectual disability beyond delays at the Court of Protection.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

General Comment

The College understands that there were considerable resources given to Local Authorities to promote the implementation of the MCA and a great deal of training for doctors took place as part of this implementation strategy. With the conclusion of the implementation phase this enthusiasm and momentum seems to have been lost albeit with a brief rekindling of activity with the introduction of DoLs. The College was commissioned to produce 2 modules of online training for doctors to become a Mental Health Assessor (DOLS). Unfortunately there has been no recurrent funding to update and improve these e-modules.

Provision of Sufficient numbers of Medical Assessors under DOLS

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
A considerable number of Medical Assessors under the Deprivation of Liberty Safeguards received training in the lead up to the introduction of these provisions. However the College understands that there has been a fall off of numbers over time. Currently accurate figures are not available as lists of Mental Health Assessors are held by individual Supervisory Bodies, although this information will eventually be held on a national database of Section 12 / Approved Clinicians.

According to the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations, in order to continue to be a medical assessor a doctor must attend annual refresher training approved by the Supervisory Body. This has been felt by some practitioners to be too onerous particularly if not working with the care group likely to require the protection of these safeguards. Thus there are very few General Adult Psychiatrist who have maintained the Mental Health Assessor status. As a result, Supervisory Bodies cannot always call upon specialist expertise should an unusual situation arise eg in the general hospital, brain injury, alcohol related conditions.

This has resulted in some areas having to rely on a very small numbers of practitioners, many of whom are independent doctors, to provide assessments with the consequent risk of delay if there are difficulties in finding a suitable assessor as there is such a small pool to call upon. There is also lack of clarity as to governance of this work and identification of which organisation has responsibility for this and for ensuring sufficient numbers.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

General Comment

All doctors, irrespective of speciality, should have an understanding of the principles underpinning the MCA and have a working knowledge of the key components of the Act, given that capacity is one of the essential components of valid consent. They should, with others, lead on promoting fundamental rights by putting the principles of the Act into day to day practice.

Research (pre the MCA) showed that doctors in general hospitals failed to identify those who lack capacity. The study concluded “mental incapacity is common in acutely ill medical inpatients, and clinicians tend not to recognise it.”

There is some indication that the Act has not improved practice in the general hospital: A recent audit of medical records in an English hospital dating from 2010 looked at 95 records, of which 52 listed conditions which may well impair capacity (e.g. delirium or dementia). However, only 7 patients had capacity assessments, and notably they had all disagreed with the course of their treatment. This suggests that others were possibly incapacitous, but were not assessed as they were compliant with treatment.


294 Isobel Sleeman and Kate Saunders ‘An Audit of Mental capacity Assessment on General Medical Wards’ Clinical Ethics (2013) IN PRESS

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Psychiatrists are aware of the concept of best interests and generally understand that a range of factors (social, emotional) need to be considered, not just medical ones. Anecdotal evidence supports the view that when formal best interests meetings are held this has supported teams to promote enablement, sometimes agreeing on a strategy of positive risk taking.

Psychiatrists should be expert in the assessment of capacity in those suffering from mental disorder and will also have a role in assisting other colleagues in undertaking complex assessments. In clinical practice the assessment of capacity can be extremely challenging in certain situations for example, those with borderline personality disorder who present in crisis, frontal brain injury, Autistic Spectrum disorder and young people in crisis.

Anorexia can be a particularly challenging area, and this is addressed in more detail in a separate submission to the Committee from the College’s Eating Disorders Section.

It would be helpful if the Code of Practice could give more detailed guidance about assessment of capacity in those situations. One key message may be to underline the importance of emotions in interfering with decision making rather than over relying on the more cognitive aspects of the test.

In the actual assessment of capacity, psychiatrists may have difficulty with deciding the extent to which the ability to weigh up information should account of an individual’s cognitive style or emotional tone – for example:

- the person whose thinking is too rigid for them to give due weight to alternatives
- the person who is too impulsive to weigh up
- the person who is unable to appreciate adequately the consequences of the potential decisions they have to make.

The Code touches on this in 4.22 using anorexia nervosa and serious brain damage as instances when these might apply. However, the psychiatrist is likely to encounter these issues more frequently in people with neurodevelopmental disorders (ASD & ADHD) and personality disorders where the clinical conclusion can be a finely judged call requiring wide consultation of those involved. Our suggestion is that 4.22 might reflect this better.

Training

Given their particular roles, Psychiatrists will need detailed training in specific areas of legislation particularly an in-depth understanding of the MCA / MHA interface.

The MCA and the Code of Practice are clearly written, in marked contrast to DOLS schedules. Doctors however tend not use primary sources (The Act itself or the Code of Practice) as the first port of call for information. Training materials that produce simple targeted information are particularly effective. For example, folded credit card sized information cards on key areas of the MCA – principles, test of capacity and best interests checklist- produced by Oxfordshire County Council MCA / DOLS lead in 2009 are still being used by practitioners today and are valued as an effective prompt.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Many organisations/ bodies will have a role in ensuring their staff or trainees receive training on the MCA. These will include educators (from medical school onwards), employers and professional organisations.

The College provides in-person and online training modules about the MCA/DoLs:

Two online modules on DoLs:
http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/legalandpolicy/dolstraining.aspx

Onsite training on the Mental Capacity Act:
http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/legalandpolicy/mentalcapacityacttraining.aspx

Various online CPD Online Modules:
http://www.psychiatrycpd.co.uk/learningmodules/thementalcapacityact20051.aspx
http://www.psychiatrycpd.co.uk/learningmodules/competence,capacityanddecision.aspx
http://www.psychiatrycpd.co.uk/learningmodules/dementiacapacity,empowerment.aspx
http://www.psychiatrycpd.co.uk/learningmodules/ethicalandlegalchallenges-1.aspx
http://www.psychiatrycpd.co.uk/learningmodules/advanceddecisionsinpsychiatry.aspx

The College also provides free information aimed at the general public/media:
http://www.rcpsych.ac.uk/expertadvice/problemsdisorders/mentalcapacityandthelaw.aspx

R (Sessay) v South London and Maudsley NHS Foundation Trust

The Committee should be aware of the recent case R (Sessay) v South London and Maudsley NHS Foundation Trust (2011) EWHC 2617 (QB), which reflected an instance of misunderstanding and misuse of the MCA by the police and hospital. The College does not have information about wider understanding of the MCA/MHA within the Police.

“...The police entered the claimant's private accommodation, unaccompanied and without a s135 warrant, purporting to be acting under ss5-6 MCA 2005 in her best interests; she was taken to hospital and, after a 13-hour delay in the s136 suite, detained under s2 MHA 1983. (1) Sections 135 and 136 MHA 1983 are the exclusive powers available to police officers to remove persons who appear to be mentally disordered to a place of safety. Sections 5 and 6 MCA 2005 do not confer on police officers authority to remove persons to hospital or other places of safety for the purposes set out in sections 135 and 136. (2) The MHA provides a complete statutory code for compulsory admission to hospital for non-compliant incapacitated patients, so the common law doctrine of necessity does not apply during the period in which a patient is being assessed for detention under the Act. If there is urgent necessity to detain then the s4 procedure should be followed; if even this procedure is too slow then the police can be asked to detain under s136 (an..."
A&E department being a place to which the public have access): there is no lacuna in the MHA. There is unlikely to be unlawful detention or breach of Article 5 if there is no undue delay during the processing of an application under ss2 or 4 MHA 1983. (3) On the facts, as the detention was purportedly under s5 MCA and the application for detention under s2 MHA was delayed, the claimant had been detained in hospital without lawful justification, and deprived of her liberty in breach of Article 5; she was entitled to damages."

Banking Sector

The Office of Fair Trading (OFT) recently issued guidance for lenders about assessing applications for credit from borrowers who are understood (or suspected) to have ‘limited mental capacity’.295 The publication of the OFT guidance is a positive development. However there are reports that translating these OFT guidelines into lending processes, procedures and protocols is proving extremely challenging, and emerging evidence also exists which questions whether borrowers with ‘limited mental capacity’ are receiving support and guidance from lenders.

The College has worked for a number of years training and working with lenders on translating mental capacity policy into operational practice. During this, the most common problem has been the understandable instinct of lenders to try and ‘work this out ourselves’, as opposed to working with external organisations with the relevant expertise and experience. Unfortunately, this has too frequently resulted in operating procedures which lenders believe in good faith secure compliance with the OFT guidance, but which actually:

• conflate ‘mental capacity’ with ‘mental health problems’ – this can result in only borrowers with mental health problems being discriminatorily focused on, rather than a wider list of conditions

• rely on customer disclosure of a named mental capacity limitation before action is taken – this may mean an easier process for lending staff to follow, but it can mean that customers who exhibit signs of a mental capacity limitation, but who do not tell the lender they have any limitation, are not given any support, help or intervention

• treat mental incapacity as a life-long state –lenders regularly wrongly assume that a person who currently lacks the mental capacity to enter into a loan agreement, will also be unable to enter into any agreement in the future

• or overlook mental capacity issues entirely–through a misinterpretation of the OFT guidance requirement that as a starting point lenders presume that each borrower has the mental capacity to make an informed decision, some lenders do not actively look for any indicators of a mental capacity limitation. Consequently, these borrowers do not receive the support they might otherwise benefit from.

To our knowledge, there has only been one research study which specifically provides evidence of such difficulties. In 2011, the College and Mind published findings from a survey


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of 878 people with experience of debt and mental health problems.\(^{296}\) This provides some indication that mental capacity limitations among loan applicants with a mental health problem are not uncommon and that support from creditors is not being provided. Among the 878 people surveyed, approximately 450 respondents were asked about the effect of their mental health problems on their ability to make an informed decision during loan application processes:

- one-in-three respondents reported feeling unable to make a ‘reasonable decision’ about whether to take out a loan
- one quarter reported not understanding the terms and conditions of their loan (i.e. what they would need to do to repay it)
- one half could not remember what they had been told about the loan
- more than one third reported not being able to ask questions or discuss the loan with the lender.

**Comment from the Section of Eating Disorders Psychiatry**

Many professionals are still unclear about how to utilise the MCA in practice. It would be fair to say that while the assessment of capacity for making particular decisions is probably on the increase, this is not accompanied by an increase in confidence in utilising the provisions of the Act itself, for the majority of clinicians in eating disorders.

**Comment from the Faculty of the Psychiatry of Old Age**

The MCA is widely known and used by doctors, social workers and nurses; it is not widely applied by other health professionals eg ambulance staff conveying patients. One Old Age Psychiatrist told us he had “personally experienced two situations where patients with life-threatening medical problems- (bleeding from wound and haematemesis) were not taken into hospital by ambulance staff as staff felt they "lacked capacity". The patients were not even refusing to go into hospital but were just ill and drowsy. Bizarrely, an Act which was supposed to support clinicians in making decisions for incompetent patients is being used as a way to deny patients access to treatment.” He added that colleagues had mentioned many other similar incidents to him.

Less serious are the frequent referrals to psychiatrists requesting capacity assessments from social workers, physicians, surgeons etc about issues of capacity they should be addressing. This is contradictory to what the Act states about how those with best knowledge of the decision to be made should be assessing the capacity of the patient/client to make that decision.

The solution to these problems would appear to be training- but there’s lots of training available and indeed MCA training is mandatory- so perhaps the training needs to be made

more relevant to the profession/working environment of the staff group with specific clinical vignettes being used as teaching aids.

Comment from the Faculty of Child and Adolescent Psychiatry

The Maturity issue, mentioned in 12.13 p220 of the Code of Practice, referencing young people who are capacitous but still unable to make a decision, continues to be a rather unhelpful aside in terms of the medicolegal treatment of mental disorder. The Faculty’s understanding is that it comes up rarely as a clinical issue, but generates a disproportionate amount of concern and confusion in trying to teach on the subject. It may well be less of an issue within mental health care where there are alternative legal frameworks for treatment, whether people can’t or won’t consent, but may be more of an issue in higher age adolescent paediatrics, where potentially life changing interventions eg transplant, chemo/radiotherapy may be truly overwhelming for the genuinely capacitous.

Comment from the Faculty of the Psychiatry of Intellectual Disability

Intellectual Disability services are very tuned in to MCA issues but generic services are less so and a continuing education role is required. Rome was not built in a week and so education and roll out rather than new laws at this point, is a strong request please. There is much benefit around ensuring sensible decision making around finance or restrictive practices or Psychological/Psychiatric interventions in specialist services. There is anecdotal evidence of routine and unnecessary tests, restrictions etc being delayed or stopped altogether which is a good thing. However there is also anecdotal evidence of enormous time wasting and procrastination around making fairly simple decisions because of nationally driven blame game and risk avoidance cultures.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

Comment from the Faculty of the Psychiatry of Old Age

The MCA can provide a framework for decision making about care of people who lack capacity and this can be reassuring to relatives and carers.

8. Has the Act ushered in the expected, or any, change in the culture of care?

Comment from the Faculty of the Psychiatry of Old Age

The MCA has not ushered in a change in the culture of care - it has only formalised good practice.

Comment from the Faculty of Child and Adolescent Psychiatry

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The MCA didn’t necessitate enormous changes in practice, but rather made decision-making processes, especially around the care and treatment of 16-17 year olds more transparent, defensible and consistent.

Comment from the Section of Eating Disorders Psychiatry

Probably the MCA per se has made no difference to the engagement of eating disorders services with carers – they have always been seen as very important and good services will always want to engage with them as fully as possible.

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

Comment from the Faculty of the Psychiatry of Intellectual Disability

The Faculty is aware of some delays at the Court of Protection.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

No comment.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

No comment.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

No comment.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

No comment.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

No comment.

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

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17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

**General Comment**

The College agrees with the concerns raised by other organisations and individuals that these safeguards are not uniformly available to vulnerable individuals as evidenced by the variation in the application of these safeguards, lack of easy access to a body to challenge decision making and poor uptake of IMCAs.

A small survey of Intellectual Disability psychiatrists suggested that, where there is a high level of awareness, regular training, good access to experts, those working regularly as eligibility / capacity / mental health assessors have a generally positive view of these provisions. 297

There is some anecdotal evidence that where MCA / DOLS works well there is promotion of person centred care and protection of rights.

**Comment from the Faculty of Child and Adolescent Psychiatry**

There is a discrepancy in that the MCA applies to people aged 16-17 years, but DoLs safeguards only apply to people aged 18 and over.

**Comment from the Section of Eating Disorders Psychiatry**

There are still a group of patients, informally in hospital, about whom there are dilemmas as to whether Deprivation of Liberty is taking place or not. An admission to hospital for treatment of a severe eating disorder involves a stay in a very structured environment, which is necessary to manage both the physical and psychological risks of the disorder. For example there is no choice over meal times, patients are expected to complete meals, fluids, exercise and time off the unit are all strictly regulated. Patients who are admitted are often of critically low BMI and have more or less subtle cognitive impairments.

**Comment from the Faculty of the Psychiatry of Old Age**

DoLs has failed - the process is too complicated and restrictive.

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

**No comment.**

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

No comment.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

No comment.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

Comment from the Faculty of the Psychiatry of Old Age

Generally these procedures and systems are gaining momentum and becoming more useful. The systems should not be changed as they are complicated enough.

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

General Comment

To what extent knowledge of the Act is translated into practice is difficult to identify as, at its heart, are a set of behaviours and attitudes that promote fundamental rights.

The College is working with CQC to identify key quality measures.

While poor documentation of capacity assessment / best interests/ person centred plans suggest MCA principles are not being implemented, good documentation does not necessarily guarantee an MCA rights promoting culture – although it may be a starting point to capture good practice.

The College could assist in raising the quality of care that people lacking capacity receive from psychiatrists who are involved with MCA assessments and DOLS by providing feedback on their use of the Act compared to nationally agreed standards and the performance of peers. To achieve this aim the College would: develop a series of auditable standards on use of the Mental Capacity Act; develop a data entry and management system that would allow those participating in the audit to assess their practice against these standards and against the performance of their peers; provide a summary of audit findings for those clinicians that participate in two or more rounds of the audit that can be incorporated into the revalidation portfolio; and provide national aggregated data to NHS England, national and local commissioners of mental health services, Mental Health Trusts and other provider organisations on adherence to national standards at the level of Trusts, County districts/ Boroughs and across England and Wales. Such work would require a modest amount of funding estimated at around £100,000 for a nine month pilot study (phase one) which would be sufficient to develop auditable standards and pilot these across the country.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Comment from the Section of Eating Disorders Psychiatry

The role of the old MHA Commission in inspection of the implementation of the MHA was pretty well understood by Trusts and clinicians, but it is less straightforward for the CQC to assess the implementation of the MCA. They tend to look for the word ‘capacity’ in notes, which is some indication of the awareness of capacity issues.

Comment from the Faculty of the Psychiatry of Old Age

CQC have failed in regulating use of MCA; there is a need for senior clinicians to be involved in regulating.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

General Comment

The GMC is unlikely to have a major role in regulating work carried out under the MCA as the level of information collected for revalidation is too aggregated to identify performance relating to the MCA unless there were gross violations of professional behaviour. Additionally, the GMC regulates individuals whereas team culture will also be an important component of good practice.

For some professions such as psychiatrists it may be possible to expand appraisal documentation to include specific evidence of training and performance in use of mental health legislation utilising the usual measures used to assess good medical practice in other domains of work. The College is currently in the early phases of exploring this in relation to both Section 12 / Approved Clinician roles and this could easily be extended to include work under the MCA.

24. How well is the relationship with the mental health system and legislation understood in practice?

General Comment

The College welcomes the recent research from the University of Cambridge “Understanding the Interface between the Mental Capacity Act’s Deprivation of Liberty Safeguards (MCA – DOLS) and the Mental Health Act (MHA)” and understand this team will be making a separate submission.

The College would recommend that consideration is given to revising both the MHA and MCA Codes of Practice to offer further clarification of difficult areas. Practitioners from all professions also found it helpful and supportive of clinical practice when the Department of Health published guidance as part of the implementation strategy. Consideration should be given to producing simple guidance focusing on the practical application of the Act and interpreting complex case law for frontline practitioners. A decision-making tree could be helpful in this regard.
Previously the Mental Health Act Commission produced practice guidance and consideration should be given to CQC producing guidance on the MCA / MHA interface. The College would be pleased to contribute to advising on areas of confusion.

Areas that would benefit from clarification

A clear statement that the approach to assessing if someone is deprived of their liberty in a psychiatric hospital does not rely solely on the presence of active objection but should take into account factors that would point to deprivation of liberty as outlined in DOLS guidance. Pointers such as *not free to go* or *staff exercising full and effective control* are simple and easily understandable pointers to thinking about whether there is a deprivation of liberty.

Clarity about this would reduce the unacceptable situation where a team correctly identifies that a deprivation of liberty is occurring but the eligibility assessor under the DOLS regime concludes that the person is ineligible for the safeguards and is more appropriately detained under the MHA to protect Article rights but then the MHA assessment team conclude they cannot use the MHA as the incapacitated person is not trying to leave or refuse treatment.

A common problem, and a situation that is advised against in DoLS code, is holding separate assessments for DoLS and MHA, with separate personnel. Much better, if there is any doubt about which Act will provide the appropriate framework to protect rights, is to combine the two assessments, and work together. As DoLS code points out this is less stressful for the patient too.

For non-objecting persons who lack capacity admitted for assessment or treatment to a psychiatric hospital but who are deprived of their liberty the College would favour a clear statement that the MHA should be the preferred statutory route (assuming criteria are met) to protect Article 5 rights as it is the legally defensible route, provides much clearer and accessible safeguards for patients and is a statutory regime that is much more familiar to staff. The rule of thumb would be that the MHA will most always be used in a psychiatric setting and the Deprivation of Liberty Safeguards would only be used in very limited situations (which could be described) in a psychiatric hospital.

This would address the problem of ‘de facto detention’ and may result in closer scrutiny of individual care plans with a view to limiting the restrictions a person may be subject to and therefore the necessity to detain under the MHA. Rather than increase detentions such an approach could serve to promote fundamental rights.

Comment from the Section of Eating Disorders Psychiatry

There has emerged a sort of consensus that the Mental Health Act needs to be used in preference to the MCA.

Comment from the Faculty of the Psychiatry of Old Age

298 Monitoring the use of the MHA 2011 -12 p34. See quote regarding misunderstanding of powers under MCA

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
If at all possible psychiatrists defer to the Mental Health Act; this is often not the least restrictive option.

Comment from the Faculty of Child and Adolescent Psychiatry

The Faculty supports the primacy of the Children Act, and would like the Committee to consider the intersection between the MCA and the Family Reform law Act. This allows parental responsibility to trump incapacitous decisions by 16-18 year olds, which is therefore legal but probably not best practice.

25. Does the implementation of the Mental Capacity Act differ significantly in Wales?

No comment.

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

A view from the RCPsych Scottish Division:

The principles of the Adults with Incapacity Act are sound.

In light of Bournewood Scots Incapacity Law is also in need of reform, specifically the relationship between guardianship appointments and deprivation of liberty.

Definition of incapacity

- The MCA definition says nothing about the capacity to act. In Scotland, even though there is a requirement to assess capacity to act, there is uncertainty as to issues of undue influence. See the MWCS reports on Mr and Mrs D. http://www.mwcscot.org.uk/media/56140/powers_of_attorney_and_their_safeguards.pdf

- Memory and decision-making.
  The MCA requires that P must be able to retain information for long enough to make a decision. The AWI in Scotland requires the adult to retain the memory of decisions. In the latter case, guidance is that spontaneous recall of the decision is not necessary but, if the adult does not spontaneously recall the decision, he must either agree with the decision when presented with a record of it or make the same decision consistently given the same information

Powers of attorney

- There is some controversy in Scotland as to whether or not welfare attorneys can use their power to deprive an adult of liberty. There would be no independent periodic judicial review and therefore it may be incompatible with ECHR. The MCA may have the same problem, even though it is prescribed in the act that the attorney may authorise restraint.
- Also, see above report on possible abuse of the powers

Financial management

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Royal College of Psychiatrists – Written evidence

- Part three of AWI was intended to set up a simple mechanism to manage the adult’s funds. Uptake has been low due to lack of awareness and some difficulty interpreting the powers.
- Also, part four on managing residents’ funds has not worked well in care homes. Providers do not want to take on added responsibilities.

Medical treatment
- In Scotland, incapacity in relation to medical treatment requires certification. For ongoing complex treatment, an additional treatment plan may be required. Compliance with this part of the act is improving but still incomplete, especially in general hospitals and care homes. [http://www.mwcscot.org.uk/media/127960/section_47_report.pdf](http://www.mwcscot.org.uk/media/127960/section_47_report.pdf). There is no general authority to treat. A suggested “in-between” provision is the requirement for a principle-based statement in the case record as to why the treatment should proceed.
- The use of force for medical treatment is a problem in Scotland. See the MWC report “Right to Treat” [http://www.mwcscot.org.uk/media/51822/Right%20to%20Treat.pdf](http://www.mwcscot.org.uk/media/51822/Right%20to%20Treat.pdf).

Guardianship and deprivation of liberty
- Scotland has no equivalent of the DoL safeguards. There are a number of options, but the “Bournewood gap” remains an issue and is the current subject of a Scottish Law Commission consultation.
- In hospital, the adult should be detained under mental health legislation if wishing to leave. The decision will depend on the frequency of requests to leave and whether or not the adult accepts reasons to stay in hospital and agrees to do so. For informal patients, section 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a mechanism to appeal “de facto” detention to the tribunal.
- In care homes, and to effect admission to care homes, the choice lies between welfare guardianship under the 2000 Act or S13ZA of the Social Work Scotland Act 1968. Guardianship is necessary if the adult resists or if there is dispute as to the best form of care. S13ZA is designed to be used for the compliant adult who lacks capacity.
- The use of welfare guardianship continues to rise and places severe demands on practitioner and court time. There are ideas for future “graded guardianship” where only guardianship that deprives the adult of liberty would require court authorisation.
- Deprivation of liberty remains a concept that defies a clear definition. There is a recent analysis of the law as it applies to Scotland on the MWC website. [http://www.mwcscot.org.uk/media/124856/mwc_deprivation_of_libertyanalysis-2.pdf](http://www.mwcscot.org.uk/media/124856/mwc_deprivation_of_libertyanalysis-2.pdf).
- A major problem for mental health practitioners in Scotland is the lack of a mechanism to intervene quickly using the Adults with Incapacity Act. This can subject individuals to potentially unlawful deprivation of liberty while a guardianship application is being made, or result in (arguably) inappropriate use of mental health legislation.

A view from the RCPsych NI Division

Northern Ireland is in the process of developing a single, comprehensive legislative framework which will embrace the reform of our mental health legislation and the introduction of capacity legislation. A rights-based approach is the guiding principle.

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Professor McClelland, Chair of the Bamford Review of Mental Health & Learning Disability, describes it as “respect for the decisions of all who are assumed to have capacity to make their own decisions”. The proposed legislation aims to protect both the individual and members of the community where a person’s decision making capacity is impaired but recognises that restriction cannot be imposed on those who have decision making capacity. Appropriate Criminal Justice Legislation must be provide to support this.

The NI Division welcomes the direction of travel of the reform, but cannot comment on the final detail until it becomes available.

In developing the legislation the DHSSPS drafting team and the Department of Justice Team have both been involved to ensure there is a well functioning interface. The legislation is due out for consultation next year.

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

No comment.

5 September 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Royal Hospital for Neuro-disability – Written evidence

To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The MCA has provided a framework for research projects to recruit participants who cannot consent for themselves. The MCA has clarified how researchers could enrol people who lack capacity and how consultees could be involved.

The aim of the Mental Capacity Act is to ‘make a real difference to the lives of people who lack capacity…..to empower people to make decisions for themselves wherever possible and protect people who lack capacity by providing a flexible framework.’ There is considerable evidence that the MCA has made the management of ‘p’s’ affairs more flexible in some respects with that person being able to manage some of his/her assets within limits under the supervision of the deputy and it is has enshrined the rights of informal carers to manage day to day decisions for the person where necessary. The introduction of the Health and Welfare Deputyships and Attorneyships are reported as being a helpful means to ensure that a person’s rights are advocated for on matters outside management of a person’s property and affairs and has been particularly welcomed by those carers of people with a learning disability and in situations where there are disputes regarding placement or serious medical decisions. The introduction of DOLs through the Mental Health Act following the Bournewood Judgement have been a welcome contribution in specific situations in care homes and hospitals by providing a formal process for permission for restraint and containment if this is clearly demonstrated as being in the person’s best interests though the process has been criticised by many as being too complex and unwieldy for ease of use and, therefore, possibly has discouraged some from using it. The Code of practice provides an essential handbook for informal and formal representatives but the expectation that all deputies should be familiar with its entire contents is somewhat unrealistic. The common statement by deputies and attorneys is that they are swamped with paperwork and do not find it easy to access advice from the relevant departments. Some professional and lay deputies who have transitioned from receiverships to deputyships have criticised the Ministry of Justice for adding to their burden by new and over complicated processes and new deputies and attorneys have equally criticised the Ministry of Justice for introducing a very onerous system which is costly and is not easy to operate and which often necessitates the instruction of a lawyer for formalities at some considerable cost which lay receivers used to be able to manage independently. Many have criticised that six years after the introduction of the Act many financial institutions still do not appear to recognise deputyships despite reference to it being included in the British Banking Authority regulations and thus the role of the financial representative can be increasingly difficult if this is the case. The length of time from application to Order is also reported as being too long which means that financial representatives are left having to lend or borrow money for the client for considerable periods of time if for instance the client is placed in a care home and deemed a self funder and if that person’s assets are mainly in the ownership of a house that cannot be sold without an Order from the Court.

Which areas of the Act, if any, require amendment; and how?

The machinery of the Ministry of Justice with particular reference to the Court of Protection and the Office of the Public Guardian is very complex and it is reported that deputies and attorneys and those involved in supporting them can find the paperwork
and processes overwhelmingly difficult and are fearful of falling foul of their responsibilities in some cases. There is considerable high feeling about the costs involved, particularly if a deputy has to go back to Court to change their Order for even the smallest reason. The significant split between the COP and OPG is criticised by some for creating more work and anxiety for deputies as communication between them is said to be poor at times. The Code of practice is helpful but it does not always reflect what the associated paperwork states. For instance 4.42 of the Code sets out a range of professionals who can assess capacity for complex decision making but yet the COP 3 form sets out a much more limited range of professionals. This means in effect that the stated requirement for the person to assess capacity to be a professional who knows the person well cannot necessarily be complied with. Social workers are not named as possible assessors on the COP 3 form for instance (despite being referenced in the Code of Practice) yet social workers are often the professionals who know the person well, have identified the need for the client have their affairs protected through he court process and are involved in supporting the person through an application to the Court.

Health and Welfare deputyships have been limited in being authorised and this matter needs to be reviewed and an explanation given as to what rationale there is for such an application to be accepted. If the rationale were made clearer it might prevent many of the applications being made and failing. At present approximately only 10% of Health and Welfare Deputyships are being accepted. Additionally if this matter is reviewed it might mean that more might succeed.

There continues to be a very varied application of DOLs countrywide and this needs to be reviewed and further guidance issued to help those in hospitals and care homes to understand this process.

3 At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

These seem to be appropriate. There are some difficulties in understanding that research isn’t based on best interest of the individual but best interest of the group which makes it very difficult for patients controls group to be integrated in the research design.

There is considerable evidence that seeking assessments of capacity is not always easy as there are apparently a limited number of professions which are allowed to do this and also not all professionals are clear as to how to undertake an assessment. This is certainly with regards to the application for a deputyship. It is suggested that the list of professions be broadened to include for instance social workers and other social care workers and professionals who may work closely with the person. This might be considered better practice and it would also spread the load from the current limited pool of assessors. Best interest decision making provides a broad reaching reference point which is widely understood though at times can be confused with substituted judgement. It is suggested that guidance information should set out the difference between the two more clearly. Best interests decisions are guided by a statutory checklist focusing on the client’s needs but can also reflect broader issues and can incorporate the needs of others. It is generally agreed that best interests are preferable to substituted judgement and the Bolam test which were in use prior to the Act.

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Implementation

4 To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

1. The principle of presumed capacity has been very useful in frontline practice.

2. Giving people all the appropriate help/support that they need to make a decision has been more difficult. Some people continue to regard the need for support in making a decision as evidence of a lack of capacity. Also within this organisation we are used to working with specialist services and have a much wider understanding of what this support might entail. Others with less experience in this area judge very differently what support is possible or indeed viable within their resources rather than what the needs of the patient are.

3. Where individuals do wish to make what others may perceive to be unwise decisions despite, demonstrating clear reasoning, it continues to be met by others (particularly family members) as demonstrating a lack of capacity.

4. Our experience of best interests decisions has been that generally they are managed well by professionals but it is clear that many family members do not understand the principles of best interests.

5. Finding the least restrictive intervention does appear to have caused a great deal of confusion at the interface between MCA and DoLs. Individuals need to be quicker to seek suitable guidance from professionals with a good understanding of the Act to ensure that least restrictive options are developed and observed.

At the frontline the evidence of implementation of the MCA lies within patient notes and reports, care plans, legal forms and forms such as the health needs assessments or community care assessments which are used on a national basis. It also lies in the arrangement of financial representation for the person who lacks capacity, health and welfare representation, best interest decision making, the inclusion of the IMCA service if needed, the consideration of DOLs, involvement of family and others as representatives of the person.

Overall if the five principles are followed, the balance between enablement and protection is likely to be satisfactory though there can be significant resource implications for instance where there are extreme communication issues and these resources are not always available. However where these principles are not followed or for instance the application of them is inconsistent or where the person has fluctuating capacity there may be a shift towards over or under protection.

5 How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

The implementation plan occurred when it was not clear how the Act would work and when aspects of it were not clear (such as a recommendation for IMCAs without In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
clear knowledge of who they would be, what their training would be, how accessible they would be etc). Since the original implementation training in this area for professionals has been very accessible, although at a cost.

There has been sustainable change in the professional arena but this is not matched for families who do not know about the act and whether they are given or find helpful information is very variable. Bad press has not helped to give the public confidence. Note the recent indictment on the Court of Protection as being a ‘secret court’. Charities such as Age UK, the Alzheimer’s Society, Mind, Mencap, Citizen’s Advice Bureaux and Headway have played an important part in making information available to families and individuals about mental capacity as have legal firms, local authorities and professional bodies. Online information is accessible to those who are IT literate but not to many of the elderly or those who are unable for whatever reason to be able to access online information. Online information can only ever form part of the information people need and it is increasingly difficult due to cutbacks and other priorities for people to get satisfactory human support on this matter which has a negative impact on families and individuals.

6 Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

The Act is apparently widely known about within the legal, banking, health and social care sectors but there is great variation in the understanding of it across these and other sectors. Financial institutions vary considerable in their understanding of financial representation and need to be upskilled urgently. Some practitioners make significant charges for completing paperwork and guidance on this is urgently needed.

Typically when the Act is poorly applied individuals err on the side of protection rather than enablement, particularly when others perceive decisions as unwise.

It is still common for there to be a lack of understanding that capacity is decision and time specific.

7 Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

The Act does not appear to be well known by people affected or by their non-professional carers. Those who have a close relationship with the affected party will typically take a highly risk averse approach to decision making. Lay deputies and attorneys report difficulty in understanding the complex information detailing the processes, have difficulty in completing the relevant paperwork and in accessing suitable help to explain it to them and to support them through the processes unless they pay a considerable fee for this. Even then they can get wrong advice and find that for instance they have to go back to court to have their Order changed as they have not stipulated that they need to sell a property.

Where a person is judged to lack capacity in a certain area the Act could go further in supporting people in making least restrictive option decisions.
Typically carers appear to be well protected in so much as we have not heard of any action being taken against carers who have taken overly protective decisions.

8 Has the Act ushered in the expected, or any, change in the culture of care?

The Act has caused organisations and professions to consider involving patients in decision making processes more, the principal of the presumption of capacity has helped this. Carers acting as lay deputies often report that they are very anxious about managing a person’s finances in case they are accused of mismanagement of it. They often report that it is difficult to get advice from the Office of the Public Guardian particularly as it cannot give legal or financial advice. With the change in the charging arrangements by independent financial advisers deputies and attorneys are worried about the cost of this advice which often they might actually not use ultimately.

9 Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

It is assumed that the COP and OPG should have this data as should they monitoring applications.

Decision making

10 Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

There is evidence that this is so. Some deputies and attorneys allow the person to be able to make a range of day to day decisions and some allow the person to handle various amounts of their assets depending on their abilities. This is more flexible than it appeared to be under receiverships. The counter to this is that people are ever more risk averse and this may have an impact in some situations.

11 What evidence is there that advance decisions to refuse treatment are being made and followed?

Our experience here is variable. Advance decisions are encouraged with patients with a degenerative disorder (HD) and where they have been made they are followed here.

One of the important factors on this topic is that decisions should be regularly reviewed and updated as people change their minds particularly if they have an illness which advances.

12 Has the MCA fostered appropriate involvement of carers and families in decision-making?

From a professional perspective it has certainly helped having better definitions and guidance when best interest decisions are needed. I would suspect that some
families find it very helpful because they feel a reduction on pressure on themselves but for others it is extremely difficult if best interest decisions are reached which do not mirror their own views.

The MCA has enshrined the rights of carers to make day to day decisions lawfully. It has involved carers in formal decision making matters. There are added protocols being introduced increasingly in the NHS and by local authorities which make decision making more inclusive of informal carers.

13 Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

Now that there are IMCA’s available to complete this work they have demonstrated the ability to provide a voice for clients where required. We have seen some variability in their knowledge of the Act and the degree to which they engage with clients.

The IMCA service helps also to ensure that the decision making process follows relevant protocols.

14 Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

IMCA services appear to vary. Their involvement will depend on the knowledge and training of their referrers to some extent. Their role is not always clear to professionals who sometimes have the wrong expectations of them.

15 Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

No – great variability. See response to question 13 above.

The IMCA services would be best placed to discuss the resourcing of their services.

Deprivation of Liberty Safeguards

16 Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

Generally they appear to be adequate to protect clients. Emphasis on the ‘least restrictive options’ and exploring all alternatives before embarking on a course to deprive someone of their liberty has been a positive change to cultural practices

DOLs appears to vary greatly in its implementation across the country and this gives cause for concern about how it is understood and if people have adequate training in it.

The complex processes of applying for a DOLs may account for some of the national variation in take up.

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17 Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

The system for implementing DoLS could be quicker if it is to carry out its safeguarding role adequately. Incidents where liberty is temporarily deprived can resolve prior to the DoLS process taking place. Such situations could lead to bad practice where least restrictive methods are not followed.

The paperwork assumes considerable resourcing and training in organisations to carry it out

The Court of Protection and the Office of the Public Guardian

18 Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

No they are not well understood by other professionals and family members. For example the Office of Public Guardian information is accessible via internet – but only a small portion of info about the office on the ministry of justice page. Provides forms but with no explanation/direction of which ones are appropriate to complete for which circumstances and what the forms are for. It assumes some background knowledge. More leaflets could be available for those without internet access. The new website is not as accessible as the previous one was. The communication between the COP and OPG is poor at times and users find that, and the lack of helpful advice, very frustrating. Those who were receivers often bemoan the loss of caseworkers who knew their particular case. They say that the current system is impersonal at times.

19 What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

Substantial impact. Attorneys have been involved in decision making for current treatment practices and also decisions regarding finances/funds etc., have attended all formal meetings in regards to patient’s care. Appear to have more influence over welfare decisions than clinical decisions however, but are kept well-informed of clinical reasoning, treatment and how to continue care upon discharge. Patients appear happy with arrangement of LPAs.

Difficulties may arise with joint LPAs in discordant families. This has been managed by having clear discussions, providing regular updated information and considering patient’s preferences. In worst case – discussing changes to LPA arrangements.

In general we come across more LPAs for property and financial affairs than health and welfare.

20 What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

Relatives become very concerned about costs for the Court of Protection, as well as the length of time it takes for an application to succeed. Some costs appear to be
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21 Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

We are aware that there are huge reforms to legal aid taking place to reduce government spending and that legal aid will be significantly reduced. Those suffering from brain injuries / mental health problems will likely be affected by the blanket removal of civil legal aid which covers issues such as housing, debt, welfare etc. We understand there will be a ‘telephone advice only’ system available under new proposals, which are totally inappropriate for many people with brain injuries / mental health issues and others. Those on state benefits will also be asked to contribute larger sums to their legal aid bill than previously, making legal advice almost impossible to access for those on low incomes.

Regulation

22 Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

The Care Quality Commission should work more closely with institutions in advising them of the required standards within the context of the particular environment.

23 Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

This should not be necessary as the requirements might conflict and effort might be duplicated.

Other legislation

24 How well is the relationship with the mental health system and legislation understood in practice?

Within Neurological settings there is limited understanding of this amongst professionals. There is a dependence on Psychologists and Psychiatrists to identify, act on and disseminate this information.

There appears to be overlap between the two acts though the Mental Health Act trumps the Mental Capacity Act regarding detainment.

Devolved administrations and international context

25 Does the implementation of the Mental Capacity Act differ significantly in Wales?

N/A

26 What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

In order to protect individuals, the Committee has chosen in some cases to remove identifying information from the submissions.
27 Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

N/A

2 September 2013

ALEX RUCK KEENE, NEIL ALLEN, VICTORIA BUTLER-COLE, ANDREW BOWMER, JULIE CORNES, CHARLOTTE HAYWORTH HIRD, LAURA HOBEE-HAMSHER, LAURA JOLLEY, JOHN McKENDRICK, POLLY SWEENEY, RACHEL TURNER AND PAULA SCULLY – WRITTEN EVIDENCE

Submission to be found under Victoria Butler-Cole in Volume 1.

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TUESDAY 12 NOVEMBER 2013

Members present

Lord Hardie (Chairman)
Baroness Barker
Baroness Browning
Lord Faulks
Baroness Hollins
Baroness McIntosh of Hudnall
Baroness Shephard of Northwold
Lord Swinfen

Examination of Witnesses

Alex Ruck Keene, 39 Essex Street Chambers, Alex Rook, Partner, Public Law Department, Irwin Mitchell LLP, Julia Lomas, Partner, National Head of Court of Protection Department, Irwin Mitchell LLP, and Michael Mylonas QC, Barrister, Serjeants’ Inn Chambers

Q247 The Chairman: Good morning and welcome to Mr Mylonas, Mr Keene, Mr Rook and Ms Lomas. Thank you for your written submissions. This session is intended to supplement them with matters that the Committee wishes to explore further. I should tell you, as you are probably aware, that the session is being recorded and transcribed, and is being broadcast on the parliamentary channel. We have a lot of ground to cover in the limited time available, so could I ask the witnesses—I am sure you will do this anyway—to answer the questions as directly and succinctly as possible? If you agree with another witness, it would be useful that you say so but not repeat their evidence.

I start by saying that when the Act was in contemplation, the reason why primary legislation was preferred to codes of practice or government guidelines was to provide the prospect of redress against bad practice. We have heard a lot of evidence that the law is frequently not complied with, with no sanctions being applied and breaches seldom prosecuted. Could I ask: has the Act been as effective as anticipated in changing practice? Is the answer to that

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question different when one thinks about health and welfare issues, as opposed to financial matters? Can I start first with health and welfare, and start with Mr Mylonas?

**Michael Mylonas QC:** Insofar as health and welfare are concerned, we thought that the decisions were being taken very adequately by the judges exercising their inherent jurisdiction previously. There has been an advantage in that the new legislation codifies the way in which the courts approach it, so there is perhaps more uniformity about the way in which decisions are taken. Certainly in terms of the acute decisions, end-of-life cases or cases where one is providing treatment against a patient’s stated desires, we think that the system has provided a codification to it but has not necessarily improved it.

**Alex Ruck Keene:** What I would say is that, purely limiting myself to the Court of Protection, which is really the area I know most about, as opposed to speaking more generally about a culture change, there is only so much that the Court of Protection can do to bring about the culture change—all the witnesses, almost without exception, have used that phrase—that the Act embodies. It is incredibly important not to underestimate the power of judgments such as the Neary judgment. Of course, you will be hearing from Mr Neary later on. There has been a great deal of publicity about those judgments. It seems to me that the aspect of publicity of judgments such as Neary cannot be underestimated and emphasises how important it is that the current president focuses on transparency in the Court of Protection, and trying to increase the amount of knowledge of the Court of Protection and of the consequences, to put it negatively, for instance to public bodies if they get decisions wrong, but also of how complex and difficult decisions can be made on behalf of people without capacity.

The only other point I would make in that regard is to emphasise the importance of the recent Supreme Court decision in the Aintree v James case, which, as I am sure the Committee knows, was the first case in which the Supreme Court has considered the Mental Capacity Act. The judgment of Baroness Hale is one that I think we will be studying for a very long time. The fact that she emphasised that the purpose of the best interests test is to consider matters from the patient’s or from the person’s point of view is something that has come down from the highest court in the land. I know that all those who practise in the area will be emphasising that message loud and clear. That is how important the Court of Protection is, which is all I can really speak to in this area.

**Alex Rook:** Part of the problem with the Court of Protection is that it is a forward-looking court, which is generally a good thing. When you come to the court, the question before it is: what is in this person’s best interests? The court is often described as being inquisitorial rather than adversarial. You do not win or lose: you just establish what is in this person’s best interests. That almost acts as a disincentive to look at what has happened in order to get there in the first place. I am sure as well, partly due to resources and time, that the court is quite often quite reluctant to look at what has gone wrong rather than at how we solve it. That is perhaps in contrast to a lot of other civil proceedings, where you are generally looking backwards and saying, “What has happened there? Was it right or was it wrong?”.

As a case example, we acted for an elderly lady who went from her own home into hospital and was then moved from hospital into a care home. Then, once she was in the care home, an authorisation of her deprivation of liberty was made. That was plainly too late.
court tends to say that is too late and to express some disappointment at that, but it does not go much further, because the court is actually looking at the primary question: should she be in that care home or should she go home? There is not really emphasis in the court to actually look at that non-compliance that has already taken place, if that makes sense.

The Chairman: Do you regret that?

Alex Rook: Yes, I do. The counterargument to that is that we want the court to be accessible and user friendly and we want to encourage its use. In most civil proceedings, the remedy where a body does something wrong is an order against them in costs. The normal rule is that the loser pays the winner’s cost. In welfare proceedings in the Court of Protection, that is not the normal rule; the normal rule is no order. The unfortunate consequence of that is that where there is non-compliance, cost orders do not flow from that quite often. That means that there is an element of getting away with it, rather than a brighter light being shone on that authority, saying, “Look, that was not right”, and therefore encouraging better practice going forward.

Alex referred to the Neary case, which is a classic example of that light being shone, but that is quite an unusual case, and quite an extreme case frankly. A lot of the examples that the Committee has heard before, from charities for example, tend to be about more day-to-day issues, where families feel they are not being consulted or their views are not adequately being put. Those are not the kinds of things that are likely to end up in a cost order.

Q248 The Chairman: Could I ask about the financial aspect of the question, Ms Lomas?

Julia Lomas: Absolutely. I have practised in this area both under the old legislation and the new. Therefore, I have managed my clients’ affairs both under a receivership and under a deputyship. From my point of view, the Mental Capacity Act has taken matters a huge step forward, inasmuch as under the old system there was no welfare jurisdiction. Now, there are occasions when I do need to think about things other than the property and affairs of my clients. In those situations, I will consult my colleague on my right. It is extremely helpful to have access to that particular jurisdiction.

The majority of my clients, I have to say—although not exclusively—are clients who have an acquired brain injury and have received large damages awards. That does not, however, mean that I do not have clients on my list of much more modest means. We have quite a lot of referrals through from charities such as Age UK. In those situations, it is usually families making inquiries about the need to take over perhaps an elderly relative’s affairs, because mum has gone into a nursing home, for example. They cannot access bank accounts in order to be able to pay fees and the like. I think that for people of more modest means it can be hugely difficult. I do not think that the banks, for example, are always as helpful as they could be. Sometimes it is because of other conflicting legislation; sometimes it is through lack of understanding and awareness. Very few banks actually have somebody in branch who understands the workings of the Court of Protection Act, and will frequently ask, “Have you got a power of attorney?”.

It is not easy and costs are prohibitive, because for modest estates you are talking about a £400 application fee. Even if you can get a solicitor perhaps to wave their fees, you still have
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a court fee to pay. There is means-testing but, of course, there can be money in the bank account that you cannot get at, so you are in a catch-22 situation. That is also a difficulty.

In terms of financial abuse, unfortunately I have had instances on my case list where I believe there is evidence of financial abuse and I have tried to take that forward. Again, there can be difficulty with organisations such as the banks giving the evidence, and with the police perhaps not understanding this area, and then the Crown Prosecution Service actually declining to bring a prosecution because of the difficulties, sometimes, of the evidence, where perhaps your main witness lacks capacity. It is not easy and it is quite encouraging to have seen the recent cases that have hit the news where successful prosecutions have been brought.

Q249 Lord Faulks: Julia Lomas, may I ask you this? You have a perspective, first of all, as acting as a receiver and as a deputy for people who have received large sums of money by way of damages. I have seen, and perhaps you could comment on this, statements from solicitors acting as a receiver, claiming very large sums of money in order to discharge their duties to look after somebody who lacks capacity, on the basis that they have to be involved a great deal because the Mental Capacity Act requires capacity on a specific basis, so the fees involved are very large. Is that a danger? Although one wants, of course, to adhere to the Mental Capacity Act, it could rather bring the whole thing into some disrepute.

Julia Lomas: There is no doubt at all that the costs of running a deputyship have increased proportionately, as opposed to the costs of receivership. Partly the fees themselves have increased. Obviously hourly rates have increased. However, it is the fact that you have to consult. That is right; you should be consulting P on the decisions that are affecting them on a day-to-day basis, whereas receivership is much more paternalistic and you could use substituted decision. I would not like to go back to that. I think that the ethos of the Mental Capacity Act is correct, but there has to be a recognition that the whole thing slows down, particularly if you have a difficult client, as in my situation, where I have a number of acquired brain injury clients who actually have quite a high level of functioning but impaired cognitive ability and very little insight into their difficulties.

In that situation, if I sat a client in front of me, asked them a question and got the right answer, is that enough? No, not really, because if I then asked that client over a period of time and had evidence of a pattern of behaviour, that pattern of behaviour might demonstrate to me that actually that client did not have the capacity to make that decision in the way that perhaps that first conversation might have suggested.

Q250 Baroness Hollins: Many of the submissions to this inquiry have asked for clarification of the types of decisions that should be ruled on by the Court of Protection. Do you think that such clarification is both possible and necessary?

Alex Ruck Keene: If I may just pick up on that, prior to the coming into effect of the Mental Capacity Act, there was a practice note that the Official Solicitor had issued with the endorsement of the court, explaining the sorts of decisions that should be taken to the High Court for a decision under the inherent jurisdiction and, rather importantly, who should be taking that sort of decision to court. For instance, it outlined in terms of serious medical disputes who should be taking it to court, but it also outlined welfare disputes. That practice note has not been reissued. There is some reference in the Code of Practice to what sorts
of decisions should go to the Court of Protection, but it is not in very concrete language. On the Rules Review Committee, which was convened several years ago to consider changes to the Court of Protection Rules in the light of the first years of our experience of it, we suggested that it would be a jolly good idea, to use a technical term, to revisit and reissue that sort of practice note by way of practice direction. Yes, it would be possible and, in my submission, very helpful to have a document that set out clearly that these are the sorts of decisions that should be taken to the Court of Protection and this is who should be taking them.

One of the big dangers is that where you have a person without capacity who has no family member to kick up a fuss and no one else really to take any issue, if there is a real problem they are entirely reliant on the local authority, if it is that sort of welfare issue, to make sure that the matter is brought to court. Of course, we have the supporting regime IMCAs and Relevant Person’s Representatives, but at the end of the day those cannot properly be said to be entirely disassociated from the local authority. If something very clearly says, “In these sorts of circumstances this needs to go to court”, I would certainly be very much in favour of that.

Alex Rook: If I could add to that, the only point from any of that that I would slightly disagree with is the way in which it is done. Things like Practice Notes, Practice Directions, et cetera, are all very accessible to us as lawyers, but I am not sure they are to the members of the public. It seems to me a classic thing that the public should know about: “This is the kind of decision that is liable or is able to go to a resolution at the Court of Protection”. That seems to me to have to go through the Code, and I know there has been quite a lot of debate before the Committee already about whether or not there needs to be a redrafting of the Code or a tweaking perhaps of the Code. I agree entirely with Alex that there need to be some clarity on it.

At the moment, the Code says “serious decisions affecting healthcare and personal welfare matters”. If you are a layman or member of the public, that is pretty general. What one person thinks is serious is not necessarily what another person does. Also, part of the problem that underpins all this is what happens if this is not a decision that should go to the Court of Protection. If you have a more mundane, day-to-day type of issue and there is a dispute between you and a public body, for example, but it is not an issue that is thought to be sufficiently justiciable to go to the court, how is that resolved? That is a difficult one, because quite often what happens in practice is that the public body thinks of themselves as the ultimate decision maker when in fact that is not right. That has a difficulty. What flows from the question, “Should there be some clarity?” is, “Yes, I think there should be”, but I also think there needs to be some clarity about what happens if it is not a matter for the Court of Protection.

The Chairman: What would you suggest in that situation?

Alex Rook: Again, the Code gives some kinds of suggestions, but it was described before the Committee as motherhood and apple pie. Things like advocates, mediation and genuine engagement with families are really the only way to try to resolve that. There has been some suggestion, again before the Committee, that there should be a tribunal that could look at things, rather than the Court of Protection, although I have to say it is not something of which we would be in favour. I am not sure what it would achieve, because decisions are
already taken at district judge level that are fairly accessible. It is probably equivalent to a Mental Health Review Tribunal already.

**Q251 Baroness McIntosh of Hudnall:** I am interested in this issue in relation to the question of non-compliance and a lack of sanction, which appears to be a problem with this Act. Obviously, what you are saying, Mr Rook, about the issues that are not going to be resolved in the court is true. I would suppose that most such issues are going to be of that nature. If the Act itself is insufficiently robust to put pressure on local authorities in those situations, it appears that it is not really doing what it was originally intended to do. Can you reflect on that for a moment and tell us, any of you, whether you think there is something about the law itself and/or the Code of Practice that can address that matter?

**Alex Rook:** What is inherently difficult about the Mental Capacity Act is that it sets itself, as a piece of legislation, an incredibly difficult task. On the one hand, you have the absolute most complex decisions, like the case of James that we have referred to. On the other hand, you have decisions about what clothes an incapacitated person should wear on a day like today and whether, if you left them to their own devices, they would go out in a T-shirt or something like that. All of it is dealt with in exactly the same piece of legislation with the same approach.

Again, I know that the Committee heard from Mencap, and we drafted a document with them addressing the exact concern that they were raising to us about parents or carers feeling like they were not being consulted about decisions, which quite often can be low level-type decisions. The only answer to that can be better explanation within the Code about how those types of decisions are resolved.

**Baroness McIntosh of Hudnall:** I might put it to you that the problem is that the Mental Capacity Act just is not frightening enough. Is that the case?

**Alex Rook:** It might well be, yes. The answer to that is partly in the cost rule that I talked about previously. The consequence of not acting in compliance with the Act should perhaps be that that public authority is then going to face cost consequences, whereas at the moment the way the rules are drafted means that they rarely do.

**Baroness Hollins:** Can I just follow this up slightly further? It seems to me that one possible difficulty of specifying the types of decisions is that the consequences of the type of decision vary according to the individual. For one person, going out in a T-shirt might be a very small decision, but for another it might be a really major health-limiting decision. In a sense, the type of decision cannot be separated, can it? I just wondered. I can see the point of trying to specify the types of decisions that should be considered, but you are right: it is the whole set of decisions that are being considered.

**Alex Ruck Keene:** One difficulty—well, is it a difficulty?—is that the Mental Capacity Act, unlike lots of pieces of legislation, does not state outcomes. It is about processes. Section 4 of the Mental Capacity Act is very firmly not saying, “In any given case, this is going to be what is in P’s best interests”. It is very firmly saying, “This is what you need to do in order to come to a decision”, so it makes it terribly difficult then to have, as it were, a measurable outcome against which you can say that this local authority or this decision-maker has or has not acted in compliance with the law.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
For instance, the only bit of the Act that really provides a clear sanction in a prosecution sense is Section 44, which is the offence of committing neglect or abuse of someone without capacity. That is a clearly measurable thing that the law says thou shalt not do, but the rest of the Act is so much more subtle. It is incredibly important, but it does make it terribly difficult then to say how one then goes about bringing really measurable outcomes. I think that is one of the reasons, reflecting on all of the transcripts of the evidence that has been given so far, why so many people have been saying that it is a cultural change.

Of course, lurking in the background, as the Committee is incredibly well aware, we have the Convention on the Rights of Persons with Disabilities, which is telling you, by the way, that we probably have not even got it right with the Mental Capacity Act. That is even more of a culture change. As a lawyer practising in the area, when I am confronted with the Convention and what it really means my first instincts are, “I cannot see how that can possibly be right”. As people have helped me to think through cultural changes, I can see what the point is. Those sorts of things are incredibly difficult and take a great deal of time, which goes back to resources, which goes back to training, which goes back to publicity of decisions.

Q252 Baroness Shephard of Northwold: Many submissions to the inquiry have also asked for a statutory definition of what constitutes a deprivation of liberty. Do you think that such a clarification is possible? Is it necessary even?

Michael Mylonas QC: A number of the submissions that we have read so far have highlighted the different judicial interpretations and the onward march. We are all waiting, as I know the Committee is aware, for the Supreme Court’s decision in Cheshire West. I do not know when that will be out, but that will provide, we hope, some helpful analysis. The problem with deprivation of liberty, as with so many of the areas we have discussed this morning, is not what is issued in a practice direction or what clarification is provided by the Supreme Court to advocates, to solicitors, perhaps to heads of legal departments in primary care trusts and the heads of local authorities. The problems are that the people who are responsible for taking these decisions at ground level are healthcare assistants and social workers. With appropriate training, they may be empowered and they may be sufficiently confident to take the right decision.

One of the areas where I perhaps disagree with Alex on my left is that, yes, it is right that the MCA sets out a process. There is no harm in that; it is a very good thing. For once, instead of having to look at reams of judicial authority, there is, in Section 4, what you have to do, with appropriate guidance from the Code as well. What is wrong is that people at the ground level are not actually taking the decision at all. That is where we have cases coming to court where there has been no assessment, or even consideration, of whether there has been a deprivation of liberty. Those are the problems. I am not sure that a wholesale rewriting of the Act or sections of it is necessarily required, rather than an approach to training of the people at the ground level, at the grass-roots level, who are going to be enforcing it.

Lord Justice Munby refers to “nuanced decisions” that have to be taken in a particular context. For example, a patient is out for a walk, appears to be going back to the unit of their own volition and then suddenly stops and wants to go off. You are asking a healthcare
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

Q253 Lord Faulks: Baroness McIntosh, although she put it more elegantly than this, was saying that perhaps we need a bigger stick. Do you think, in view of what you have said, that there is a danger that if you have a big stick you are going to paralyse the process of decision-making in just the way you have described?

Michael Mylonas QC: As I heard that, I could see exactly why the suggestion was there. If there is a little more fear, will it coerce authorities and trusts to provide more training? I am not sure at the moment that that is the way forward, but equally I do not have any answers to deal with the issue of how to compel the state, or the various embodiments of the state that are providing employees, to provide training down the line. To give a personal example, my own father was recently in a home, and it is quite clear from the late-night, frenzied telephone calls that they are terrified of what I, as a barrister specialising in the field, am going to make of what is being done to him. They are extraordinary telephone calls. One speaks to the people treating him when I go at the weekend, and one offers to go and speak to them to provide training because it is clear that they have no idea. On a daily basis, there is a team of them; he is receiving excellent one-to-one care. The one area that really worries them is, “Am I actually depriving him of his liberty? Should I be making an application?”. That is where advice and training needs to be given.

Alex Ruck Keene: One really important thing is that quite often it seems to require, in my experience on the deprivation of liberty side—doing lots of training for deprivation of liberty—the light-bulb to go on for one person in the relevant organisation to go, “Actually, these DoLS safeguards are jolly useful. I can use them as a stick internally to try to push my agenda of trying to empower, for instance, the people in care homes”. I know you heard evidence from Lorraine Currie earlier. What she has done in her area is incredibly helpful and incredibly important. They have a very good DoLS team up and running, and they really push DoLS as empowerment. From a definitional point of view, yes, we will get a definition from Cheshire West, and from the Supreme Court ultimately, but I could not agree with Michael more that it is so much more about the training.

Just to pick up on evidence that was given to you at least in writing by the Mental Health Alliance, this is also about recognising the really critical issue. It is not just Article 5, it is not just deprivation of liberty, it is wherever the state has a degree of control over the incapacitated and making sure that those decisions are taken with a proper degree of scrutiny and a proper degree of respect for P’s best interests. If we focus too narrowly on whether it is a deprivation of liberty or not, although of course we have to because that is what Strasbourg tells us we have to, we risk losing sight of a very important class of person, about whom we really need to make sure proper decisions are being made.

Q254 Baroness Browning: The submissions that we have received, including the one from Serjeants’ Inn Chambers, have flagged up the possibility of opening up a new Bournewood gap. The case of the gentleman who was detained under the Mental Health
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

**Michael Mylonas QC:** I will not go into the background of the specific case, because that is set out in our submissions. The issue only arose because a patient was detained under section under the Mental Health Act, as you have identified, and because of the operation of Section 16A and Schedule 1A he was ineligible to be detained. Those in my chambers, on the instruction of the official solicitor, suggested that in that case justice could be done by including into Section 16A a provision that allowed a deprivation of liberty for treatment that was unrelated to the mental health disorder.

The judge, Mr Justice Baker, said, “I am not prepared to go that far in this case, but what I will do is use the court’s inherent jurisdiction”. It is a way to get around that issue, where you have a patient detained under the Mental Health Act but who requires treatment not for his or her mental health disorder. It is a way of getting around that situation and all the difficulties with the current legislation. I think the solution is straightforward. I hope we have provided one option in our submission, which is simply to include a small revision to Section 16A.

**Baroness Browning:** Can I just clarify this? Are you saying that in the decision on the part of the patient to go on hunger strike he was regarded as having the capacity to make that decision?

**Michael Mylonas QC:** The court’s decision was that the decision to go on hunger strike did not arise out of the mental health issue; it arose because of decisions to try to repatriate him.

**Baroness Browning:** Do you think there is anything we should change now in the existing legislation to close this gap?

**Michael Mylonas QC:** Just for the purposes of the record, we set out in paragraphs 14 and 17 of our submissions proposed revised wording for Section 16A. We think that might be helpful for those contemplating any redrafting. That should close off what might otherwise be a worrying gap. In the interim, we would hope that Mr Justice Baker’s approach could be adopted by any other judges faced with a similar situation.

**Q255 Lord Swinfen:** Are there sufficient protections within the Mental Capacity Act, the operation of the Court of Protection and the Office of the Public Guardian against financial or other abuse of those who lack capacity?

**Julia Lomas:** This comes down to whistleblowing. The Office of the Public Guardian has an investigative section. It also sets security levels and effectively risk assesses particular deputies. Now, at the moment, I know that the Office of the Public Guardian has just started on a consultation exercise to look at whether or not those are effective at the present time. I would say that they are possibly not as good as they could be. They made some adjustments a couple of years ago, and you then had type 2 and type 2A. However, it is very hard to see, other than through the visitors who the Office of the Public Guardian...
sends out, any particularly robust and effective supervision. That can then lead to financial abuse.

When a professional deputy receives an order, frequently that order is extremely wide. One would hope that that professional knows what they are doing. If they do not, they have the bond and they have their indemnity insurance. I am not saying that things do not go wrong, but at least on the professional side if it goes wrong it tends more to be from negligence rather than abuse. I would have concern in some instances, and I would hope that they are the minority rather than the majority, where you have lay deputies acting. I do think that in that situation the supervision ought to be much more robust than it is. Again, I will be contributing to that review with the Office of the Public Guardian.

Alex on my right made the point about publicity. There is an awful lack of understanding and information out there about the Court of Protection, what it can do and how it can be used to help P. I would like to see leaflets in every doctor’s surgery, for example, because the majority of clients under the Court of Protection who have property and affairs deputyships actually do not have acquired brain injuries; they have illness, dementia or whatever. For the ordinary members of the public, there needs to be more information, which in turn would then help people to whistleblow. If they have heard of the Court of Protection, if they think they see that something is not right, they would have the ability and the information to know what to do about it. I do not think that it is as robust as it could be. It could be better.

Also, as far as the Office of the Public Guardian is concerned, one also has to acknowledge that they are extremely short of resources. The population is getting older and living longer, so its workload is obviously going to increase proportionately, yet its resources are not. That is a problem.

\textbf{Lord Swinfen}: How would you improve it? Do you think, for instance, that two people should act together rather than a single person?

\textbf{Julia Lomas}: That can be difficult. The court will appoint joint deputies, but if you are acting jointly and severally, you could have one at the other end of the country, because families these days do not live within a mile of each other anymore. It could be a safeguard, but it can also slow the process down.

\textbf{Q256 Baroness Barker}: Several of our witnesses have talked about the difficulties people have in accessing the court. What do you think are the causes of lack of access to the court or the things that hinder people in making freer use of the court services?

\textbf{Julia Lomas}: In relation to property and affairs, again it is volume. It would help to have the courts regionalised. Some recent changes that the court has made have helped. I know that they are increasing the number of judges. Better training would help, because better consistency would help. We do have to recognise this increase in volume.

\textbf{Baroness Barker}: Is the Court of Protection always the most effective way for somebody to seek enforcement of the Mental Capacity Act, or are there other ways in which they could do it?

\textbf{Michael Mylonas QC}: Do you mind if I deal with that from the health perspective? We deal in chambers with a large number of medical decisions, and they always arise when there
Alex Ruck Keene, Alex Rook, Julia Lomas and Michael Mylonas QC – Oral evidence (QQ 247 – 259)

is an intractable dispute between clinicians and family members. They inevitably arise in the most sensitive cases, often involving the withdrawal of treatment from children, the decision not to provide life-sustaining treatment to children or, as yesterday, the conclusion of a two-day case where a family required a Trust to provide aggressive resuscitation to a 72 year-old father. That was a case where we were much helped by Lady Hale’s judgment in the James case.

In terms of accessing that, there is more publicity, which means that families are empowered to approach the Court of Protection. There is a problem with that. Instead of taking decisions themselves, they feel, particularly with infant cases, “I don’t have to take that decision. I can give it to the judge to deal with”. It is a shame that decisions such as that are now being taken more frequently in the courts when in fact they should better be taken by a team of clinicians. The corollary to that and the answer to your question is that in the course of this last hearing, when we were contemplating the costs of an extremely sensitive High Court judge, of experts from around the country, of clinicians from the north of the country, of and the family having to go through two days of hearing, one wonders about a mediation process that has to be kicked off early on in these disputes, not late on.

The problem that we have and one of the issues that was raised yesterday was the delay in bringing proceedings to the court. By the time they arrive, it is very difficult in fact to give sufficient time, perhaps because somebody’s life is ebbing away. We hear about cases being dealt with in extreme urgency, overnight, over weekends, at two or three o’clock in the morning. We can do that, but decisions like that should be taken when all the parties have more time to collect their evidence, and I remember—I think it was mentioned in the submissions—a case that was brought so late that we had to take evidence over a mobile phone in the middle of a court in London from a family who were running a shop in a town up north. Whilst important evidence as to what their family member would have wanted in their dying moments was being taken, we heard the ding-dong of the doorbell of the shop as the door open and shut and the mother was continuing to serve.

Cases like that should be brought to court much earlier, but fewer cases should be brought, and fewer cases can be brought if there is an alternative mediation process. That will only work, and I am conscious that it is another avenue or workstream, if mediators—trained, emotionally intelligent mediators—are brought in early on, and not brought in by families, because one cannot expect them to go off when they are dealing with all the issues, but are brought in, as in the cases we deal with, by the Trust. For the case that we were dealing with yesterday, it was flagged up in June that there would be an issue. Early on, mediation would save an enormous amount of money. Of course, it would be difficult for whichever organisation is funding it, because it would be an added cost to them, but the saving generally to the country and public’s purse would be very significant.

**Alex Ruck Keene:** Can I just echo that plea from the welfare side? I have seen a number of cases where a good mediator has brought about a truly astonishingly good outcome, especially in the sorts of cases where the underlying issue is a breakdown in trust between a family and a local authority, and the family feeling that people are not listening to them. If you get the mediator and you get the structure, so the family does feel that someone has listened to them—sometimes the local authority wants to feel that someone has listened to them too, but it is really from the family’s perspective—that is incredibly powerful and effective.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
This also picks up on a point that Alex Rook made earlier. The thing about the Court of Protection is that by and large it is not a backwards-looking court, it is forward-looking. It is trying to make decisions about what should be happening going forwards. One of the really important things about mediation is that it is, apart from anything else, trying to salvage relationships that need to be in place. The judge has made the decision about where P should live. The judge then disappears from the case. All the lawyers disappear, but the social workers and the family on the ground have to carry on working together. To divert people off down that course saves money; it saves relationships. It is an incredibly important alternative, which is really just not well publicised enough and not utilised enough.

Alex Rook: Could I just add one more point as well? Again, I agree with every word of that. One other issue that really hinders people’s access to the court is who should bring this to the court in the first place. There is a real lack of clarity. Again, it was one of the issues that was raised in the Neary case. It should be clear in the Code that where there is a dispute, it is incumbent upon that public authority to bring that issue, if it is justiciable, to the court. I do not think that happens quite a lot at the moment.

We hear from a lot from the charities that we work with that, again, families feel that the public authority think that they are the decision-maker. If the Code was clear that, “Where you have a dispute on these types of issues, you, the public authority, need to take that to court”, that would make it much clearer.

I agree 100% with everything that was just said about mediation. The only caveat to all that—the elephant in the room—is funding. Of course, mediation itself still needs to have a paid mediator, and families will often feel, particularly if they are in dispute with a public authority, that they want to have the benefit of legal advice before they go to that mediation. It is definitely something that without question should be encouraged, and again it needs to happen earlier on in the process, but there is still a legal aid question mark there, which we may be about to come to.

The Chairman: The costs would be offset by the savings in the court systems.

Alex Rook: It would definitely end up being more cost-efficient, without question.

Michael Mylonas QC: Could I just add to that? In terms of what is in effect a case management decision, it is perhaps putting the burden on the Trust or the local authority to take the case to court, in the same way that in civil proceedings we now have rigid case management, which requires the parties to confirm that alternative dispute resolution has been considered and rejected, and, tellingly, to require the solicitor who says, “It won’t work”, to draft a witness statement explaining why. If as a precursor to bringing a matter to court a local authority, a primary care trust or NHS England is required to take a decision about mediation and perhaps approach a mediator, that would be one way of kicking that mediation process off.

Q257 Lord Faulks: Just following on from that, the principle in the civil jurisdiction generally is that getting to court means that you have failed. All other avenues ought to be exhausted before you get to court. I suppose one of the problems with having an inquisitorial system, which is the way the Court of Protection works, as opposed to an...
Alex Ruck Keene, Alex Rook, Julia Lomas and Michael Mylonas QC – Oral evidence (QQ 247 – 259)

adversarial one is that people might not quite feel the same incentives to exhaust all alternative remedies before going to the Court of Protection.

Alex Rook: The Code is quite clear that you should try to do that. The Court of Protection is where you have failed to try to resolve this in other ways. Mediation is referred to already. The problem is probably more that people feel slightly unempowered, if that is the right word. There probably needs to be more work with the Legal Aid Agency to make sure that there is funding available for people before you go to court, in order to give that the best chance of succeeding.

Lord Faulks: That leads me to the question: do you think the lack of legal aid, or generally the costs of going into the Court of Protection, are preventing people from accessing the Court of Protection?

Alex Rook: “Yes” is a simple way of responding to that. I know that the Committee has already heard from Nicola Mackintosh, who appeared on behalf of the Law Society but is also a community care lawyer. She raised a number of points about problems with legal aid, every word of which I entirely agree with. When I was considering the question, I had six separate points where there are problems with legal aid, which I might be able to rattle through.

The first is that changes were brought about in April that mean that people who are on a passported benefit, income support for example, still have to pass a capital test, which is proving a real hindrance to people being able to access the court. We hear, often, of where you have a caring family who have saved up an incapacitated person’s benefits for a rainy day, and then find either that they do not qualify for legal aid or that they are going to have to pay those savings over to a lawyer before they can get legal aid. That is the first one.

The second point is that the Legal Aid Agency will only fund cases that engage Article 8, if it involves a family life rather than a private life. The classic example of that would be if you have somebody who is in care home X and there is a dispute about whether they should move to care home Y. The Legal Aid Agency will say that that involves your private life and not your family life, so you will not qualify for legal aid.

The third problem is a real, practical one. It seems almost not worthy of being raised here, but actually it is probably the largest of all of them. It is the need for evidence. The Legal Aid Agency takes a very rigid box-ticking approach to providing three months’ bank statements and providing a benefit letter from within the last month. These are the kinds of things that incapacitated people could often find very difficult to get hold of. In a number of these cases, the person who will have those—their parents, et cetera—may be another party in the proceedings and it is in their interest not to provide it. It causes a huge logjam in getting people to get legal aid and to be able to try to resolve the issues.

My fourth point is about paying for experts, where again the Legal Aid Agency now takes the approach that every party should pay their share of an expert, regardless of whether they have legal aid. You will quite often have family members who may not even want to be in court in the first place, who are then being told, “You are going to have to contribute to the cost of this expert”.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
My fifth one, which is slightly more technical and relates to the paper that I sent in advance, is about the availability of legal aid in DoLS cases. There is what seems to me to be an illogical position that is adopted at the moment, which is that where a standard authorisation is in place and somebody wants to bring a challenge to that, a Section 21A challenge, they will qualify for non-means-tested legal aid. You can challenge that regardless of whether or not your finances take you outside the legal aid threshold. Where the court authorises the deprivation, as opposed to a standard authorisation, you do not. If you have too much money, you will not benefit from legal aid. Similarly, if you are saying, “My family member, et cetera, is being deprived of their liberty”, and the public authority says, “No, they’re not”, you do not get non-means-tested legal aid. Again, that acts as a real bar to them being able to challenge that, because you either have to do it yourself or pay for a lawyer.

The last point about that again comes back to a lot of the points that have been made previously about whether or not there is a stick. Where there has been an unlawful deprivation of liberty, the damages that are awarded in those cases tend to be relatively modest—a few thousand pounds. These cases are often told by the Legal Aid Agency that they do not meet the cost-benefit criteria, which means that the amount of money that it is going to cost to bring this to court does not make it worth while in terms of the amount of money that is successfully claimed on behalf of that person. Of course, we would all say, and I am sure everyone in the room would agree, that a lot of this is not about money but about saying that you have deprived that person of their liberty and it is highlighting bad practice. It means that it is difficult to get legal aid and then there is something called the statutory charge. That means that if you get legal aid and you recover money, you have to pay that back to the Legal Aid Agency. Again, if you are awarded £10,000 in damages because you have been unlawfully deprived of your liberty but your legal fees are either that much or more than it, all that money will then go to the Legal Aid Agency. The actual person who has been deprived of their liberty will get no benefit from it either.

Julia Lomas: Just to add very succinctly, there is no legal aid as far as property and affairs are concerned. The result is that I have no doubt that there are a lot of family members out there who as a result are put off making applications to the Court of Protection, where one is warranted. As a result, I suspect that there is all sorts of creative accounting going on, with banks and post offices and the like.

Q258 Baroness McIntosh of Hudnall: On the question of whether there are other ways of making justice under the Act accessible, you understandably stress mediation as a very important issue. Do any of you think that an intermediary tier of a tribunal-like nature would be a useful way of stepping the process, which eventually might wind up in the Court of Protection?

Alex Ruck Keene: The slight difficulty is, as Alex Rook mentioned earlier, that we have the nominated district judges, who sit pretty much all the way around the country. At least in theory it is very accessible. I know that the current President is really trying to push the regionalisation of the court. From my part, that seems to me an incredibly important aspect. I suppose the question you would have to ask yourself is: what exactly would it be achieving? If the ultimate point is that you need to get to an independent body or independent person who can take a decision, because there is a dispute, the reality is that one is into a judicial arena very quickly, unless you are going down a mediation route. For my part, I do not think that trying to put in a tribunal layer would necessarily add anything.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
We do, though, need much more aggressive time limits on how quickly a case needs to be progressed through the system and how quickly the court would be expecting to see evidence being produced by people. That would then allow decisions to be made quickly. One of the problems is that at the moment, especially on the welfare side, there are quite a lot of cases where there is a lot of evidence-gathering going on but not necessarily in the quickest way possible. Some of it is very important, some of it is perhaps slightly Rolls-Royce. You then end up in a position where really what you needed was a relatively quick decision from a judge about a dispute, without having had umpteen expert reports or independent social workers going out and visiting. Each time one gets an expert report, that is by and large another three months’ delay, because there are so few experts who are able to report.

It is really a question of calibrating to the nature of the dispute what the judge is being asked to do and the timeframe in which they are being asked to do it. That is something that, on the welfare side, people have been feeling their way with. I know that the President is very keen to take a grip and to say, “We have to sort this out and to get it more efficient”.

Baroness McIntosh of Hudnall: In the sorts of circumstances you are describing, what would be the legitimate sources of evidence, for example, that a judge would have access to if he or she were not going to be able, because of time constraints, to go through the whole process of seeking independent expert testimony?

Alex Ruck Keene: I am not for one second saying that you just dispense with the whole thing. It is a question of calibrating what the judge needs. There are incredible powers in the Court of Protection in the Mental Capacity Act, for instance Section 49, to direct reports to be produced by NHS bodies or by local authorities. Then the Court of Protection has the power to require a visitor to report—either a general visitor or a special visitor with a psychiatric qualification. The court already has, in the Mental Capacity Act, a wide range of tools that it can use. It is a slight cultural issue in the way in which welfare proceedings were brought initially and conducted initially. People were finding their way in a new jurisdiction and saying, “We can’t really move without expert evidence on absolutely everything”. I am not for one second—please do not get me wrong—saying that independent evidence is not vital and that expert evidence, where necessary, is not important. However, it is a question of calibrating it, and we are getting there on that.

Julia Lomas: From the point of view of property and affairs deputies, I do not think that tribunals would be helpful. Under receivership, the court had something called nominated officers, and those disappeared when the Mental Capacity Act and deputyship came in. It was realised that that perhaps was not a good decision, and as a result they have arisen out of the ashes like a phoenix and are now called authorised officers. I would like to see the number of those increased, particularly if there is regionalisation of the courts, simply because they can cut through so many of the standard decisions that are needed on property and affairs, such as permission to purchase a property, as a very easy example.

Lord Swinfen: Many submissions to the inquiry have raised the issue of delay in proceedings, particularly those concerning non-controversial decisions affecting finance and property. Is this your experience? What proposals do you have to improve the situation?
Julia Lomas: Yes, it is. I think I have already touched upon this in one of my answers previously, inasmuch as there is a real resource issue. The workload is increasing. There are procedures whereby you can make an urgent application if something is required. Of course, the trouble is that the system becomes abused. If the system is slow and you are not receiving your order through in a timely manner, too many people will try to access the urgent procedures and it will then get clogged up. Generally speaking, and again I think that this is the difference between an experienced professional deputy and the layperson, the experienced professional deputy will know what buttons to push in an urgent situation. A lay applicant will not. That is simply again one of resource.

Q259 The Chairman: Finally, could I ask what your expectations are of the reforms proposed by the president of the Family Division? Will they have a positive impact, in your experience of individuals with families, as far as the Court of Protection is concerned? I am really interested in the fact that although there has been a suggestion of various recommendations or suggestions for improvement, and we have touched upon them—increased regionalisation and what have you—the only one that has been committed to so far is greater transparency.

Alex Ruck Keene: I take this slightly personally, in the sense that I sat on the Rules Review Committee, which was convened two Presidents ago, of the Family Division, where we did an awful lot of work essentially recognising that the Court of Protection was trying to weld two very different cultures together—the health and welfare side, and property and affairs—and had done so in one set of rules. We were recognising that that perhaps had not entirely worked and trying to come up with a better system that would resolve the matters of calibration of evidence and of getting things on the right track in the right way. The previous President accepted those recommendations. With the exception of the associated officers absolutely, frankly, nothing was done. I know that was not due to any default on the part of the judiciary; I am afraid that was the Ministry of Justice and a resources issue.

There are a lot of recommendations that are already sitting there, waiting to deal with the problems that have been raised now. At least from the court perspective, or from a practitioner’s perspective, they really are not very different from those that we were already aware of back in 2009. There is a suite of recommendations that are ready to go, as it were. I know that the current President has indicated he wants to take those forward as quickly as he can.

The other aspect that I understand he wants to take forward or consider is tied into the two cultures. It is recognising on the welfare side that practitioners and the judiciary have been finding their way, and it recognises we need to be tighter about how we manage this so that we can do this more quickly, more efficiently and more proportionately, in a similar sort of way to the way in which he has dealt with or he is seeking to transform the adoption and the care order proceedings in the Family Division, which has really put in a big cultural change in setting very strict time limits and very strict sorts of evidence and controls. My understanding is that he would like to translate that at least into the welfare side. It is totally different on the property and affairs side, which is 94% of the court’s work. It is the welfare side that takes up an awful lot of the court’s time, because when one gets into that one is quite often into the big, heavy, disputed cases.
Julia Lomas: For my part, I would see it very much as the curate’s egg: good in parts. I would welcome the efficiencies that might be introduced as a result of bringing it under Family, but I would be concerned that we do not simply give Court of Protection property and affairs matters to family judges. We have a great deal of expertise in our Court of Protection judges and I would like to see that preserved, enhanced perhaps, or increased, but nevertheless that core specialism preserved.

The Chairman: Thank you very much to each and every one of you for your evidence. It has been very helpful indeed.
Potential revisions to Court of Protection Rules 2007 (additional to those amendments already suggested by the previous ad hoc Committee)\textsuperscript{299}

Generally

1. I would respectfully suggest, insofar as they relate to welfare proceedings, that the proper template for these Rules is not the CPR but rather the FPR 2010 (insofar as they relate to public law proceedings) given that (as with such proceedings):

   *The processes of the Court of Protection are essentially inquisitorial rather than adversarial. In other words, the ambit of the litigation is determined, not by the parties, but by the court, because the function of the court is not to determine in a disinterested way a dispute brought to it by the parties, but rather, to engage in a process of assessing whether an adult is lacking in capacity, and if so, making decisions about his welfare that are in his best interests.*\textsuperscript{300}

2. This would suggest, in turn, that an exercise should be done to cross-refer the COPR to the FPR so as to ensure that the former is updated to represent ‘best practice.’ The most obvious area of mis-match as they currently stand is in relation to expert evidence (COPR Part 15/FPR Part 25) and also as regards the rules relating to publicity (COPR Part 13/FPR Part 27).

3. Where there remains a proper case for continuing to use the CPR as the template (and source of miscellaneous procedural guidance to fill the gaps – as per COPR r9), there are some important areas where the COPR and the CPR are now out of step, notably

   a. Costs (COPR Part 19) – in particular, to make clear how the post-1 April 2013 CPR costs regime applies in the COPR; and

   b. Enforcement (COPR 21 – r 184)

Potential areas for consideration

4. It may be appropriate to consider the inclusion of the equivalent to FPR r29.4(2) in respect of the withdrawal of proceedings (at least of welfare proceedings). It is, in fact, not clear at present what, if any, test is applied by the Court when a party wishes to withdraw proceedings. I would respectfully suggest that the dicta of Ryder LJ in *RW v Neath Port Talbot County Borough Council* [2013] EWCA Civ 1227 have some considerable analogies to welfare proceedings:

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\textsuperscript{299} NB, these are prepared on a personal basis, rather than in any representative capacity.

\textsuperscript{300} Cheshire West and Cheshire Council v P and M [2011] EWHC 1330 (Fam); [2011] COPLR Con Vol 273 at paragraph 52 per Baker J. This aspect of his decision was not the subject of challenge upon the Official Solicitor’s appeal to the Court of Appeal nor was it raised in argument before the Supreme Court.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
40. Once an application is made, however, it cannot be discontinued by the local authority. Rule 29.4(2) Family Procedure Rules 2010 (FPR 2010) requires the permission of the court before an application may be withdrawn. Such an application is ‘a question with respect to the upbringing of a child’ and accordingly the welfare test in s 1(1) of the Act applies whenever permission is asked (see, for example: Redbridge London Borough Council v B and C and A [2011] EWHC 517 (Fam); [2011] 2 FLR 117 per Hedley J and WSCC v M, F, W, Y and Z [2010] EWHC 1914 (Fam); [2011] 1 FLR 188 per Hedley J). Strictly, as explained by Waite LJ in London Borough of Southwark v B [1993] 2 FLR 559 at 572, such an application may not represent an occasion when the court is ‘considering whether to make, vary or discharge an order under Part IV’ of the Act for the purposes of section 1(4)(b) so that the welfare checklist may not apply. It may or may not do so and given the function of the checklist as a non-exclusive aide memoire, the consequence of analysing welfare by reference to it is hardly likely to change the end result. The question upon such an application is whether the proposed withdrawal will promote or conflict with the welfare of the child. The discretion is in the court, that is it is not for the local authority to refuse to pursue an application or pre-empt the outcome, for example, by declining to present the evidence: see for example, R v Birmingham Juvenile Court ex parte G and Ors (Minors) and ex parte R (A Minor) [1990] 2 QB 573; [1989] 2 FLR 454.301

5. I would suggest that Part 17 of COPR and its associated PD should be the subject of reconsideration in light of the fact that it is now clear that the Official Solicitor cannot act as litigation friend for P in as many welfare proceedings as had perhaps been envisaged when the rules were drafted. If, as I would suggest is appropriate, P is joined as a party to proceedings and requires representation by a litigation friend and, if, as is happening, there are moves to increase the use of IMCAs as litigation friends, then there is an increasing need for there to be clarification as to:

a. Whether an IMCA organisation can be appointed to act as litigation friend, or whether only an individual (nb, a trust corporation can be appointed to act as property and affairs deputy, and such a deputy would appear to have the power to conduct litigation in P’s name (see s.18(1)(k) and s.19(1)(b) MCA 2005);

b. Given that there is no equivalent to the undertaking as to costs required for civil proceedings, the basis upon which a litigation friend (1) incurs liability for costs on P’s behalf; (2) can recover costs incurred in acting from P’s assets/a legal aid certificate granted in P’s favour; and (3) (perhaps most importantly) when and the basis upon which a litigation friend will be personally liable for the costs incurred by other parties to the proceedings.

6. I would suggest that there be consideration given to issuing guidance akin to the President’s Guidance in Relation to Split Hearings [2010] 2 FLR 1897 as to when fact-finding hearings are to be conducted in the COP.

301 For my part, I might suggest that there are other aspects of this judgment which may be of importance for welfare proceedings before the Court of Protection (in particular as to the division of responsibility between the Court and public authorities as regards the assessment of the proportionality of intervention by the State, but that is likely to be a matter that is more properly worked out following argument in a decision, rather than through any new rules/PDs.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Safeguarding Essex – Written evidence

The document below incorporates the views of 7 members of staff who are actively involved and expert in their jobs in relation to matters pertaining to MCA/DolS

Overview/Context

1. Achieved its aims ?-
   - Yes, in terms of raising awareness and protecting the rights of vulnerable people. The act is significant and empowering and an essential piece of legislation.
   - Integral part of practice/assessment process in Social Care, however patchy delivery despite intensive training (Essex), possibly due to the high turnover of staff (both carers and managers) in care settings. Domiciliary care agencies appear to have less of an understanding of the legislation that care homes. GPs seem reluctant to accept that the legislation appertains to them as practitioners and frequently appear to either ignore it or refer to Social Care for guidance.
   - Still a long way to go for members of the Public.

2. Which areas require amendments and how?
   - Ensuring that people vested with legal powers (Deputies/Attorneys) have properly followed and understood the Act. For significant decisions, compulsory assessments by trained professional should systematically be required.

3. Principles / definitions appropriate ?
   - Generally yes. The difficulty remains around unwise decisions when the person with capacity continues to make those type of decisions.
   - Some practitioners find them difficult to understand and think the process is too cumbersome.
   - The definition of mental incapacity based on a functional test is appropriate as it focuses on a person’s lack of ability to make a particular decision at a time that it needs to be made. The duty to support person to make own decision is significant and positive.
   - The diagnostic test as defined in the first stage of mental capacity assessment is appropriate and should be maintained as it safeguards from generalising lack of mental capacity.
   - In practice, there appears to be some confusion over the concept of ‘insight’ not mentioned in the Act, but often referred to by healthcare staff, and the test of ‘understanding of information’ as defined in the test of capacity.
   - There should be a clear laid down separation of the capacity assessment before thinking about best interests. The 2 issues can get conflated.

Implementation

4. Implementation of 5 principles in front line practice

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
• Principles embedded for those who have had good training, but the application is still patchy, particularly within Health and the care sector.
• Difficult to quantify enablement versus protection, but risk aversion is still very high on the agenda of statutory organisations and this influences the outcome. Paternalistic approach is still quite common.

5. Effective implementation plan

• Social services workers are usually more aware than health workers
• There is a sustainable change amongst professionals.
• Training aiming at families with learning disabled children near the age of 18 has been put into place. Best Interest Assessors often gives information leaflets to Families for both MCA and DoLS.
• Residential/nursing homes are often given advice about the format and contents of recording. Training has been offered to residential/nursing homes and to GPs and dentists.

6. The Act known and understood by all professionals?

• Please see above. Big differences in quality of evidence between Health and Social care staff. The poorest assessments come from medical practitioners in hospitals who do not generally incorporate all the principles of the Act. GPs don’t really gets involved in these matters very often. Doubts about knowledge remain for the Police, banking sector and other professionals, such as dentists.

7. Act known/understood by service users/informal carers?

• In general the answer is “no”.
• Some families/carers perceive the application of the legislation as a waste of time and an interference, as they believe they know best about “best interests” for the people they care for. This is especially relevant in safeguarding cases. Example: relatives wanting to place family members in residential care, or moving them from one care home to another, without questions being asked about capacity.
• The large majority don’t perceive the MCA as a protection tool. Relatives occasionally want to challenge the outcome of the capacity assessment as they find the concept of “time and issue specific” difficult. Some relatives have questioned why there is not a formal appeals route that can be taken, similar to the Mental Health Act.
• The Code of Practice, albeit written in plain English, is still nonetheless not widely known to the members of the public (families/ formal/informal carers). Actions could be taken at central government level to publicise the contents.
• The Act seems to affect people predominantly engaged with statutory services (health /social care).
• The reports from media on court of protection cases can be seen as a positive mechanism to raise awareness.
• Voluntaries organisations could play a more active role in disseminating the information

8. Impact on culture of care?
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
On the whole, there has been progress made and the vast majority of social care practitioners, including the residential care sector have embraced the principles of the Act. As stated above, at the implementation level, the NHS practitioners are less proactive in that area and many still operate along medical model whereby the dominant views are those in that field and, for instance, best interests decisions are not necessarily based on inclusion and parity in terms of the consultation process, as they should be.

9. Affects some groups disproportionately?

- It is inevitable that people with learning disabilities or severe mental health issues will be the recipients more often than others, but it is not due to the legislation, just to their inherent disabilities. There is concern that on occasion mental health practitioners will consider using the MCA/DoLS legislation to support a detention of someone against their will when they fail to meet the criteria of the Mental Health Act.
- No evidence or local data on cultural or BME due to Essex demography regarding use of MCA/DoLS

10. Those affected by the Act enabled/supported to make decisions?

- Yes, definitively, only when assessments of capacity and best interests decisions are carried out properly. For instance, with assistance of IMCAs, wishes are taken into consideration as far as feasible.
- As stated above, those with formal legal powers have not necessarily a good grasp of the Act.

11. Evidence that Advance Decisions to refuse treatment being followed?

- We have no data on this. There is awareness that locally work has been done around DNAR, for instance. In care settings, end of life wishes are being discussed with service users/families.

12. Has MCA fostered involvement families/carers in care planning?

- Yes, definite progress in terms of involvement as the best interests decision making process requires a thorough consultation with all significant parties. Nonetheless, this is not without conflicting views between professionals versus families/carers as to what constitutes “best interests” for someone.
- Some misunderstanding/misconception around the concept of what constitutes an unwise decision and this being construed as lack of capacity.

13. Role of IMCA?

- Some influence and can provide some useful insight into people’s circumstances, but not trained enough to speak out, challenge or use the legal channels available to support clients. Their involvement doesn’t go far enough.
Safeguarding Essex – Written evidence

14. Variation in level of referrals?

- In Essex, our level of referrals is above average, however, in other areas variation may be due to practitioners not understanding the role or it may be due to commissioning processes.

15. Are the IMCAs adequately resourced...?

- As demand grows for IMCAs there is a concern that demand may outweigh capacity, which possibly results in a great variation in terms of skills, knowledge and experience in IMCAs.

Deprivation of Liberty Safeguards

16. Are the safeguards adequate?

- Principles are good, but application difficult to achieve because of the complexity of the law. However, it can provide effective safeguards when the best interest assessment is completed with thoroughness and diligence.
- Need more robust protection for services users. Mechanism to go to court is cumbersome and frightening for Representatives. Tribunals would be a better and cheaper option. Also, IMCAs should be mandatory as RPR don’t always understand the implications of their role. It is difficult for people (both service users/relatives and professionals) to understand why there is no formal appeals process regarding DoLS.
- The interface between Article 8 and Article 5 when it comes to DoLS is not clear and issues around prevention/restriction on contacts in safeguarding cases need clarification.
- The legal interface between the MHA and DoLS and MCA is unclear and confusing. Issue around incapacitated patients (not objecting) in psychiatric settings needs particular clarification as it seems that for some people DoLS has abolished the usage of Mental Capacity Act 2005 and the least restrictive principle is being forgotten.
- Reviewing the definitions of what constitutes Deprivation of liberty is also desirable

17. Are the DoLS processes sufficiently clear?

- The processes are bureaucratic and complex, there is a need for simplification. Forms should not be limited in words input. Duplication could be avoided. Form 4 could be combined with form 1 for example.
- Language should be simplified. The understanding of the forms has an impact on quality of referrals received.
- Time span for completion of documentation should be reviewed. 7 calendar days not adequate and does not take into account the various difficulties that people may have (e.g. staff not working weekends, evenings, bank holidays or relatives being unable to find time at short notice to participate in the assessment). A minimum of 7/10 working (not calendar) days should be allowed as very often authorisations are not...
received on day 1 and also if clarification is required on receipt of assessments, this will take time to obtain.

- There should be an automatic challenge or right to appeal triggered by the Supervisory Body if DoLS longer than 6 months (similar to MHA tribunals).
- Review process doesn’t fulfil its function as it is only for termination of DoLS and therefore this is not effective. Review and renewal process need to be more explicit.
- Family members do not understand the role of RPR within the law
- IMCAs should be more proactive in assisting to take cases for appeal to Court.
- The Managing Authorities do not generally understand or take seriously their role and responsibilities within the legal context
- Conditions attached to the Assessments are not very often complied with by the Managing Authorities. Measures to enforce these should be considered.

The Court of Protection and Public Guardian

18. Are they sufficiently understood/ accessible to all?

- People often confused about their respective functions. Families mistake finances and property orders for welfare, believing this give them the same rights in terms of decision making.
- Court of Protection is not easily accessible and there are huge delays in getting cases heard. The process is costly and discourages individuals to make applications. IMCA organisation should be encouraged to apply.
- Regarding completion of checks by the OPG for DoLS No Refusal assessment, the search take an average of 5 days which is unacceptably long when one is dealing with a 7 days urgent authorisation and only postal service is available rather than email. Verbal confirmation is no longer available.

19. Impact of introduction of Lasting Power of Attorney

- The LPA appointed don’t seem always aware of the scope of their role/responsibilities, especially in understanding the specificity of decisions within their legal representation.

Regulations

22. Role of CQC in inspecting MCA

- The inspectors ask for the documentation on file regarding MCA and DoLS, so the Managing Authorities are more compliant in this respect, but we have no data about how many have been inspected so far.

23. Should they be acting in this area?

- Yes, it is an essential aspect of human rights and protection of vulnerable service users. The principles are rooted in social care values and evidence of their application should be made available to the regulator. However, they should take immediate action if this essential aspect of human rights is being breached.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

Safeguarding Essex – Written evidence

24/27 No feed back available within context of area of work.

30 August 2013
Jo Samanta (De Montfort University, Leicester) – Written evidence

In answer to the call for evidence I would like to feedback specifically on an aspect of question 6:

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

Shortly after the Mental Capacity Act 2005 came into force I carried out research specifically into the law and ethical basis of Healthcare and Welfare LPAs. I published a substantive article which considered this new and important initiative and its impact for end of life decision making. I compared the LPA with its counterpart in the United States (Durable Powers of Attorney) and evaluated the potential benefits and its possible limitations. A critical evaluation was published in the Medical Law Review and to the best of my knowledge this remains one of the most substantive considerations of the law on this topic:


In June 2009 I carried out a focus group study to explore the views and perceptions of lawyers and health professionals to attorney decision-making at end-of-life. Possibly in terms of the time that the study was carried out it was evident that participants (practising lawyers and health professionals) had only limited knowledge and awareness about Healthcare and Welfare LPAs. The conclusions were that whilst participants expressed guarded welcome to the introduction of healthcare and welfare LPAs several potential challenges were anticipated based upon professional norms and expectations. The consensus view was that realisation of the full potential of proxy decision-making was likely to be a theoretical, rather than real, benefit. Opinions were divided on elemental tenets such as prospective autonomy, best interests and the potential for conflict. The research and its findings was published in the Journal of Law and Society:


If the Committee is interested in either or both of these publications I can provide copies on request.

2 September 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

Submission to be found under Victoria Butler-Cole in Volume 1.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
SEAP – Written evidence

Implementation

To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection? Answer: From an IMCA point of view in Portsmouth the principles of the Act have been implemented in varying degrees depending on the service practitioners are working in. Social care are very strong in least restrictive practices whereas medical services still possibly take a view that they should work in a Best Interest way that can be seen as very risk adverse. This can mean that decisions that they gravitate towards can be restrictive. However the IMCA Service Portsmouth has had far more referrals from general hospital than any other source.

From a Cornwall IMCA viewpoint, due to resource and time constraints, often “all practicable steps” are not in theory implemented. Research into the decision-making capabilities of people with learning disabilities has shown that the presentation of information in a user-friendly manner makes it possible to move some people from being assessed as incapable to being assessed as capable (M.J.Gunn, J.G.Wong, I.C.H.Clare and A.J.Holland “Decision-making capacity”, Medical Law Review (1999), 7(3), 269-306).

Decision makers for SMT decisions tend to gravitate towards best medical interests rather than encompass “medical, emotional and all other welfare decisions”.

1. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change? Answer: Referrals to the IMCA Service have grown consistently for change of accommodation decisions since implementation of the act. Serious medical treatment decisions seem to be less regularly referred to the IMCA Service and safeguarding referrals are rare. This might suggest different levels of awareness in different domains of decision making. Our experience of advocacy involvement with families of people who lack capacity suggests that general awareness of the act still needs to be worked on.

1. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others? Answer: Social care professionals have benefited from training and awareness raising that other sectors may not have received, consequently awareness amongst social care professionals is likely to be higher. This has been the experience of our service in Portsmouth which provides issue based advocacy to wide variety of people. From experience in Cornwall it would appear that social care teams are more aware of the MCA than other sectors.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
1. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance been struck between protection of the carer and protection of the individual lacking capacity? **Answer: Our experience of the advocacy service suggests that awareness is higher amongst social care professionals than the rest of the population. This imbalance leaves informal carers at a disadvantage when dealing with professionals i.e.: in Best Interest Meetings where informal carers feel that they are not informed enough. This can affect the contribution that they feel able to give. In Cornwall, there has been a shift in the culture of care towards involving individuals in their own decisions and a greater awareness of the legal responsibilities of professionals.**

1. Has the Act ushered in the expected, or any, change in the culture of care? **Answer:** The Act appears to have had a strong effect in the social care professions where our advocacy service in Portsmouth has encountered a change in direction from Best Interests to a least restrictive led perspective. In practice this means that individual's views are being given more weight and Best Interest Meetings are being used to explore how those choices can be respected whilst safety is maintained.

1. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

**Decision making –**

1. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? **Answer:** Those people in Portsmouth that are affected and are referred to the IMCA Service are being supported to get their view across and their rights upheld. In Cornwall, this is very much dependent on whether the individual and/or their family is aware of the Act and whether the decision maker is following the principles of the Act. Individuals that are referred to the IMCA service are now supported to ensure that their voice is heard and that their legal/human rights are upheld. Having the support of an IMCA helps to ensure that the legal process is being adhered to and that any decision made is in the person's best interests and that the least restrictive option is implemented. Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making? **Answer:** IMCA involvement means challenges can be made, if necessary during the decision making process. Awareness provided by IMCA Services can improve the understanding and knowledge of professionals who make the decisions.

2. What evidence is there that advance decisions to refuse treatment are being made and followed? **Answer:** Our IMCA Services have no experience of supporting clients who have made advance decisions. This topic has been raised by social care professionals during awareness sessions recently. We believe more work should be undertaken in this area, and consideration given to GP's providing
drop-in surgeries to support patients to understand their rights to make advance decisions.

1. Has the MCA fostered appropriate involvement of carers and families in decision-making? Answer: Families and carers can feel disempowered. They can feel that professionals have the greater say and they feel powerless, yet they may have known the person at the centre of the process for many years. IMCA’s can promote the involvement of carers and families by insisting that their views are considered.

1. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf? Answer: In our experience yes. IMCA’s provide support in those settings where abuse and exploitation can take place. Being a safeguard for a vulnerable person who lacks capacity is a vital part of the role. However, as the IMCA role is decision specific and often short term, once the decision has been made the individual is often left without ongoing support.

Please see below an example of our organisation’s Evaluation Form received from a professional in Cornwall regarding the IMCA service:

1. Please describe your role: Registered manager of ******* House Care Home where ****** is a client

2. How well do you think the IMCA engaged with...

   A) The person Assessed to lack Capacity? Very well. ** was very good at communicating with ** and spent time to ask relevant questions and to gain an understanding of her needs and wishes in a caring and empathic way. She was very forward in ensuring ** needs were represented at meetings and with other professionals and acted well as an advocate to **

   B) You? Very well. ** ensured she got all the information she needed to ensure ** voice was heard and that her needs were met.

3. How useful did you find the IMCA involvement? Very useful. In all interactions with clients I feel all agencies have their own agenda, intentionally or not, and will act in a way that runs in line with their organisations needs as well as clients needs. It is hugely important to have someone who shows impartiality towards organisational needs and is solely there for the clients needs as this helps those around the table reflect on their own practice and ensures that the clients voice is heard.

4. Do you feel that the IMCA accurately represented their wishes and feelings? Yes

5. Did you see the IMCA worker as facilitating or hindering the Best Interests process? Facilitating best interests of the client in a non biased way which it is often difficult for other organisations to achieve due to organisational constraints, budgets etc

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
6. Is there anything you feel the IMCA could have done differently? No

7. Do you feel that IMCA involvement provided a safeguard for client? Yes

8. Is there anything else you would like to add? I would recommend (your organisation) and ** in the future as I felt they provide an excellent service in ensuring that organisations work in a client centred way

1. Has the level of referrals to IMCA's met expectations? What are the reasons for the regional variations in the number of referrals? Answer: In Portsmouth we would say no. There was a lack of knowledge, understanding and awareness of the IMCA Service initially, which was expected. However, there continues to be areas of low referral rate. Our local authority does not refer to us for Safeguarding. ‘Advocates’ are mentioned in their policy, but not IMCA’s specifically.

In Cornwall the situation is different. However judging by the number of SMT referrals received they are lower than expected.

The demographics of an area could be one factor of regional variations. During the period January 2013 – July 2013, a breakdown of referrals to the Cornwall IMCA service show that 40% of referrals were for accommodation, 25% were for care reviews, 23% were for SMT and 21% were for safeguarding.

1. Are IMCA’s adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity? Answer: No. IMCA’s benefit from office environments which promote discussion and good practice, which is vital for non-instructed advocacy and not all services can provide that due to contract stipulations. There has been no significant updated training provided since inception. The role links more and more to formal reporting and evidence for the Court of Protection, but IMCA services have to fund and seek out this training themselves. There is no on-going process or funding to check on continuing professional competence and development of IMCA’s.

In our experience IMCA services are under-resourced and this may be a reason why decision makers do not always refer to the service as they are aware of the resource constraints. IMCA’s could provide more support for vulnerable people if adequately resourced. IMCA’s require on-going professional development and should receive regular training including updates on case-law to ensure they are aware of all recent court judgements. This information would support more robust decision making which in turn leads to safeguarding vulnerable individuals whilst upholding their rights.

Deprivation of Liberty Safeguards

1. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate? Answer: No. DoLS is needlessly bureaucratic and this leads to delays and inefficiencies which mean that they end up being very restrictive and at times not in place when they would be of use.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
1. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely? Answer: No. Again the bureaucracy of the process makes it cumbersome and opaque to those people who are not dealing with it regularly as a professional. Challenging via the Court of Protection is extremely slow and costly. This may be an area where the MCA could learn from the Tribunal system of the MHA which appears to be more efficient and timely.

The Court of Protection and the Office of the Public Guardian

1. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully? Answer: We can only comment on our awareness of the difficulties families can face in funding and arranging LPAs. We are aware of a fast track process (e.g. for people identified as needing end of life care), which appears satisfactory.

1. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare? Answer: Our IMCA services have not had experience of an impact, however evidence would suggest that people are more likely to register an LPA for property and finance rather than personal care and welfare.

1. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection? Answer: We are aware of concerns that families have regarding cost and length of time applications take.

1. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have? Answer: Anything that makes it more difficult for LPAs to be created would appear to create more barriers to the application process.

Regulation

1. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers? Answer: Recent reports would seem to suggest the role needs overhauling and consideration made regarding powers, which would enable the rights and wellbeing of the vulnerable person to be upheld at all times.

2. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area? Answer: If the CQC’s roles and responsibilities are clearly defined, there should only be a need for a communication process to exist between them and other regulators.

Other legislation

1. How well is the relationship with the mental health system and legislation understood in practice? Answer: The awareness within Mental Health services and Tribunal panels appears poor. There is little knowledge of any sort of the MCA or its requirements amongst mental health professionals. Mental Capacity tests are very rarely carried out within psychiatric hospitals. Where they are carried
out they have somehow included ‘insight’ within the capacity assessment process and this can have the effect of making decision making process very unclear and potentially restrictive. MHA Tribunal Panels do not appear to have sufficient awareness of the MCA or DoLS to include these options in their decision making process when they are dealing with appeal tribunals.

30 August 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
1.1 Sense

1.2 Sense is the leading national charity that supports and campaigns for children and adults who are deafblind. We provide expert advice and information as well as specialist services to deafblind people, their families, carers and the professionals who work with them. We also support people who have sensory impairments with additional disabilities.

1.2 Our services include on-going support for deafblind people and families. These range from day services where deafblind people have the opportunity to learn new skills to Sense-run houses in the community – where people are supported to live as independently as possible. We also provide leading specialist advice, for example on education options and assistive technology.

1.3 The following written evidence is based on the views of Sense practitioners with direct experience of applying or checking compliance against the Mental Capacity Act.

1.4 Summary of key points

- Sense considers that the Mental Capacity Act itself is sound and should not be substantially revised;
- We consider that any problems are likely to be due to the Act's implementation rather than the content of the Act itself;
- There is the need for greater levels of awareness and training for professionals to make them aware of their responsibilities under the MCA;
- Much more needs to be done to improve the understanding of MCA principles and processes among professionals working in community health settings;
- Training should focus on the need for effective communication strategies to promote and enable individual's involvement in decision-making and the complexities around making an assessment of competence;
- Professionals should be more willing to instigate and manage the capacity assessment process and to take on the role of decision-maker;
- More information should be made available to families about the key principles and objectives behind the MCA;
- There is the need for clearer guidance on the circumstances in which DOLS authorisation becomes necessary and the thresholds at which this should be applied;
- Organisations should re-assess their use of restraint in light of the requirements and principles of the MCA.

2. Overview and context

2.1 To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

2.2 Sense considers that the Mental Capacity Act has provided a useful framework on which to approach capacity and best interest decisions and we welcome the overall ambition and ethos of the Act.
2.3 Which areas of the Act, if any, require amendment; and how?

2.4 We consider that the Act itself is sound and does not require amendment. In our experience, any failings identified are due to poor implementation, rather than any problems in the content of the Act itself.

3. Implementation

3.1 To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

3.2 The MCA states that there should be a presumption that individuals are capable of making their own decisions, unless it can be proved otherwise. In practice, Sense has found that many professionals are often guilty of assuming that individuals lack capacity without first conducting a proper assessment and many are too quick to recommend that a best interests decision should be made.

3.3 Sense supports individuals with complex needs, who are often unable to use formal communication methods. In our experience, if the deafblind person uses formal language, then professionals are far more likely to assume that they have capacity, compared to those who use non-verbal methods of communication.

3.4 Individuals may be competent enough to take decisions about certain areas of their lives, but not others. In our experience, many professionals currently apply an overly-simplistic interpretation of competence. Some assume that if a person seems to be generally competent then they will be capable of making every decision, regardless of the level of complexity. In particular, individuals who are able to use formal language are sometimes assumed to be generally competent and as such are permitted to take responsibility for decisions which are well beyond their level of understanding.

3.5 We have also found that there is often insufficient support for individuals to enable them to express their preferences using their preferred method of communication. This is less likely to be the case where there are closer relationships between deafblind people and support staff as there will be fewer communication barriers.

3.6 The law clearly states that individuals should have the right to take unwise decisions and that this should not be taken as proof that the person lacks capacity. This aspect of the legislation presents a challenge for organisations such as Sense who have to balance their regulatory requirements with the person’s right to take risks. In general, organisations caring for vulnerable people can be over-protective and we find that they are also more likely to allow risks to be taken by individuals who can make requests using verbal communication.

3.7 Very few organisations have re-thought their use of restraint in light of the requirements and principles of the MCA. Sense has recently carried out an audit of the use of restrictions and restraint in a number of different areas including the use of chemical and physical interventions, environmental and supervisory restrictions and mechanical interventions. In each case identified, Sense re-visited the original decisions and made a fresh assessment about whether the use of the restraint was proportionate and the least.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
restrictive option. This led to a significant reduction in the use of restrictive harnesses across Sense settings. We consider that other social care providers should also seek to re-visit their use of restraint in light of the MCA.

4 Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

4.1 In our experience, there is variable practice across the health sector. Our practitioners have particular concerns about the performance of community-based health services in relation to MCA implementation. GPs and dentists cause the most concern although other services such as Occupational Therapy, Speech and Language Therapy, psychiatry and psychology can also have poor practice in this area.

4.2 It is our experience that in community health settings, Sense often have to prompt professionals to conduct a capacity assessment. Our practitioners regularly find that they have to co-ordinate the entire process in order to ensure that decisions are taken in the best interests of the person. Recently, there have been several concerning incidents in the dentistry field where dentists, faced with a deafblind patient who may lack capacity, have attempted to sedate them to perform treatment rather than completing a proper capacity assessment to gain the person’s consent.

4.3 There are also varying levels of understanding from GPs, many of whom seem unaware of the MCA requirements when thinking about how to treat a patient who potentially lacks capacity to make decisions about their treatment. We have experienced several cases where Sense support workers have been asked to restrain deafblind people so that a sample of blood can be taken, rather than following the correct process to gain their consent. In these cases Sense will always seek to prompt the GP to assess capacity properly. GPs can often be reluctant to commit the time needed to do this and in one case the GP attempted to make a charge for the additional time needed to complete the assessment.

4.4 In contrast to the concerns about community based health services, in our experience hospitals have a much clearer process for assessing competence and making best interest decisions. In some respects, dealing with capacity is less ‘new’ for people working in hospital settings as they have always had to make decisions on behalf of people who are incapacitated. In general we find that issues of capacity and consent are taken far more seriously where serious treatment is being administered, compared to more minor health procedures.

4.5 For the most part, local authority staff have a clear sense of their obligations under the MCA. Front line social workers in particular, seem to have a good level of knowledge and understanding. We still have concerns however, about the potential for local authorities to misuse the act – prioritising cost savings ahead of best interests. For example, Sense regularly challenge local authorities who seek to bring individuals back to live in-county or in supported living settings when this may not be in the person’s best interests. In these cases there could be a risk of collusion in determining that the person lacks capacity to make a decision.
4.6 In best interests meetings involving more than one agency, in our experience, it can be extremely difficult to determine who the decision-maker should be. In our experience, professionals are often not comfortable in assuming this role. For example, in health-related best interests meetings, clinicians regularly expect the Sense support worker to make the final decision rather than taking on the responsibility for medical decisions. It is extremely rare for the decision-maker to drive the process and Sense practitioners are often forced to assume this role.

5 Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

5.1 Family members of severely disabled people have often fulfilled the role of primary decision maker for their relatives since birth. The requirements of the MCA therefore present a challenge for some family members as the Act can be seen to shift the balance of power away from them towards the individual and professionals. We have found that many families do not have a clear understanding of the purpose and principles of the MCA and this can often lead to tensions between family members and the professionals involved, especially when the individual chooses to make a decision which is ‘unwise.’ In response to this, Sense now delivers training to parents to help them understand the requirements of the Act.

6 Has the Act ushered in the expected, or any, change in the culture of care?

6.1 This has not been the case in organisations which have failed to implement the Act properly. However, we have definitely seen that where the principles of the Act are properly applied within organisations such as Sense, that this has had a positive impact on the culture and ethos and effects how the whole range of decisions are taken.

7 Decision making

7.1 Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

7.2 In our experience, external agencies rarely put in place specific communication strategies to enable individuals to express themselves. In most cases, external agencies rely heavily on Sense Support Workers to help them communicate with deafblind individuals. On several occasions, social workers arrive to conduct an assessment or review when they are only able to communicate using speech, relying upon Sense staff to bridge the communication gap. Professionals also can fail to recognise the need to find ways different ways to present information on the consequences and impact of a decision to the individual. Appropriate communication support is needed to allow individuals directly affected by the act to express their preferences effectively.
8 Are IMCAs adequately resourced and skilled to assist in supported or substitute decision making for people lacking capacity?

8.1 IMCAs do not always have the skills needed to communicate effectively with sensory impaired people. For example, in a recent case a Sense service user was allocated an IMCA who was not able to use British Sign Language. This meant that a Sense support worker had to be present at all meetings between the individual and the IMCA meaning that conversations could not be held in confidence and the person was less able to share information about the services they receive from Sense. This could be a serious issue in cases where there are allegations of abuse and exploitation.

9 Deprivation of Liberty Safeguards

9.1 Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

9.2 Sense has made a number of applications for DOLS authorisations where individuals were being deprived of their liberty for safety reasons. Recent examples have included locked doors, bed doors and individuals kept in hospital without their consent. Overall, we have found that the threshold for a DOLS authorisation is quite high with most applications deemed unnecessary. Different authorities operate slightly different thresholds but these are largely consistent. In general we consider that there is not a clear sense of when a DOLS authorisation should be necessary, especially if the individual involved does not show any signs that they object to the use of restraint being used.

20 August 2013
Serjeants’ Inn Chambers – Written evidence

Our Perspective

1. For more than twenty five years Counsel from Serjeants’ Inn Chambers have advised and provided representation in relation to all aspects of “welfare” and “medical treatment” decisions. We are regularly instructed by the Official Solicitor, CAFCASS, Primary Care Trusts, the NHS, Local Authorities and relatives: Re F (1990: sterilisation), Bland (1993: PVS, withdrawal of treatment), Re MB (1997: needle phobia, test for capacity), re A (2000: conjoined twins), Masterman-Lister (2002: capacity); Burke (2004: withdrawal of treatment) and more recently in determining patient autonomy Re E (2012: force feeding an anorexic), XB (2012: advanced decisions), CA (2012: capacity to enter into sexual relations), Re X (2013: schizophrenic patient seeking termination) and re DE (2013: learning disabled patient, vasectomy). We publish and lecture extensively in the field. We hope our views will assist the Committee. We would be pleased to provide further evidence or assistance if the Committee so required.

(Q4) To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

2. We respond by reference to the second principle: “A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success”.

3. A recurring feature of cases we see is low-quality capacity assessments, requiring the capacity assessment to be carried out afresh (prompted by advice from lawyers or ordered by the Court of Protection). The Act (s3) and Code (e.g. 3.7 - 3.9; 4.16) are clear that identification of “the information relevant to the decision” is a necessary step prior to assessment of capacity. Our experience suggests this does not routinely happen. Yet without identifying that information, it is not possible to try and assist the person to make the decision for themselves. Nor is it possible to conduct a capacity assessment capable of standing up to scrutiny.

4. There are some cases where there is room for genuine debate about what the relevant information is (e.g. A Primary Care Trust v (1) LDV (by her litigation friend the Official Solicitor) (2) CC (3) B Healthcare Group [2013] EWHC 272 (Fam)). However, there are other cases in which those responsible for assessing capacity simply fail to comply with the Act and the Code: for example, CC v (1) KK (2) STCC [2012] EWHC 2136 (COP) in which a local authority failed to give an elderly lady the details of available support if she were to return to live at home. Further submissions that reflect poor implementation are set out in response to Q 6 below.

(Q 6) Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors such as health, social care, banking and others?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
5. Some elements of the act are not widely understood by the healthcare or social work professions. We agree with the oral evidence of Professor Jones on this issue.\(^{302}\)

“many people who should be aware of the Act are not, and those who are aware of the Act often have a flawed understanding of its provisions. In that respect I take issue with the evidence that this Committee received last week from officials who indicated that the Act was well embedded in our culture. My experience, and, in my opinion, most of the evidence, points in the opposite direction”

6. **Capacity:** We regularly review assessments of capacity performed under the Act (on formal COP 3 forms or in separate witness statements prepared by doctors during proceedings):

   a. **Written assessments often do not appear to have been performed by reference to the criteria set out in s3.** In subsequent discussions with the assessor it is often the case that the elements of s3 have not been properly identified or considered;
   b. The assessors sometimes **fail to appreciate that capacity is issue specific** and that on a proper (issue restricted) analysis, P does have capacity to take the relevant decision;
   c. In our individual practices some of us provide doctors/assessors with **outline witness statements** specifically directing their attention to the issues in the case that require consideration when assessing capacity and best interests;
   d. We are instructed in many cases where communication is difficult but there is often a **failure to take sufficient steps to facilitate communication and decision making.**

7. **Best Interests:** In cases that come to us there is usually a dispute as to best interests which gives rise to the application for a declaration from the Court:

   a. Assessors often **fail to make sufficient inquiry of relatives as to P’s interests**, beliefs and likely decisions;
   b. Medical assessors can be **too quick to substitute their own values and judgments without having regard to the non-medical factors**;
   c. **Medical assessors often entrench** when relatives advance different views and can appear **reluctant to revise earlier opinions** despite new evidence on best interests;

8. **Timing:** We are frequently instructed in cases where a PCT seeks a declaration that it is lawful and in P’s best interests to either (a) administer urgent life-saving treatment (and prolong life); or (b) withhold resuscitative treatment in the event of P’s collapse (thereby ensuring death). These applications may be made overnight or at weekends in circumstances where it is difficult, sometimes impossible, for the Court to obtain all the necessary evidence. Occasionally the facts of a case make this unavoidable. More frequently though there has been a failure to properly identify the---

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\(^{302}\) Corrected version of the evidence taken by the Committee. Foot of page 27 onto page 28.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
issues early in the case and seek the relevant assessments and input early on. That failure means that the Courts are forced to take life determining decisions with insufficient information or input from the family. In one case a Trust sought a declaration that life prolonging treatment should not be provided to an elderly patient. Due to very late notice of the application, the only way for the Judge and Counsel to obtain evidence from the family as to best interests was to telephone the family shop from a mobile phone in Court. The relative giving evidence had little notice of the call and his evidence as to best interests was punctuated by the shop door bell ringing as customers came and went. This was avoidable and unacceptable. This happens with sufficient frequency that Judges dealing with these cases often express frustration at the failure to appreciate that a situation was developing and take proper and timely action. In some cases a delay in bringing the application will mean that the opportunity to obtain evidence directly from P about his best interests is lost.

(Q11) What evidence is there that advance decisions to refuse treatment are being made and followed?

9. We have seen little evidence to support the proposition. There is (as far as we are aware) no widely available and approved standard form for an Advance Decision with the result that on the rare occasions when doctors are presented with one, the text will be unfamiliar and they will be anxious about providing or withholding further treatment. We would be very surprised if many doctors were aware of the general principles relating to Advance Decisions that are contained in the Act.

(Q16) Are the safeguards in the Deprivation of Liberty Safeguards Scheme (DoLS) adequate?

10. We think not. The Committee has already heard in oral evidence reference to the variations by region in the number of DOL authorisations applied for. Our experience is that not infrequently a deprivation of liberty is missed. There are cases which come to court by some other route (such as a best interests challenge under section 16 of the Act) where the court, a relative or the Official Solicitor flags the possibility that “P” is being deprived of his liberty at the placement in which P lives. In our experience, once flagged, this does lead swiftly either to the Court authorising the deprivation of liberty (in appropriate cases) or to the Schedule A1 process being engaged. However, the fact the process is triggered at court, rather than days, weeks or months earlier by those working “on the front line”, demonstrates, we would suggest, a weakness in the system. Given the complexity of identifying a deprivation of liberty, it is not surprising, but we would question the effectiveness of a system where the trigger for engaging the Safeguards relies on social workers, healthcare workers and other front line workers understanding a complex and developing line of case-law.

Interaction and Conflict between the MCA and MHA – Need for amendment

303 Page 15, correct oral transcripts: Anne-Marie Hamilton, Department of Health

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
11. This section of our evidence addresses a gap in the Mental Capacity Act 2005 (MCA) and concerns some areas of the Act which may require amendment (question #2 in the list of questions set out in the call for evidence). The particular concern arises from the Court of Protection decision of Mr Justice Baker in A NHS Trust –v- Dr A [2013] EWHC 2442 (COP). The concern relates to patients who need life-saving medical treatment but are ineligible to be deprived of their liberty for that purpose because of some of the provisions of the MCA.

12. Dr A had worked as a GP in Iran but came to this country in August 2011. He applied for asylum but his applications were refused and his passport confiscated by the UK Border Agency. He was admitted to hospital suffering from a mental illness and went on hunger strike in an attempt to recover his passport. By the end of the hearing in the Court of Protection he was detained in hospital under s3 Mental Health Act (“MHA”).

13. The Court decided that Dr A lacked capacity and it was in his best interests to be force-fed, which would entail a deprivation of his liberty. The force-feeding could not be carried out under the MHA so the Court had to consider the MCA. However, because Dr A was the subject of a section under MHA there was no power under the MCA to deprive him of his liberty.

14. The problem arises because the Court may not authorise a deprivation of liberty if a person “is ineligible to be deprived of liberty by this Act”: section 16A MCA. Under paragraph 2 of Schedule 1A to the MCA a person is ineligible to be deprived of his liberty if he is detained under the MHA. An order authorising deprivation of liberty may not be made under the MCA if the person is detained in hospital under the MHA, even if the order is required for medical treatment unconnected to a mental disorder.

15. The Official Solicitor (for Dr A) suggested that the problem might be overcome by adding (in accordance with the interpretive obligation under the Human Rights Act 1998) the words to the end of section 16A(1) MCA “save where such provision is necessary to uphold a person’s right to life under Article 2 of the European Convention on Human Rights” so that there was no ineligibility in a case in which such ineligibility might lead to the person’s death. The Court did not accept this argument stating that it would have the effect of fundamentally altering the clear meaning of section 16A, MCA.

16. The Court found a solution in one of the submissions made on behalf of the Official Solicitor by permitting the deprivation of liberty to be justified under the High Court’s inherent jurisdiction thus enabling Dr A to be given food and hydration. The Court deployed the European Convention on Human Rights in order to fortify its conclusion. This is unsatisfactory because the MCA should be a comprehensive code enabling legal advisers and others to understand when DOL orders may be made without recourse to the pre-existing inherent jurisdiction.

17. A clear case could therefore be made for the reform of section 16A and / or Schedule 1A MCA (specifically Case A in the table in paragraph 2), permitting in appropriate cases the deprivation of liberty of a person lacking relevant capacity, for
the purpose of medical treatment which is separate from the person’s mental disorder.

18. More generally, we suggest that consideration should also be given to an “overhaul” of Schedule 1A of the MCA. That Schedule is far too complex and, for example, the wording of Case E in paragraph 2, Schedule 1A is lacking in clarity. We question the value of making all those who are or could be subject to the MHA potentially ineligible to be deprived of their liberty under the MCA. The rationale for having the MHA regime “trump” the MCA regime should be re-considered. There may be no proper objections in principle to persons being subject to two overlapping regimes so that the Court of Protection can make orders depriving persons of their liberty under the MCA even if they are or could be subject to the MHA regime.

9 September 2013
Sheffield Safeguarding Adults Board – Written evidence

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The aims of the Act are built on good practice and seldom, if ever, have we heard criticism of the principles. The extent to which the aims are being achieved is a different matter. There is still a considerable problem in terms of compliance in all relevant professions and at all levels of organisations.

There are some excellent examples of good practice but it can be equally as bad or non-existent resulting in breaches of human rights - particularly Articles 5 and 8.

The MCA is the cornerstone of good care and some of the provisions have been embedded within practice but some areas of the Act have proved challenging to practitioners and organisations. A level of confusion between the Mental Health Act and the Mental Capacity Act exists.

2. Which areas of the Act, if any, require amendment; and how?

Section 44 Ill treatment and neglect needs to be elaborated upon with more detailed guidance to increase the numbers of cases subject to the criminal justice system.

More detailed guidance for health and social care staff about the need for assessments of capacity for self-funding individuals.

Creation of statutory forms for recording assessments and decisions would improve consistency.

Revisions to the Codes of Practice, DoLS in particular is needed (see question 9).

The Principles are sound but not fully embedded into day to day practice. Linkage with Human Rights, dignity and respect and personalisation (positive risk taking) agendas would be helpful.

Principle 1 Presumption of capacity. Greater clarity about when capacity assessments are required; the presumption of capacity is often misjudged and assessments are frequently inadequate as time allocated to these is insufficient to address all areas of capacity/decision-making thoroughly.

Principle 2. Not enough being done to support people to make their own decisions with adequate regard to positive risk taking.

Principle 3. Unwise decisions. This causes much concern and anxiety for professionals and can “skew” decisions about capacity.

Principle 4. Best interests is commonly used and well known.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Sheffield Safeguarding Adults Board – Written evidence

Principle 5. Least restrictive intervention. Not always evidenced that lesser restrictions have been used or contemplated.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

Yes

Implementation.

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

The five principles have been instrumental in upholding individual’s rights. However, there are situations where professionals are unwilling to take and manage risks associated with caring for an individual in their own home and a best interests decision has been made to move them to a care home putting too much emphasis upon physical risks. This is evident in the number of article 8 breaches.

Court rulings on mental capacity show judges overruling professional opinion by overturning capacity decisions. The threshold according to judicial opinion appears to be set too high and appears risk adverse; this suggests that practitioners confuse the principles of capacity and best interests.

There are also examples of practitioners not assessing capacity when there is an element of doubt using the first key principle ‘assume a person has capacity unless proved otherwise’ to avoid the responsibility of assessing capacity when it is needed.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

Some good information was provided with support at DH level and regionally but this was removed too quickly and before it could be evidenced that the Act had been well implemented nationally across all organisations. Changing practice requires a “hearts and minds change of practice” which needs constant review and support by all organisations. Limited work has been completed nationally to evaluate how much progress has been made to date.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

Little evidence to give assurance that service users and families directly affected by the Act know about it and this limits their ability to effectively advocate with professionals.

Knowledge in health and social care sectors is at best patchy and even if knowledge is robust the recording of decisions leaves most practitioners vulnerable to criticism. GPs and

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consultants struggle to adequately record capacity and best interest decisions taken, especially when this relates to hospital discharges. Limited evidence exists locally to suggest banking and registrars are not fully engaged with the legislation which may lead to unlawful marriages/civil partnerships. Housing providers may not be fully engaged with the Act and may unwittingly create illegal tenancies and benefit claims.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

It is difficult to generalise but this is an area that needs more input on top of training. Perhaps there needs to be a media campaign to raise awareness. Indeed the media can confuse the issue. For example before the BBC Winterbourne documentary there was a statement informing that they had obtained parents’ consent to show the film.

The Act is not understood and used as well as it should be across all sectors. In some cases carers are hesitant to make full use of the Act for fear of litigation.

8. Has the Act ushered in the expected, or any, change in the culture of care?

The Act has reinforced/established good practice principles. However, it has not created a consistent and robust approach in health and social care settings. There can be a danger that a decision-maker assumes more power than they actually have to effect change, hence breaches of Article 8. The Act is about empowering but once a person has been deemed to lack capacity to make a decision they become vulnerable to the opinion of the decision-maker and when those decisions are not reflective of their best interests it often leaves them powerless to challenge. This is especially the case where DoLS or the IMCA service are not fully utilised. Clearer links with other national drivers may prove helpful.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

Limited research exists. However, the socio-economic indicate that individuals who enter care as self-funders are often not subject to the Act as neither health or social care are involved in the assessment of their capacity/choices/best interests. This has led to breaches of the individual’s human rights. Individuals whose access to social care relies on funding from social care are often “encouraged” to enter 24 hour care as this is often “cheaper”, “safer” and “requires less monitoring” even if the person is indicating they would prefer to remain in their own home.

**Decision making**

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Act has provided benefits and better protection. There are areas of concern, as when an individual loses capacity and is reliant on best interests decisions, these do not always evidence a balanced view. Judge Mumby’s quote “what is the use of making someone safe, if it makes them miserable” emphasises the risk averse culture that has often meant that the views of people lacking capacity are discarded by professionals making best interests decisions unless they are represented by family, paid representatives etc.

Not sure that LPAs for health, for example, are being adhered to as not necessarily recorded in hospital medical records so how can staff know they have to consult an attorney? As a BIA, this is generally discovered on consulting with family and friends. Not sure how many patients have LPAs but when brought to the GPs attention, they are scanned into the system with a ‘reminder’.

The court of protection is still too expensive and many Local Authorities are reluctant to seek early views in the current financial climate.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

We are seeing little evidence of advance decisions having been made. Support for individuals and families to consider this in advance of losing capacity would be beneficial.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

The MCA facilitates involvement. However, limited knowledge exists and families and carers are often “side-lined” in key decision-making.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

The role of the IMCA has succeeded in supporting vulnerable people and reviews have been called and appeals made. May possibly benefit by a longer training course for practical skills development but IMCAs are, in the main, adequately resourced and skilled

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

Some areas have had high numbers of referrals but this does not necessarily mean that the IMCA usage should also be high. It is more important that the service is effective when it is called upon.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

Additional training to meet the needs of individuals with complex learning difficulties and/or communication issues – stroke/language etc. would be beneficial.

**Deprivation of Liberty Safeguards**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

Yes, if correctly applied and followed but it is an overly bureaucratic process that needs to be simplified and the process and timescales needed to be reviewed. Section 44 needs more clarity and is more difficult to apply in hospital settings.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

Appealing against a DOL takes too long and the CoP is too costly. Consideration of a tribunal process (similar to the MHA) would be helpful. Additional information about how to make a section 21a appeal for families, carers etc. would be useful.

The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

The Court of Protection needs to be made more accessible. Professionals and staff in many cases are still unaware of the CoP and OPG and what they do, although always included in training sessions. Some staff have also experienced difficulty in contacting the OPG for getting information from the LPA register for example.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

A number of family members are appointed as attorney mainly for health and welfare for the RP but their understanding of the MCA is not always as good as it should be to undertake this role effectively.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

Costs may be prohibitive in some cases where exemptions are not applicable.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

We have concerns about lack of knowledge and understanding of the MCA, particularly the deprivation of liberty safeguards. Would be good if the CQC had additional powers to enable it to question whether conditions applied to authorisations have been implemented and whether the RPR has maintained minimum contact with the relevant person. Also, whether the CQC could do anything about this as currently some MAs cannot evidence whether they have implemented (all) the conditions or recorded RPR contacts and other

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Sheffield Safeguarding Adults Board – Written evidence

than a reminder that it is a legal requirement, there are no checks being made and, in some cases, this would be difficult to do. Very often significant concerns are missed and there is over emphasis on less important matters.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Yes, compliance checks and auditing needs to be routine practice.

Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

There is a lot of confusion or misunderstanding in following areas:

-When a person lacking relevant capacity is subject to the MHA or is an informal patient.

-Around eligibility for DoLS when a person is in hospital

-The GJ test (case law in this area) needs incorporating into the code of practice and used in training mental health assessors.

There are incorrect assumptions about when DoLs can be used and is thought by some to be a less restrictive option to using a section of the MHA.

2 September 2013.
Shropshire Council – Written evidence

The MCA has achieved its aims in part. Successful implementation has varied dependent on the priority it has been given. The key element in successful implementation has been the continued provision of the MCA grant and where local authorities have managed to maintain a specialist role, implementation has been successful.

A specific power to convey following a best interests decision to remove someone to a care home or hospital may make this process clearer for practitioners.

The principles underpinning the Act are clear and if followed, ensure compliant practice. They provide a value base on which training and development can be based.

All Local Authorities completed a best practice tool in 2007; this was a highly effective in assessing readiness for initial implementation. Follow up to this could easily be developed nationally. Local audits have taken place. Links with Safeguarding Boards are essential for ongoing monitoring of implementation.

The initial provision of Regional and National Leads gave a coherent message and direction was established. This support was withdrawn too soon into implementation. Grant funding has continued but is not ring fenced. There is no central assistance to provide consistent interpretation of case law.

Professionals working in health and social care are aware of the Act and it has formed an integral part of the assessment process proportionate to the amount of training delivered

One of the difficulties in application of the Act is identification of the decision maker. When this is family or informal carers they do not usually have the knowledge or expertise in the application of the Act needed to make compliant decisions. Disputes are more likely to be placed before the Court now to ensure the rights of the carer are equally heard.

The Act has brought about a move away from paternalism towards empowerment and rights based provision in the person’s best interests. Capacity is no longer seen as the remit of “experts”.

People are being better supported to make decisions but generic staff need specialist training. Service users who are self-funding need support with assessing capacity and making best interests decisions. The MCA, if correctly applied, strikes an appropriate balance between families’ rights and responsibilities. The involvement of an IMCA ensures a voice for service users. Their role has developed into a highly specialised resource. Serious Medical Treatment referrals are low in Shropshire and this may relate to the difficulty engaging hospital Consultants with training.

The DOL safeguards are a rights based and capacity-focussed response to an identified gap in the UK Law. They are effective in subjecting cases of suspected deprivation to scrutiny and assessment. People are going home from care homes that may otherwise have been forgotten. However the time limit for Urgent authorisations is too short. There should be one application with a longer (perhaps 14-day) response time.

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The overlap between MHA and MCA in general is misunderstood. Joint training is needed between BIAs, AMHPs and DoLS MHAs to ensure learning takes place from each perspective.

DoLS authorises a deprivation of liberty on the basis of best interests. This is compatible, in our opinion, with the United Nations Convention on the Rights of Persons with Disability.

**Shropshire Council Evidence for**
**HOUSE OF LORDS**
**Select Committee on the Mental Capacity Act 2005**

**Overview and context**

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

Assuming the aims of the Act were:

- To empower people to make decisions for themselves where possible
- To protect people who lack capacity by providing a flexible framework that places individuals at the heart of the decision making process.
- To ensure that individuals participate as much as possible in any decisions made on their behalf and that these decisions are made in their best interests.
- To allow people to plan for the future when they may lack capacity for a number of decisions.

Then

1.1 Yes, it has achieved these aims in part. Successful implementation has varied dependent on the priority it has been given within areas. The changes inherent in the Act required an enormous culture change across the health and care economy. This was far reaching, perhaps further reaching than at first envisaged. Every aspect of the core business of health and care professionals is impacted by the Act.

1.2 Anywhere that there is a decision to be made by an individual on behalf of someone who lacks capacity to make that decision, the Act is engaged, whether that is simply to invoke the assumption of capacity or whether it is a formal two stage assessment. Once the Act is at the forefront of a practitioners’ thinking and practice, people are empowered as a result of that. Local Authorities and other bodies have had to accept that they cannot make decisions for people where they have capacity, even if this involves them in risky decisions. This core culture change will continue to take time to embed.

1.3 The changes in documentation, assessment content, policies and procedures needed to ensure that people are empowered to make decisions, take time to put in place. The key element in successful implementation has been the continued provision of the MCA grant and where local authorities have managed to maintain a specialist role, implementation has been successful. The additional skills required by practitioners to support decision making and empower people have required additional training which goes beyond what was originally envisaged and this is still expanding.

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CASE EXAMPLE: SUPPORTED DECISION MAKING

A young woman with a learning disability was admitted to an acute hospital due to extreme weight loss and muscle wasting - she was non weight bearing. She was transferred to a Community Hospital. During her stay many issues of concern were identified. She was a selective mute and was controlled at all times by two members of her wider family. She had been removed from school and from “the system” at age 12. The family members remained with her at all times. After an assessment of capacity a P.E.G was fitted to feed her. This was opposed by the family and was subsequently cut twice during the hospital stay. A DoLS authorisation was put in place and family visits were restricted to outside of therapeutic interventions. The young woman could not use cutlery and did not appear to be familiar with many foods. Her capacity was in doubt mainly due to her refusal to communicate by any means. Following hospital she was moved to a care home and another DoLS authorisation was put in place. Due to the restrictions on family visits and the opportunity for therapeutic input her language returned and she regained capacity, eventually moving into supported employment and living independently with minimal support.

1.4 Shropshire Council has maintained a dedicated MCA/DoLS Lead since 2008. This post has been instrumental in reviewing all policies for MCA implications and reviewing paperwork relating to assessment and review to ensure issues of capacity are addressed throughout. The post holder provides advice on complex issues, develops guidance for staff and delivers higher level training across the health and care workforce.

1.5 In Shropshire any practitioner’s requests for funding for long and short term care must be supported by assessments of capacity and best interest’s decisions. Tools have been developed to support this. This is leading to a fundamental shift in culture.

1.6 Training across the health and care workforce, the independent sector and families and carers has been instrumental in disseminating the messages of the MCA. Where the local authority and/or the PCT (CCG) have maintained a training profile by utilising the grant funding, implementation has been wider reaching.

Extensive MCA training has been carried out by Shropshire Council over 5 years. This has always been well attended and this continues to be the case.

Shropshire Mental Capacity Act Training data from 2008 to 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Numbers trained</th>
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<tbody>
<tr>
<td>2008/9</td>
<td>1249</td>
</tr>
<tr>
<td>2009/10</td>
<td>1658</td>
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<td>1998</td>
</tr>
<tr>
<td>2011/12</td>
<td>1252</td>
</tr>
<tr>
<td>2012/13</td>
<td>1341</td>
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</table>

Training Courses attended to Support MCA implementation

- MCA Awareness
- MCA Level 2/3

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Shropshire Council – Written evidence

- Dols Awareness
- DoLS Level 2/3
- Chairing Best Interests Meetings
- Best Interests Problem Solving
- MCA and Policies and Procedures
- MCA and Record Keeping
- MCA and Do Not Attempt Resuscitation
- MCA and Young People
- MCA and Medication
- MCA and Hospital Discharge
- MCA and The Court of Protection

Examples of staff feedback from training

“It was fantastic to have a trainer who was so knowledgeable about their subject. Great course, very useful crucial information for my role as SW”

---oOo---

“The course was excellent, very informative, directly assisted with practice”

---oOo---

“Informative learning left me wanting to find out more

I like the reference to situations in normal life, it helped to understand how complex the mind is

The training will make me consciously consider the MCA and whether my service users have capacity to make individual decisions”

“I will have more confidence with MCA assessments/BI decisions”

1.7 A comprehensive MCA audit was also carried out in 2010/11 to assess implementation. The findings from this led to the development of a MCA Staff Competency framework and training was redesigned to target staff working at different levels of decision making.

1.8 Flexibility is inherent in the Act. Having one definitive process for assessing capacity, no matter what the decision, makes for a consistent response. Training can be delivered at a basic level covering the entire Act across the health and care workforce, as well as the Independent sector as well as to families and carers. Bespoke training can then address specific more complex areas. As implementation has progressed the application of the principles has increased. Best Interests decision making meetings are becoming a routine part of social work practice. People are more likely to be involved to the extent that they are able in decisions affecting them. Specific training is needed to fully educate practitioners at all levels about the interpretation of best interests.

1.9 As case law has developed the need for dissemination of concepts must keep step with this. The concept of best interests was not defined in the Act and our understanding has

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been developed by case law. These decisions need to be shared and the effects of them must be incorporated into practice. Having a dedicated MCA lead helps to achieve this.

Shropshire has continued to provide a dedicated MCA lead to facilitate this work. Best Interests decision making tools exist for practitioners. Training courses are offered at 3 levels and specific bespoke workshops address specialised areas such as Chairing Best Interests Meetings.

1.10 The West Midlands Regional DoLS Leads Group has carried out extensive work to review the original DoH DoLS Forms. This was primarily to ensure the voice of the relevant person was clearly heard and represented in the process. Best Interests Assessors were often consulting, as required by s4 of the Act, but were not recording the views of P or of relatives and others. This has been addressed by adding specific sections to the Forms.

2. Which areas of the Act, if any, require amendment, and how?

2.1 Amendments to the substantive Act may be required in terms of Conveyance. There is still confusion as to where the MCA and the DoLS diverge. Direct care providers and social care and health professionals are often reluctant to accept that the Act gives them the power to carry out specific acts on a person’s behalf.

Issues of particular difficulty are removal from home and restraint necessary to provide essential care.

2.2 Greater clarity could be provided in the Code of Practice addressing the more complex areas which social care and health professionals encounter, rather than the very simplistic examples which are given.

Specific power to convey following a best interests decision to remove someone to a care home or hospital may make this process clearer for practitioners and provide a more robust instruction to the ambulance service, for example.

Shropshire Council is currently developing practice guidance to its care staff on removal from home. This will be supported by specifically commissioned bespoke training in September 2013.

2.3 The West Midlands Regional DoLS Leads Group (WMRDLC) is developing a regional conveyance policy under the MCA. It is also developing a regional document on restraint, restriction and removal from home. This is to ensure regional application of the MCA principles with consistency and to give a clear lead and direction across the region in relation to definitions and application in practice.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

3.1 The principles underpinning the Act are clear and if followed, ensure compliant practice. They provide a value base on which training and development can be based. The definition of capacity is clear although the diagnostic test is open to interpretation. There is no indication of the need for any degree of impairment as this is tested by the functional approach which comes next. There is sometimes a tension with the assessment of mental In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
disorder and the diagnostic test for general capacity decisions. The diagnostic element is sometimes overlooked as the focus can too easily be on safety and risk thereby directing professionals to best interest’s decisions without the essential qualifying tests being met.

CASE EXAMPLE

A case conference was arranged by an acute hospital due to concerns they had relating to an unsafe discharge. Facilities at home were felt to be less than adequate. Entry to the property was difficult due to greatly impaired mobility. An Independent social worker was engaged to carry out an assessment of capacity in relation to the specific question of discharge home. A multi-disciplinary meeting was called to consider best interests. The Independent social worker found that there was no evidence of an impairment or disturbance in the functioning of mind or brain. The diagnostic test had been overlooked and was not met. Therefore the MCA was not engaged and the woman made her own decision to return home.

3.2 The concept of best interests is still developing. Its progression from being almost an entirely medical concept, to a holistic concept encompassing well-being and emotional and psychological health, is an extremely positive effect of the MCA. The Court of Protection is leading the way in directing professionals away from the “protection imperative” and towards rights based responses which incorporate positive risk taking. This is a highly successful outcome of the Act. It promotes and encourages holistic assessment and directs professionals back to some of the core elements of practice such as risk assessment. This is particularly powerful in the work of BIA’s who are becoming a highly skilled set of professionals. Their ability to step outside generic practice and focus on best interests is producing excellent work and challenging risk averse practice.

3.3 The WMRDLG have developed a new Form 10 for BIA’s which assists with best interest’s decision making for DoLS. This form is based on a best practice document also developed by the group and shared with all BIA’s in the region. The group also developed guidelines for practitioners and DoLS Authorisers to support more robust and consistent decision making and they are just about to begin an audit of practice with a specifically designed audit tool.
Implementation

1. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

1.1 All Local Authorities initially completed a best practice tool developed by the DH in 2007; this was a highly effective tool in assessing readiness for initial implementation. Follow up to this could easily be developed nationally.

Local audits have taken place. Shropshire Council carried out a comprehensive MCA audit in 2010/11. Copies of the full written report are available, if required.

Following this an MCA Staff Competency Framework was produced and training was redesigned. All partner organisations adopted the framework and it is now part of the Quality framework the CCG has with its commissioned service providers.

1.2 Some Local Implementation Groups still meet and where they do this provides a valuable resource. Shropshire has a very effective group which meets regularly. All partner organisations contribute to discussion and debate as well the development of policy, publicity and addressing concerns. This group reports at least annually (more often as necessary) to the Vulnerable Adult Safeguarding Board. Protection issues are directed to the VASB. This group holds all partners responsible for implementation and addresses any areas of concern. DNAR decisions have recently been discussed, Consent Policies and IMCA referrals for Serious Medical Treatment decisions. The group ensures a robust response and monitors progress to address any identified weaknesses.

1.3 Joint working is key to successful implementation and the delivery of a coherent and consistent message. Shropshire Council has a joint working agreement with Shropshire CCG (previously PCT) which has continued for 5 years. This ensures that the message is consistent through the provision of joint training, shared publicity and promotional material, consistent advice for difficult cases and jointly developed policy and procedures.

2. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

2.1 The initial implementation plan was effective. By providing Regional and National Leads to support the work a coherent message and direction was established. This support was withdrawn too soon into implementation. Grant funding has continued but is not ring fenced and is not transparent therefore easily transferred to other areas of spending. There is no central direction on interpretation of case law as there was in the beginning and no centralised circulation method or methodology for dissemination of information.

Some areas have managed to sustain and develop their own support networks for example Shropshire has a very effective Local Implementation Group, well supported by all partner organisations and linked to the VASB.

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2.2 The West Midlands Regional DoLS Leads group has risen from the ashes to become a highly functioning group providing leadership and direction across the region in improving practice, developing tools and raising standards.

2.3 The work with families is still ongoing and an area of much needed investment. Publications, films, support and advice are still needed to ensure that families are aware of the rights of the person they care for. The implications of the Act for 16 and 17 year olds is a specialist area in its own right and the parents of young people need targeted material to support them, and the young people need specific programmes to inform them of their rights under the Act.

3. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

3.1 Professionals working in health and social care are aware of the Act and it has formed an integral part of the assessment process. This appears to be dependent on the amount of training delivered and whether this training is organic and grows in response to new issues.

3.2 A one size fits all approach does not work. Shropshire Council has developed its training in line with the expertise and needs of staff. It has developed guidelines for staff to make clear which decisions they are able to take at which level. This level of clarity was missing from the Code of Practice.

3.3 From experience of training provision the harder to reach groups are medical Consultants working in hospitals. This group does not have an easily identifiable corporate identity and it has been hard to persuade them of the relevance of MCA for everyone, not just for those working in Mental Health. Some of the audit responses gathered by Shropshire Council in 2010/11 evidence this.

Decision making in hospitals often seems to be age discriminatory and very risk averse with decisions made by statements rather than by assessment as directed under the Act.

CASE EXAMPLE: ROLE OF BIA IN ENSURING MCA IS FOLLOWED AND PROMOTING LESS RESTRICTIVE OPTIONS WHILST BALANCING RISK.

Mr B is an 89 year old widow who lives alone in a detached bungalow. Notably he was a fighter pilot during the Second World War flying Hurricanes and Spitfires in the Far East.

He was admitted to an Acute Hospital as a planned admission to have a right knee replacement operation. Following surgery he was transferred to a rehabilitation Ward. A head CT scan indicates extensive bilateral chronic ischaemic change, with atrophy and generalised ventricular dilation and increase in CSF spaces. Initially Mr B was agitated post-operatively, trying to get out of bed and mobilise when he was unable to. Subsequently, although this settled down, he continued to demand to leave.

A DoLS Authorisation was issued for three weeks because Mr B was making purposeful efforts to leave. He clearly expressed his wish to return home. He attempted to leave and the exit door was locked. Mr B continued in his determination to return home. He was
unable to remember his address. He did not acknowledge that he had care needs and was “not too worried” about returning home. He appeared to lack insight into his care needs.

The doctor said that Mr B would be “unsafe” to return home due to his cognitive impairment. He said he had “failed” the OT assessment and his inability to sequence actions and his lack of insight into his care needs would pose risks. He said that a likely placement would be an EMI residential setting. No home assessment had taken place. His only relative wanted him to return home at least for a trial.

A Best Interest meeting was arranged. No home visits or home assessment had taken place as it was felt Mr B would refuse to return to the ward. The social worker expressed concern at Mr B’s lack of insight into his own care needs however no contact has been made with Mr B’s neighbours. It was confirmed Mr B was not previously known to social services, his GP had not expressed concerns.

The social worker was reminded that less restrictive options must be investigated. The BIA attended the Best Interests planning meeting and a decision was made that Mr B should return home with a care package, which he subsequently did. He remains well at home.

Some Solicitors seem to have little awareness of the assessment of capacity when providing evidence for Lasting Powers of Attorney.

4. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

4.1 One of the difficulties in application of the Act is identification of decision maker. There are times when this is family or informal carers but they do not usually have the knowledge or expertise of the application of the Act needed to make compliant decisions.

Practitioners need to be alert to this and willing to support people. There are many self-funding service users who require help and support due to issues of mental capacity and therefore need allocation to a social worker. The role of IMCA only supports those who do not have family or friends when often it is the family and friends who need support to understand and apply the principles of the Act.

4.2 As implementation has progressed tensions have arisen between the rights of the carer and the cared for. The individual is at the centre of the process and their best interests may be at odds with the wishes and desires of the carer. It has taken time for Local Authorities and CCG’s to understand fully the role of the Court of Protection in settling disputes and ensuring compliance with Human Rights Articles.

Disputes are more likely to be placed before the Court now to ensure the rights of the carer are equally heard.

CASE EXAMPLE: COURT OF PROTECTION

A young man with a severe learning disability could not be cared for at home due to risks of violence. He had been supported in a care home who could no longer meet his needs due to

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the erratic interventions of one family member. A DoLS Authorisation was in place and restrictions were made in relation to family visits but the placement broke down. The next move was to a specialised setting out of the local area which a family member strongly opposed. The Council made an application to the Court of Protection for a welfare decision in relation to the move and to sanction the restrictions on contact as these went beyond the authority of DoLS

5. Has the Act ushered in the expected, or any, change in the culture of care?

5.1 The Act has brought about changes in the culture of care. A move away from paternalism towards empowerment and rights based provision in the person’s best interests. The Act ensures Human Rights issues are appropriately considered in the assessment and care management process.

5.2 Staff working at all levels expect to consider capacity in their day to day work. It is no longer seen as the remit of “experts” or of mental health professionals. However it is essential that the principles are correctly embedded and supported by rigorous training programmes as it is easy for direct care providers, for example, to pick up the language of best interests without acquiring the understanding of its full meaning.

The balance is always between rights and risks, and the MCA helps to ensure this is correctly applied.

CASE STUDY : CAPACITY, RISK AND THE ROLE OF PAID PERSONS REPRESENTATIVE (P.P.R)

Mr A is 85 with early stages dementia and short term memory problems. He was admitted to a Residential Care Home following a breakdown of care at home. His wife has physical problems and is wheelchair bound. They have been married for 66 years. On admission he presented as having some self-neglect issues.

His wife had initially refused to have him back home. Mr A was adamant that he wished to return home. This resulted in a DoLS Authorisation.

When the BIA met Mr A he appeared low in mood. He was able to communicate verbally, but appeared withdrawn and distant. His communication was limited. He said that he “wanted to go home” and that he had been ringing his wife to tell her but “could not get through”. He accepted that he needed help with personal care and would benefit from a care package on his return home. He expressed his frustration at not being able to return home through his words and facial expression. His medication had recently been changed.

The PPR expressed significant concern about Mr A’s “low and flat” presentation. She was strong in her opinion that his needs must be considered of equal value and merit as Mrs A’s. She commented that as shared occupants of the home he had as much right to live there as his wife.

She expressed the view that if the placement was made permanent she would be very concerned about his mental state.
The Social Worker expressed on-going concern regarding the situation at home mainly due to a previous incident where Mr A went out to the shops and got on a bus and was returned by Police after getting lost.

After a short respite break Mrs A later stated that she wished her husband to return home. She stated “they won’t let him home unless there is a (care) package in place”. “I do want him to come home with a bit of support”.

Mr A’s medication was reviewed as both BIA and PPR had found him to be sleepy, withdrawn and uncommunicative. His medication was reduced significantly and within a few days he was assessed to have capacity to make the decision about where he is accommodated for care and as such plans were put in place for a speedy return home.

This case demonstrated the role of the PPR and the BIA as advocate and also highlighted the different attitudes towards incapacitated risk taking and capacitated risk taking. Professionals were much more cautious, highlighting risk rather than promoting autonomy at the time they felt Mr A lacked capacity. Once he was assessed to have capacity their concerns fell away.

6. **Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?**

The only data which is mandatory relates to the DoLS and this does not suggest that the provisions are experienced any differently by any particular group.
Decision making

1. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

1.1 People are being supported to make decisions more than previously but this is an area which can be developed further. Generic staff will not have had training in communication. The Act has made this a priority and specialist training is needed - communicating with the person with dementia, communicating with severely autistic people, for example, are specialist areas.

Shropshire Council offers training for all its social workers on “Communicating with the person with dementia”. The MCA/DoLS Lead also commissioned specialist training in this area for their BIA’s.

1.2 Service users who are self-funding still need support with assessing capacity and making best interests decisions. Even if family members hold an LPA, they are rarely aware of the requirements of the Act and need the support and guidance of social workers. This has resulted in increased workloads for social workers.

The need to apply to the Court of Protection for resolution in areas of dispute or complexity has provided welcome scrutiny for local authority decision making. Although the process is lengthy and time consuming, the decisions are helpful and often influence the policy development for others.

Sadly, the cases which attract publicity from the Court of Protection are often those where Local Authorities have failed in their duties under the Act, or failed to correctly apply the principles.

There are numerous other examples of good decision making where applications have been made to the Court in a timely manner and the Act has been correctly applied to empower the service user.

CASE EXAMPLE: WELFARE DECISIONS

A 30 year old man lived alone in a rented property which he had previously shared with his father until his death. The property had become a health hazard due to obsessive collecting and hoarding. The Landlord (a Housing Association) desired to move the young man, temporarily in order to de-clutter and decontaminate the property and carry out essential repairs. The man would not engage with professionals, or his G.P, or let anyone in to his property. Occasionally it was possible to chat with him briefly on the doorstep. He had always been told by his father that if he was ever in trouble he should go to the Police. Hence this is where he went when his electricity ran out or he had other household problems.

Many different ways were considered to seek access to the property, none of which were successful.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
A preliminary assessment of capacity was carried out based on the knowledge that he had attended a special school and some minimal input from the GP. An application was made to the Court of Protection to remove him to a care home for a temporary period to allow for the repairs and other necessary work to be carried out.

A plan for the move was agreed by the Court involving a range of proportionate measures including Police, ambulance, G.P and a variety or restraint methods. On the day a Policeman attended and simply asked him to get into the car, which he did without hesitation.

A short stay in residential care greatly improved his wellbeing, his mental capacity for decision making improved and he returned to a safe and clean home.

2. What evidence is there that advance decisions to refuse treatment are being made and followed?

NOT ANSWERED

3. Has the MCA fostered appropriate involvement of carers and families in decision-making?

3.1 The MCA, if correctly applied, strikes an appropriate balance between families’ rights and responsibilities, and clarifies who is the decision maker and when this is or is not the family member. The IMCA role would be beneficial if it also applied to situations of dispute rather than simply where there are no family or friends to consult with.

3.2 Best interests meetings ensure that families and carers are fully involved in the process of decision making. Even where families offer a dissenting or oppositional view their views are recorded and considered by the decision maker. It can often be the case that the vehicle of a best interests meeting is the means by which family understand the implications of the MCA for the first time.
CASE EXAMPLE: PARTICIPATION IN BEST INTERESTS DECISIONS

A young man with autism, challenging behaviour and complex needs was placed in a specialist care home. His parents were very involved with his care and were experts on his disability. They were fierce advocates for him. Due to acceleration in his behaviours and a conclusion that living with others was not meeting his needs a move was proposed to a more bespoke provision.

A best interests meeting was called. The father attended to share his views. He was clearly of the opinion that a decision that his son lacked capacity in relation to the choice of home would mean that his son was no longer involved in the decision. The best interest meeting allowed professionals the opportunity to explain that his son must be permitted and encouraged to participate fully in the decision. They explained that his views would still be important even though the decision would be made by others. He would still have as much input into the move as he was able to have. This was a significant fact for the family and made collaborative working much easier.

Family consultation is at the heart of the DoLS process often during a very difficult time for them.

3.3 The role of the BIA as a conduit to other professionals is becoming extremely valuable. The family member is able to give their views and opinions on best interests and to see these views recorded thoroughly in the final report.

The role of the BIA in clearly explaining to family members the meaning of DoLS cannot be underestimated. People can be very frightened by the language and need to understand this as something to protect their loved one rather than something punitive.

Hello “BIA”
You spent so much time on my father’s case at the Care Home in Shropshire that I felt duty bound to get in touch.
Sadly he passed away on Saturday last, after a debilitating week with a UTI. He gave up on food and meds and ended up bedbound for a week, then inevitably succumbed and died very peacefully. The staff were marvellous with him in his final hours, and I was with him until near the end. Thank you all for his two and a half weeks of “freedom”. He loved wandering around in and out of the conservatory, bantering in his own way, with staff and residents. I feel sure that his case has left a legacy for others who will follow, thanks to your intervention. Thank you for all the time which you invested in him. It was worth it, even if short lived.

Family members are often selected as the Relevant Persons Representative under DoLS and can have additional support with this role from an IMCA. It is rare for family not to be selected if they wish to take on this role.

Shropshire Council has developed a satisfaction survey following a DoLS request. These are sent to family members and carers; a copy is attached at APPENDIX EIGHT. Some of the responses include

“Thank you for the help at a very difficult time that changed my life”

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
“The best interest’s assessor was extremely knowledgeable and helpful. I found the process very informative and feel it will provide a clearer focus to those people involved in the individuals care, the individuals family and the individual themselves”
“Really excellent everybody involved cannot do enough for you”
“My father’s well-being was put first at every stage of the process. I was impressed by the concern expressed by everyone concerned”

4. **Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?**

4.1 The involvement of an IMCA is generally very valuable in ensuring a voice for service users. Their role has developed into a highly specialised resource. There is perhaps a need for a more robust system to implement the actions identified in the Report they produce to Decision makers. The interaction of all parties required by the Act ensures the appropriate response. It can sometimes be the situation that an issue is identified by one person carrying out their role but, due to the dissemination of wider knowledge and information, IMCAs are in a better position to highlight the need for a statutory referral.

**CASE STUDY- INTERACTION WITH SERIOUS MEDICAL TREATMENT**

A man with a brain tumour was in an acute hospital. A DoLS authorisation was in place on the ward as he was constantly trying to leave the ward - he was wandering about the Ward trying to get home, agitated and aggressive to staff.

He had been referred to a specialist hospital, with a view to surgery. They had concluded that there was no surgical intervention possible and he was to be treated conservatively. The hospital had omitted to make a Serious Medical Treatment referral to an IMCA as the proposed treatment was in fact no treatment. The BIA identified this error and an IMCA was instructed retrospectively.

5. **Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?**

5.1 There is a still a way to go in terms of IMCA referrals. Serious Medical Treatment referrals are low and it would seem that this may directly relate to the difficulty engaging hospital Consultants with training programmes.

Care referrals are generally as expected.

DoLS referrals are made directly from the DoLS team and are likely to be accurate. Regional variations probably depend on the existence of a clear expert or MCA lead, the amount of training provision and the existence of local Implementation groups for scrutiny as well as demographic circumstances.

In Shropshire referral data is reported to the MCA lead and is broken down by source of referral so it is possible form this data to identify teams or hospitals where referrals are less than would be expected.
IMCAs themselves are a specialist source of non-instructed advocacy and useful in situations outside the generally commissioned service.

CASE EXAMPLE: USE OF IMCA OUTSIDE SPECIFICALLY COMMISSIONED SERVICE

A young man with severe autism and challenging behaviour was facing a move to a bespoke service provision. He did not meet the formal criteria for an IMCA as his family were fully involved with supporting him. However, it was felt that he would benefit from the input of a specialist non-instructed advocate and as such the local IMCA service were contacted. An arrangement was made for them to provide specific support before during and just after his move, to ensure that his involvement in the process was promoted and his choices were maximised.

6. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

The IMCA service is commissioned by Local Authorities who have rigorous methods for selection of Tenders. Shropshire Council ensures that its service provider gives robust evidence of training to ensure skilled advocates. Contract monitoring meetings are regularly held. Data is supplied quarterly and the Manager of the IMCA service attends the local operational group. Joint training is provided by the MCA lead and the IMCA service.

Deprivation of Liberty Safeguards

1. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

Is this question - are they an adequate safeguard to prevent arbitrary detention?

1.1 Nationally there is some dislike of the DoLS Safeguards, generally this seems to be from those with a long working connection in the Mental Health field, who may not administer them or apply them.

1.2 Shropshire Council holds the view that the safeguards are a new, rights based and capacity-focussed in response to an identified gap in the UK Law. The DoLS are effective in subjecting cases of suspected deprivation to scrutiny and assessment.

1.3 The ongoing development of definition and interpretation of the statutory regime is challenging but people are protected now who have never been protected before, such as those with a learning disability who do not fit the criteria for detention within the MHA. The process ensures this protection is provided to them and is scrutinised fully.

1.4 The dissemination of information and meaning requires ongoing communication and training for Managing Authorities, and centralised support and leadership was withdrawn too soon. Managing Authorities lack confidence in identifying restrictions and supervisory bodies need to respond to this. Shropshire Council provide ongoing training for Managing Authorities on DoLS at an awareness level and also at a higher level.
Shropshire Council – Written evidence

“Trainer was interactive and gave reasons and understanding of previous experience. Very knowledgeable and answered all questions in detail and was able to give advice. Use of scenarios interesting, enabled more understanding. I am now clear about standards and process to follow”

Shropshire Council DoLS team have found a direct link between training and referrals.

1.5 The concept of BIAs as a distinctly different role to AMHPs is extremely valuable. A new type of professional is emerging skilled in putting the person first, challenging assumptions, challenging risk averse practice and clearly identifying the least restrictive option. People are going home from care homes that may otherwise have been forgotten.

As an independent professional, the BIA is able to challenge over-protective practice within Local Authorities. MCA principles are adhered to in establishing the building blocks to support placements and challenge inadequate risk assessments.

Clinical decision making which often is made on the basis of age alone can be challenged and changes are made which promote the persons autonomy.

Part of the process also ensures scrutiny of care planning within care homes and many changes have occurred for the person resulting in improvements to their care even though they may be deprived of liberty, as a result of the involvement of a BIA.

CASE EXAMPLE: ENVIRONMENTAL CHANGES TO CARE PLAN

A man with dementia was placed in a care home. The home found the man very difficult to manage as he was inclined to want to walk at will and without purpose. This usually included him going into other people’s rooms. The care homes response to this was to place him on the first floor in a corridor which they locked at both ends. This of course limited where he could walk and made it inevitable that he would go into other people’s rooms.

The other residents on the corridor were all bed bound so locking the corridor was purely to deal with his behaviour. It was described as an EMI wing but it was a corridor with bedrooms there were no social rooms. The man was not sleeping, very bored and isolated. The family mistakenly thought this was a symptom of his dementia and so initially supported the actions.

The BIA made the requirement as a condition of the DoL that the locks were removed and attempts were made to involve the man in social activity. Following this the man was transferred down stairs. He enjoyed sitting in the conservatory, having a wider area to walk in, he began singing along with Welsh choirs and began to play board games. The staff were greatly encouraged by the change in his demeanour and presentation. It had just not occurred to them to take this action before the involvement of the BIA.

1.6 The WMRDLG have carried out extensive work to provide leadership and direction in relation to DoLS practice across the region. The groups’ focus is on benchmarking aimed at raising quality and consistency of practice.

The opponents of DoLS appear to focus on the interaction with the Mental Health Act and the ways in which Guardianship could have been used instead. It must be remembered that this option was explored initially and rejected by the Government. The DoLS focus is on the person, their wishes and feelings and their perception of the situation and it encompasses

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the whole of the MCA principles. The assessment is complex but holistic and consultation is a key element.

CASE EXAMPLE: LESS RESTRICTIVE OPTION

Mr J was admitted to a care home following the death of his wife. He had a diagnosis of Dementia. The family were very concerned about his ability to cope alone at home. His daughters who have an LPA for health and welfare decisions live some distance away. Mr J was not expressing a wish to return home but to go out for long walks whenever he wished, as he previously did from home. He was described by his daughters as someone who needed to be outdoors.

A DoLS Authorisation was in place for two months in order to see what further positive effect the substantial family support and frequent visits would have on his experience of residing in the care home. This period would also allow time for family to consider and if possible to implement the use of a volunteer to facilitate walks out and possibly share and encourage his enjoyment of books.

The “relative normality” of his life was emphasised throughout the DoLS assessment process. Mr J had independent access to a secure garden and courtyard, and both staff and family often enabled him to go out for accompanied walks. But until admission it was normal for him to go out as often as he wished on his own – which he did several times daily. For this to be limited, as it was in the care home, represented for him a severe and incomprehensible restriction, giving rise to intense and repeated frustration and agitation. The DOLS assessment identified this as the main issue/problem for Mr J and stimulated discussion around this.

The DOLS process involved the family and acknowledged their highly significant role and reinforced the importance of their contribution to his well-being. It highlighted the importance of emotional/psychological well-being and presented a challenge to traditional residential care arrangements which tend to focus on protection against risks.

Mr J did not “settle” and continued to be frequently frustrated/agitated because he was not allowed out despite intensive family efforts to visit and accompany him out several times weekly. This led family to question whether residential care was in fact the best arrangement for him.

The BIA helped family to consider and identify a less restrictive alternative, a return home with formal care in place and family support. The subsequent best interests meeting concluded that the benefits to Mr J of being enabled to return home with support outweighed the risks.

Mr J returned home and remains at home.

Hospital DoLS ensure safe delivery of treatment for people usually during particularly difficult circumstances. DoLS in care homes are usually a longer term safeguard.

From a quick survey of 34 DoLS monitoring sheets completed for Shropshire Council DoLS Team 28 people or 82% stated that they felt the person had better protection because of the safeguards, no-one disagreed with this statement but 6 people were not sure.

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1.7 There are undoubtedly bureaucratic changes which would improve the smooth running of DoLS, some are mentioned in the response to the next question. There are some circumstances which have not been envisaged, such as suspension of an authorisation for any reason other than failing eligibility – for example the person could be admitted to an acute hospital from a care home and there is no facility to suspend the authorisation; the person could go on holiday and there is no facility to suspend the authorisation.

Repeat requests for authorisations require less detail to be given and some reviews are very specific and do not have associated Forms. Shropshire Council has developed some Forms to address this which have subsequently been adopted regionally. One is a repeat request form and another is a hospital discharge review.

The ability to set conditions is a useful tool but there is no mandatory requirement for compliance except a short statement in the Code of Practice. Sanctions for non-compliance would be a useful addition.

2. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

2.1 The process is without a doubt convoluted but it is also effective.

The time limit for Urgent authorisations is too short. The Government envisaged that Urgent authorisations would be for “sudden unforeseen circumstances” however, in practice, a substantial majority of first time applications are Urgent.

This is because a deprivation is much easier to identify if the person is in situ rather than assessing a hypothetical care plan and a hypothetical set of restrictions.

There should be one application with a longer, perhaps 14-day, response time. The Managing Authority could simply state the date from which it is required.

2.2 Although the process is administratively difficult from the Supervisory Body perspective, it is straightforward from a Managing Authority perspective (although they dislike the complexity of the forms). They are simply required to identify when restrictions exceed those allowed by the MCA and then request a DoLS authorisation.

The training needs result from the requirement that they identify, as far as possible, when a restriction has exceeded what is allowed under the MCA. This requires training for all staff in the MCA itself, in the DoLS and, particularly, the ever changing concept of deprivation of liberty.

Reviews are easily accessible.

2.3 The process of application to the Court of Protection is a huge jump from a basic decision to what is often scrutiny by a High Court judge. People who are supported by Paid Representatives are likely to be aware of their rights to challenge decisions. People with family members as representatives may not always be advised of their right to challenge decisions.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
This is because there is an inherent tension in the role. Often there is a tension between the views of the family member and those of relevant person. The relevant person may desire to leave a care home whilst the family member may wish them to remain there.

It would perhaps be better if all people deprived of their liberty had a paid representative ensuring parity of information and access to appeal, although this would require an increase in the current grant provision.

Shropshire Council have had 3 challenges to DOLs brought in the Court of Protection - all brought by the person who lacked capacity via their paid representatives. This is often a lengthy process.

It would be more timely if local tribunals heard a first tier level of appeal with the right of further challenge to the Court of Protection.

The Court of Protection and the Office of the Public Guardian

1. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?
2. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?
3. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?
4. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?
   NOT ANSWERED

Regulation

1. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?
2. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

   NOT ANSWERED

Other legislation

1. How well is the relationship with the mental health system and legislation understood in practice?

1.1 This is an area which grows in complexity as the Act is implemented in practice. The overlap between MHA and MCA in general is misunderstood, and the overlap with DoLS is still developing.

1.2 There are situations where people are assessed as ineligible for DoLS (within the scope of the MHA and objecting to treatment) and subsequently assessed as ineligible for the MHA. This is becoming known as a “mini Bournewood gap”. Supervisory bodies are advised to develop protocols to address this. The WMRDLG has developed a protocol for the region and this has been shared with the national ADASS mental health lead.

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To support the protocol the WMRDLG has also reviewed the Mental Health and Eligibility forms used by DoLS Mental Health assessors, s12 doctors were involved in this review and the new form is currently being piloted. There is within this form a requirement that a MHA assessment is requested in order to ensure the best protection for people.

There is an identified dedicated s12 lead in the West Midlands to work alongside the DoLS Leads and regional training is organised jointly for BIA’s and MHA’s. This involves an element of practice and has contributed to better working relationships and improved quality of reports.

Joint training is needed between BIA’s, AMHP’s and DoLS MHA’s to ensure learning takes place from each perspective.

**Devolved administrations and international context**

1. Does the implementation of the Mental Capacity Act differ significantly in Wales? Not answered

2. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions? Not answered

3. **Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?**

3.1 There have been issues raised questioning whether DoLS are incompatible with Article 14, liberty and security of the person, as it states ‘the existence of a disability shall in no case justify a deprivation of liberty.’ The question is does DoLS authorise deprivation of liberty on the basis of disability i.e. mental disorder?

DoLS authorises a deprivation of liberty on the basis of best interests. The person needs to lack capacity for this decision due to an impairment or disturbance in the functioning of mind or brain. They also need to have a mental disorder.

It can be argued that the requirement to have a mental disorder is an unnecessary requirement and the safeguards would have the same effect if they were operated purely on the MCA definition of impairment or disturbance in the functioning of mind or brain.

This is of course qualified within the MCA as not to be made simply by reference to age, disability, behaviour and appearance and so on.

5 August 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Sam Smith – Written evidence

1. I am a former borough councillor and a mature student at the College of Law (recently renamed as the University of Law). I have a specialist interest in the Court of Protection (CoP) and I have been assisting people pro-bono in the conduct of litigation through John Hemming MP’s Justice for Families campaign.

2. As a result of this I have assisted in the Court of Protection as a McKenzie Friend on several occasions, including exercising rights of audience on occasion at the Court’s discretion. I have been praised by judges, for example the High Court Judge Mr Justice Mostyn named me in a judgement last year thanking me for my ‘sensible’ and ‘reasonable’ submissions.

3. I have worked on cases regarding the financial and also welfare jurisdictions of the Mental Capacity Act 2005 (MCA). This is my evidence, which deals with some of the procedural weaknesses of the Act. As far as possible, I have avoided naming individuals because although I happen to believe that aggrieved members of the public should be named if they want to be, I consider it more important to focus on procedures. I have also limited my evidence to questions which are not sub-judice.

4. I have broken my evidence into four sections, which are an Executive Summary followed by Welfare / Deprivation of Liberty, Financial Deputyship and Litigation Capacity. Welfare is itself broken down into two sub-sections, General Welfare and the Deprivation of Liberty Safeguards. Finally I put in some recommendations.

Executive Summary

5. Our society does have within it people who suffer from various degrees of mental impairment. Something like the MCA or for that matter the Mental Health Act is necessary. The principles of the MCA are very good. However the weaknesses of the MCA that spark the controversy are in its procedural safeguards, which are broadly speaking very poor. The general problems are as follows, set out in bullet point here and expanded on below -

- it is too easy to procure a finding of incapacity
- it is too easy to access ex parte procedures (person alleged to lack capacity is not informed of the process or prevented from meaningful opposition)
- it is extremely difficult to overturn a finding of incapacity / restoring capacity
- the system builds in substantial conflicts of interest
- the Court of Protection under the MCA is slower, less efficient and vastly more expensive that the Mental Health Review Tribunals under the older Mental Health Act and also much less accessible to its client base

Welfare / Deprivation of Liberty

General Welfare

6. The MCA gives the Court of Protection the power to make Welfare decisions, which includes the ability to determine where someone live, whether they can have an
abortion or even sterilisation. The MCA also creates the so-called 'Deprivation of Liberty Safeguards'.

7. From time to time, contentious decisions must be made in the lives of those said to lack capacity. For example, there might be a dispute about where a person should live.

8. To start Court proceedings the applicant (usually a local authority, but possibly a family member or acquaintance) must apply to a Court and attach evidence of incapacity such as a medical report as per Court of Protection Rules (COPR) 63(c). P (the person alleged to lack capacity) must then be notified unless the Court waives the requirement. The applicant is the person required to inform P of the application.

9. The problem with this process is that the applicant asserting incapacity is de facto entitled to choose an expert and in addition trusted to tell P, which does not always happen. P is then entitled to oppose, but has little in the way of a formal procedure. They fill in a form and if they assert capacity a Court may then appoint an independent expert. Legal aid is not automatic, but may be means and merits tested.

10. Often this is simply because P is in no position to start or defend proceedings - they may be comatose, for example, or incapacitated by Alzheimer's syndrome. However, where P in fact does have capacity it will be seen that from the outset that they are severely disadvantaged. The applicant has an expert of their choice and P may get another expert agreed by all parties and may get funding.

11. COPR 141 requires that P have a litigation friend which means P is assumed to lack litigation capacity (the ability to instruct a lawyer) from the outset of proceedings. So merely by filing the form the applicant strips P of their ability to instruct or seek advice from a solicitor.

12. The only real right P has to assert capacity (which is a powerful one) are those in COPR 147 and 148 which allow them to apply at any time to restore capacity. Even if they have a litigation friend they are allowed to apply directly. The rights in rules 147 and 148 are required by European Court rulings and also even by UK case law. I draw the committee's attention to the cases STANEV v. BULGARIA - 36760/06 [2012] ECHR 46 (17 January 2012) and also Masterman-Lister v Brutton & Co [2002] EWCA Civ 1889 (19 December 2002).

13. However there are no clear arrangements to support a person making such an application for them to receive legal advice or support in doing this, nor arrangements or funding for the independent medical reports necessary. I am only aware of two successful applications of such a nature and I assisted one of them! In the most recent Court of Protection Report (shamefully that is for 2010) on page 25 the figures show that 9437 financial deputies were appointed and 106 welfare deputies were appointed. The same page shows only 2 deputies discharged due to P's capacity being restored. That is 0.02% (in other words 2% of 2%).

14. Aside from the total lack of support or legal advice for persons found to lack capacity to reverse the finding, they may find other pressures such as being held in a care home and not allowed access to phones, the internet or writing materials.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Deprivation of Liberty Safeguards

15. The Deprivation of Liberty Safeguards suffer from extreme versions of the above problems. When it is thought that a person is being deprived of their liberty, or may need to be, an assessment must be commissioned.

16. The first hurdle is that a person must be deprived of their liberty. There is no statutory definition of this, which has led to horrifying rulings such as the case of C v Blackburn with Darwen Borough Council [2011] EWHC 3321 (COP), in which a person in a care home cried and begged to be let out and tried to kick the door down. He was found **not** to be deprived of his liberty and therefore not entitled to the 'Safeguards'. This is perverse. The man in the C case may very well have needed to be in the care home but we cannot have people in such a position with no rights of review or appeal.

17. The process for starting the safeguards is that if the 'Managing Authority' (meaning care home or hospital) believes that the person is deprived they must ask for an assessment. The assessment can also be triggered by interested third parties such as family members or (theoretically) P. The Managing Authority has a conflict of interest. It is their job in the first instance to trigger a safeguards process that will scrutinise their decisions, incur costs and cause general aggro. Unsurprisingly where P lacks pushy relatives the home may simply deflect or ignore their complaints of being detained.

18. The assessment is carried out by a 'Bests Interest Assessor' (BIA). The BIA is appointed, perhaps on a consultancy basis, by the 'Supervising Authority' (now always the local council). Where the local council has a stake in the process, for example because social services initiated the compulsory placement, there is a substantial conflict of interest. If the BIA upsets the local council it can simply take its business elsewhere in future.

19. If the BIA finds a deprivation of liberty is taking place it must either cease or be authorised. If an unauthorised deprivation has occurred in may also trigger adult safeguarding procedures.

20. Authorising a deprivation of liberty under what is called a 'Standard Authorisation' requires 6 assessments. This sounds onerous but in reality most of them are trivial, for example one is the 'age assessment' and only means checking the person is aged 18 or over. The important assessments are the Mental Health, Mental Capacity and Best Interests assessments. Only 2 persons are needed to complete all 6 assessments.

21. Once a Standard Authorisation has been granted, the person must have a representative called the Relevant Person’s Representative (RPR). The BIA chooses the RPR. Often, family members have been excluded simply because they disagree with the deprivation being authorised. Where family members disagree, the BIA can choose the one who most closely agrees with the local authority. Only the RPR has access to information and critically, legal aid to challenge the detention.

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22. The conflicts of interest here are enormous. The local authority effectively chooses the 'judge' and P's representative. If P's representative does challenge the detention there will be a costly court case where council employees decisions will be subject to scrutiny so the council had a clear incentive to pressure the BIA and choose an agreeable RPR.

23. If P wants to challenge their placement and their RPR disagrees then P does have a theoretical right to do so and even to the appointment of an Independent Mental Capacity Advocate (IMCA). The local authority is required to assist. In practice P, usually a vulnerable person locked in a care home, is simply fobbed off or given inaccurate information that their only right of challenge is via the RPR.

24. I am aware of local authorities that simply ignore the requirement to appoint an IMCA and at least one whistleblower IMCA threatened with dismissal when they raised this.

25. There are two avenues for P to challenge their detention. They may ask for a review at any time. The local authority 'reviews' its own decision. Unsurprisingly this is not a robust process.

26. The second avenue is an application to the Court of Protection. If someone, somehow, kicks this process off and P is not simply ignored it is slow and I have encountered several welfare cases of this nature which went on for years. Often, family members are not RPRs and bring proceedings as litigants in person.

27. I assisted in one such case, DJ v SJ, TCBC and VCH. In that case DJ was the son and his father, SJ (a man in his 90s) had been placed by the local authority TCBC in a care home owned by VCH. In essence the elderly man, SJ, had dementia and would accuse all and sundry of various heinous assaults.

28. Because DJ had disagreed with the local authority, social workers treated every allegation SJ made about DJ with breathless credulity whilst ignoring his propensity to make wild allegations about social workers, care home staff and fellow residents. The council made a safeguarding decision to ban contact between DJ and SJ on the basis that DJ had tied SJ up and beaten him reservoir dogs style.

29. I represented DJ pro-bono. In Court, Ryder J forced the council to withdraw the allegations and reinstated contact. I was able to find DJ a proper lawyer, and the case continued. Eventually SJ died. More than a year later the council and care home were found to have breached DJ and SJ's human rights. There was no legal aid for DJ - his access to proceedings arose from drawing up more than 50 pages of documents.

30. Starting the proceedings to challenge a Deprivation of Liberty required the following forms - COPDLC (application for permission), COPDLA (start the proceedings to challenge the authorisation), COPDLD (certificate of service), COP44 (fee remission application).

31. As proceedings are slow, to get anything done quickly (or a passing semblance thereof) you need to file an application for interim relief. I helped DJ do that too,
drafting a COP9 form along with a draft order supported by a witness statement COP24 and exhibits.

32. That is 6 forms. The resulting small forest had to be copied in quintuple (5 copies, one for each of the 4 parties and one for the Court).

33. By comparison the procedure for an appeal against sectioning under the Mental Health Act requires the detained person or their nearest relative to fill in a single 2 page form.

34. In Court the decisions about P are made with the assistance of expert witnesses. Expert witnesses in the Family Courts are often criticised as often being venal and biased in favour of local authorities to get more business. I quite agree.

35. As an example in the DJ v SJ case I was allowed to cross-examine a psychiatrist who had given an interim opinion. He admitted to not having actually made a written record of his instruction, not having seen any of SJ's medical notes, not having met SJ, not having any written instructions (only oral) and giving his opinion orally to the Official Solicitors representative. An interim decision keeping SJ in the care home was made on this 'advice'. The psychiatrist was not referred to the GMC by the Court.

36. In the Court of Protection psychiatrists are chosen by the parties, which leads to real and imagined allegations of impropriety and bias. By comparison in the Mental Health Review Tribunal one of the panel is a psychiatrist. Under the Mental Health Act last year, 36% of patients who appealed were let out either by the tribunal or their doctors let them out before the appeal was heard.

Financial Deputyships

37. The financial jurisdiction of the MCA and the Court of Protection covers authorities granted voluntarily (LPAs) and involuntarily (Deputyships). I will only deal with Deputyships. A Deputyship is where a person is appointed to deal with Ps finances and P loses some or all of his rights to manage his own money or enter into contracts.

38. The procedures for appointment and discharge of a financial deputy are in some ways worse than those for welfare decisions. Unlike welfare decisions, there is never any legal aid to challenge the application to find P incapable and strip them of their capacity. Worse, the costs rules for this type of application are that usually, P must pay the costs of all parties.

39. Imagine that, tomorrow, I apply to strip my neighbour of capacity as I am concerned about them. They object (assuming I did not 'forget' to serve them notice of the application) and I fail. They still have to pay my costs. That is the rule (specifically COPR 156).

40. Once a person has a financial deputy, their only recourse is to apply to the Court to discharge them and restore capacity. Aside from being time consuming there is no legal aid for this process and no money for a fresh medical report. They have to ask their deputy for the money! As deputies are often professionals paid a hefty fee (by P

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of course) for their services, they have a vested interest in not funding challenges to their revenue stream and choosing ... compliant ... doctors.

41. I assisted pro-bono in a case of this nature. The person, NB was a man who had suffered serious head injuries in a car accident. NB had a deputy to look after their substantial damages. At first NB genuinely needed a deputy, but over the years he recovered.

42. When he sought release from the Court of Protection Deputy, the solicitor first delayed any fresh assessment arbitrarily and then appointed a particularly expensive doctor who produced what can only be described as a hatchet job.

43. I helped NB find a cheaper, more honest psychologist who was paid by NB's elderly mother. She referred NB to a prominent psychiatrist. Armed with their reports NB issued an application for release, which I understand has been granted.

**Litigation Capacity**

44. Litigation capacity means having the mental capacity to conduct court proceedings, either in person or through a lawyer. This is the most important right. The Court rules allow a person to be stripped of capacity on application by another party or their own lawyer, at which point a litigation friend must be appointed, such as the Official Solicitor.

45. European case law has found that it is appropriate, even necessary, for persons who lack capacity to have someone to protect their interests in Court. However the European Court has also found that they must have direct access to a court to challenge the decision. So even once a litigation friend has been appointed they do not have a veto on applying to discharge them.

46. The difficulty again is that the procedures are vague and often abused, as well as being poorly understood even by some judges. Stripping someone of their right to a lawyer requires a single expert witness, sometimes none if the person refuses assessment. Sometimes it is necessary but sometimes the procedure is abused.

47. In a recent case reported in the Sunday Telegraph and in which I acted as McKenzie Friend, a woman was alleged to lack capacity by her own barrister after she fell out with her solicitors. She was ambushed at short notice by the application, a week before a complex family court matter.

48. I assisted the woman and was allowed to attend the hearing by the judge, Mostyn J. At the hearing I showed that the woman had legitimate complaints about her lawyers, whether or not she had capacity. Mostyn quite rightly dismissed them from the record.

49. Had I not been there the woman, who was distraught and barely coherent (despite being a highly paid professional earning £350 a day as a contractor), would have been unrepresented against her own professional barrister. She herself admits she would not have stood a chance.
50. The woman was found to have capacity. However she was left with a bill in excess of £4000, which she had to pay herself because she had not legal aid. If I had not intervened the woman’s lawyers would have avoided being fired by having their client declared mentally incapable!

**Recommendations**

51. In this country we have a Mental Health Act 1983 which offers real and robust safeguards relatively cheaply and effectively. The tribunal is cheap, very quick and not especially controversial. By contrast the Mental Capacity Act 2005 is fabulously expensive, incredibly difficult to access, slow and hated.

52. I gently suggest to the committee that if you have two systems running side by side doing almost the same job and one works well and one works poorly, the logical thing to do is to make the failing system more like the successful one.

53. The present Court of Protection should be swept away in both its financial and welfare jurisdictions. Deputyships should be authorised by a local authority in the first instance like DoLS. Appeals in both cases should be to a tribunal, with legal aid and a single hearing.

54. There should be a simply definition of Deprivation of Liberty and whatever that definition eventually is, it should always kick in when P is objecting to end the scandalous situation where people are begging to be let out and told they are not deprived of their liberty.

55. Whatever the procedure there must be no permanent findings of incapacity and people should be entitled to an independent second medical opinion, ideally from an expert of their own choosing, at reasonable intervals. Even where a person is thought ‘permanently’ incapable a diagnosis may be wrong or the degree of the condition may change.

**Statement of Truth**

I believe that the facts stated in this evidence are true.

Sam Smith
2 September 2013
Social Care Institute for Excellence (SCIE) – Written evidence

Implementation and Cultural Change

The Mental Capacity Act 2005 (MCA or ‘the Act’) seeks to empower people to make decisions for themselves wherever possible. It allows people to plan ahead and anticipate decisions they might need to make when they no longer have capacity and ensure that when decisions have to be made for them that these are in their best interests. It should be seen as the essential framework for a human-rights based social care policy and practice which seeks to personalise care and emphasises choice and dignity. In our view the legislation is, on the whole, well drafted and contains the correct principles and definitions.

The Social Care Institute for Excellence (SCIE) has developed a number of MCA resources through its work with the Department of Health and in collaboration with the social care sector that are widely regarded as useful tools.

Our ‘Social Care TV’ films develop scenarios which aid practitioners in thinking through the issues which might arise when implementing the MCA. Our ‘quick glance’ guides to the MCA and Deprivation of Liberty Safeguards (DoLS) are referenced by professionals across the country. Our e-learning resources provide easily accessible information on implementing the Act in every day practice. We have also recently published good practice guidance on accessing the Court of Protection.

SCIE offers in-depth MCA training to a wide range of health and social care organisations and receive a consistent stream of enquiries regarding the Act from professionals and the public. Some professional bodies also received embedded support from SCIE specialists on the MCA, including the English Community Care Association and the United Kingdom Home Care Association. This range of experience informs our views set out below.

We are aware of inconsistency in the understanding and application of the Act in the various care settings and in the transition between these settings. Anecdotally, the terminology of the Act is often misused and information is not easily accessible for service users, their families and wider networks of support. This is concerning, given the centrality of the Act in granting the legal authority to treat or care for those who lack capacity.

However, it is important to understand is that the Act affects a huge and diverse constituency of professionals, not to mention millions of informal carers. Uniformity in practice in these circumstances was unlikely and the cultural and organisational shift required to implement the spirit of the law will take time. Much progress has been made, but there is much to do.

Our view is that the next stage for implementing the Act is to ensure that the principles of the act are embedded within organisational structures, governance and policy. Feedback from trainers and trainees in health and care organisations often observes that health and care staff are instinctively keen to empower patients and service users but are held back by a risk-averse organisational culture. This is especially acute in the context of the financial challenges these organisations face.

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This shift will not only be achieved through the continued delivery of staff training but through services seeing themselves as learning organisations which can retain organisational memory of the MCA and its ethos as part of their practice.

Over the past decade there has been a shift of culture in social care towards a more personalised and enabling approach. The implementation of the MCA should be central to that change.

Anecdotally however, the MCA is not automatically perceived by professionals as being part of the wider shift to personalised and enabling care. The MCA is often wrongly conceived to be a framework concerned with the restriction and safeguarding of patients and service users- a risk management approach rather than a risk enabling one. It is vital therefore, that in the context of the challenges of the Care Bill, clarity is achieved through the development of new guidance which places the MCA at the heart of the Care Bill’s intentions.

**Disproportionately Affected Groups**

A Mental Health Foundation Report funded by the Department of Health and SCIE in 2009 identified some of the barriers to implementation among BME groups. It discussed cultural taboos regarding mental health, finances and death.

The report also found that efforts to raise awareness of the Act with BME groups had been inadequate, with awareness schemes regarding the IMCA scheme focused on staff, for instance. As a result some people from BME groups were confused about the role, and also felt IMCA services were delivered by organisations with little or no links to their communities.

The report's recommendations included independent research on and monitoring of the use of the Act by BME communities and how far it was benefiting them, and a strategy to raise awareness of the Act, working with local groups and community development workers.

However, there is not conclusive evidence to state that the application of the Act has been discriminatory.

We understand from practice that applying the MCA with people with dementia is complex. The condition means that an individual’s capacity is often variable and that well-meaning concerns about safety (for example frail elderly people falling when mobile) may lead staff teams into inappropriate restraint and deprivation of liberty solutions. In these circumstances, staff teams may not easily recognise their actions as constituting a deprivation of liberty

**Carer and Family Involvement**

There has been a shift toward increasing the involvement of carers and families in decision making by local authorities and their delivery partners. The MCA provides strong support for this, for instance by making consultation with interested family and friends a mandatory part of the best interests decision-making process under Section 4 of the Act.

The Act also provides clarity for family members, as well as professionals in health and social care, about who can decide if a person lacks capacity to make an essential decision at the
time it needs to be made. In that context, it is concerning that many admission forms in
health and social care settings, and consent to treatment forms, still contain unlawful
references to ‘next of kin’ and fail to make inquiries about whether there are any advance
decisions to refuse treatment or lasting powers of attorney for health and welfare matters.

Further, there are concerns that often families and other informal care networks are not
sufficiently informed regarding the MCA and therefore lack an understanding of their rights
and responsibilities. It is clearly a responsibility of those working in health and social care to
be clear about the Act, and share in an accessible and jargon-free way with both users of
services and with their families and friends.

Anecdotally, this lack of understanding on the part of carers and families often leads to the
assumption of decision making responsibility when a person is thought to lack capacity.
Family members may begin to deal with professionals on behalf of the individual – this is
particularly concerning in clinical settings, for instance at end of life regarding Do Not
Resuscitate Orders.

**Deprivation of Liberty Safeguards (DoLS)**

The Safeguards are of crucial value in protecting the human rights of the most vulnerable in
society, those who, due to a mental disorder, require significant restraint and restriction on
their freedom, in their best interests.

It is our experience, however, that they are poorly understood among many providers. We
are pleased to see that the Care Quality Commission has committed itself not only to
clearer and more experts monitoring of the DoLS but is also committed to do all it can to
encourage health and social care to be carried out within a wider understanding of the MCA.
Without this wider understanding, it is not easy for practice to be delivered within a
perpetual search for the least restrictive options, or even to recognise deprivation of liberty
when it might be occurring.

The DoLS framework is experienced as difficult by many people. When we created training
packages for care home managers who needed to know about this subject, we found that,
provided they understood the wide MCA, they found the DoLS processes less difficult.

We encourage care home managers to create a good relationship with their local authority
supervisory body office. We do however think there is wide variation developing among
different local authorities in their approach for example to complying with the regulatory
framework for time-scales for completing the process. In our recent account of DoLS
practice, we highlight examples of good practice, and add tools for evaluation of various
parts of the process.

We do hear of excellent outcomes from the use of the Safeguards, as presented in our
recent report, which examples where it was possible significantly to reduce restrictions on
personal freedom. While there is a review process included within the Safeguards, we are
concerned that for some people a review is never carried out during even fairly lengthy
periods of authorisation. We would like to see some strengthening of the review process,
perhaps something more akin to a First Tier Tribunal under the Mental Health Act, with an
element of independence, to which a person is referred automatically after a certain period
of time.

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submissions.
Court of Protection and Office of the Public Guardian

The Court of Protection is widely perceived as a remote from practice and its workings are not widely understood. This may be due to a lack of resources in the current context. However, the court’s decisions are perceived by subject experts to be well-informed and faithful in their application on the MCA.

We think the website is far clearer, and the forms are easier to understand and complete, than formerly, although they may benefit from design review. However, there is clearly a need to publicise the role of the Court and the Office of the Public Guardian.

Lasting Powers of Attorney (LPA)

It is our view that these empowering schemes, in particular LPAs for health and welfare, are insufficiently well understood. Health and social care providers often do not routinely seek out information about whether or not a person has made an LPA for health and welfare, nor about what is contained in it. This lack of understanding is of course not confined to these settings, and we understand that families and carers experience difficulties with other sectors including banking and telecommunications.

Many people are concerned with the cost of registering an LPA, or with making an application to the Court of Protection and this, combined with a lack of understanding among many families, can lead to costly subsequent legal fees in any conflict over the interpretation of the Act.

10 October 2013
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STEP is the worldwide professional association for practitioners dealing with family inheritance and succession planning. STEP helps to improve public understanding of the issues families face in this area and promotes education and high professional standards among its members. STEP has 18,000 members across 80 jurisdictions from a broad range of professional backgrounds, including lawyers, accountants, trust specialists and other practitioners. In the UK STEP has over 6,500 members and it supports an extensive regional network providing training and professional development.

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1.1 In our view the Act is still bedding in. Practitioners and professionals in the various fields who come into contact with it are still learning when and how it applies but progress is being made.

1.2 Codification of the test of capacity has, in relevant professional circles, generally raised awareness of the need to consider capacity more actively than was perhaps the case in the past. In particular the principle of a presumption of capacity and the requirement to assess capacity on a time specific and task specific basis has resulted in many more cases of individuals being able to manage some or all of their affairs that might not previously have been the case. However, more needs to be done to improve the awareness of the Act, in particular for front line workers in health and social care environments, where capacity assessments appear to be overlooked, sometimes with adverse consequences.

1.3 The Code of Practice ought to be updated in the light of experience since the Act was implemented. It was described as a ‘Living Document’ at the time of its introduction but it has not been updated since 2007. It would be of great assistance if the update of the Code of Practice included more practical examples – possibly taken from real cases which are reported either through the Court of Protection law reports or the OPG reports.

2. Which areas of the Act, if any, require amendment; and how?

2.1 The operation of Schedule 3 (the International Protection of Adults) to the Act and the fact that the Government has not ratified the 2000 Hague Convention on the International Protection Adults in respect of England and Wales means that it is not clear whether or not all of Schedule 3 is in force. A particular problem in this regard is the lack of clarity as to ‘foreign’ powers of attorney constitute protective measures for purposes of Schedule 3, and hence whether they can be the subject of recognition proceedings before the Court of Protection. Furthermore, Part 4 states that a protective measure is to be recognised in England & Wales but does not state by whom. The Court of Protection Rules must reflect how applications are to be made, supported by a Practice Direction.

2.2 Consideration should be given as to whether the Act is compatible with the UN Convention on the Rights of Persons with Disabilities and whether better provision should not be made for supported decision-making, perhaps following the lines of the Assisted...
Decision Making (Capacity) Bill 2013, which was recently laid in the Oireachtas, of the Republic of Ireland.

2.3 It should be made clear that attorneys under Lasting Powers of Attorney have the power to maintain someone whom the donor was in the habit of maintaining. Although judicial decisions have gone some way to clarifying the position, it remains uncertain exactly whom and in what circumstances an attorney under an LPA has power to do so (and the donor cannot extend that power). The power to maintain in relation to Enduring Powers of Attorney was satisfactory and should be extended to LPAs.

2.4 The notification period to raise an objection to the Office of the Public Guardian to the registration of an LPA has little worth and consideration needs to be given as to its removal. If there is justification for notification, it should occur after the power has been registered. This would avoid duplication of process (as an objection needs to be made both to the OPG and the Court of Protection), which would simplify the process and reduce bureaucracy for the OPG, which has no power to investigate; it would reduce delay for the majority of cases where there is no objection. Objectors must in any event make their objection to the Court of Protection, which determines the matter based on the evidence presented.

2.5 The role of the certificate provider should be enhanced, with a requirement that he see the donor of the power at the time of signing. Without this, the safeguard is undermined, as the donor may not have had capacity or there may have been undue pressure at the time of signing. There is evidence that certificate providers are completing the certificate, based on a discussion with the attorney only. We would recommend random checks be made on certificate providers by the OPG to emphasise how important the role is with clear published sanctions where the certificate provider has not acted properly to strengthen the perception of the role. It would be useful to have a standardised checklist to help certificate providers with their role.

2.6 We would recommend that the OPG and Court of Protection highlight in their annual reports themes and problems they encounter with details of how they deal with them.

2.7 The wording of s.44 (the offence of wilful neglect of a person without capacity), which has been the subject of heavy judicial criticism in R v Dunn [2010] EWCA Crim 2935, R v Hopkins and R v Priest [2011] EWCA Crim 1513 and Ligaya Nursing v R [2012] EWCA Crim 2521. This needs to be reviewed.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

3.1 Generally speaking the principles and definitions are appropriate, although the application of the time/ function test of capacity to manage financial affairs is treated by the courts as a continuous decision. As such a deputy may be appointed where the person has fluctuating capacity or capacity to make some decisions and not others in respect of their finances. This is a necessary and pragmatic approach, however it can sideline the person who is deemed by the court lack mental capacity, as in practice they may be denied the ability to make decisions they are able to make.
3.2 There are real difficulties in applying the provisions of the Act to those who have suffered acquired brain injuries (ABI) and, in consequence, are suffering from problems of either lack of insight or loss of higher executive functions. There is very often a (troubling) lack of consistency as to whether such individuals are considered to lack capacity to take material decisions. A very recent case providing an example of the difficulties posed by ABIs (which is not (with respect) altogether easy to reconcile with the previous decisions) is that of Loughlin v Singh & Ors [2013] EWHC 1641 (QB).

3.3 Difficulty also lies in the area of health and welfare, as has been demonstrated by recent cases – particularly when coupled with some of the previous decisions on tests of capacity, for instance, marriage, contact, sexual relations and illnesses such as Anorexia Nervosa.

3.4 The area of “best interests” is an area that needs reviewing. On the one hand the outcome/decision can be very different in relation to the same decision where an individual is regarded as having capacity and able to make an unwise decision and where, if that individual, in respect of the same decision, lacked capacity so that the decision was made in their best interests. A “best interests” decision will often be more “cautious” than an unwise decision made by the individual themselves. Is that correct? Or should the “best interests” decision be the same as what the individual would have made if they had had capacity?

3.5 Sometimes “best interests” decisions are being made with the views of that individual alone in mind and without setting that decision in the broader context of that individual’s family life etc. It is an area of the Law that is giving rise to a significant amount of litigation. This may simply be an outworking of the fact that this is new legislation so that it will level off in due course. This has resulted in a backlog of cases where the Official Solicitor is involved – partly for financial reasons but partly also because of “manpower”. Perhaps an alternative process could be devised to deal with these issues so as to enable decisions to be made more quickly, enabling individuals to get on with their lives and also releasing the time of officials and others to concentrate on other matters.

3.6 The best interest approach when applied to statutory will applications is clearly strained as evidenced by emerging case law. There appears to be a move towards substituted decision making, where the Court puts itself into the position of the incapacitated person and makes a decision based on the evidence available at the time of the application. It is suggested that the Code be amended to make reference as to how “best interests” is interpreted in this situation.

3.7 It is still not absolutely clear how the MCA provisions fit together with existing pre MCA case law for particular decisions. Generally it appears that the Court is working it out in all situations with pragmatism and they are likely to continue to do so.
Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

4.1 The Act does in many ways set a very high benchmark as well as applying to very many ordinary day-to-day situations. This can include care home staff, bank staff and others who may have little knowledge of or training the provisions of the Act but who are, day to day, making decisions that lie within the ambit of the Act. Medical staff and local authorities are also dealing, day-to-day, with the implications of the Act. Our experience as to the outworking of the Act has been varied across these disciplines.

4.2 A particular problem is perhaps the time and therefore the financial implications for many organisations in seeking to fully and faithfully involve people with limited capacity to be involved in the decision making process. In these times of austerity this adds to budgetary and other pressures.

4.3 The general principle of presumed capacity and the ability to make “unwise decisions” does mean that vulnerable people are more likely to be financially or personally abused and at times there is over reliance by third parties on the ability for the person to make an unwise decision, without making any effort to draw out whether the reason for the unwise decision is because the person lacks mental capacity or acting under the undue influence or pressure of others. On the other hand, there are situations, where the person who has a diagnosis, such as dementia is treated as if they lack mental capacity because they want to do something which others consider to be unwise, motivated by the desire to protect that person. Perhaps this principle should be explained in more detail in the Code of Practice, so that proper consideration is given to capacity to make an unwise decision.

4.4 Available evidence to judge how this is being implemented can be obtained via the outcomes of judicial decisions, and information on the Solicitors for the Elderly and Trusts Discussion fora etc.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

5.1 In general we believe that implementation was effective for legal professionals and action taken to bring it to their attention was satisfactory. For legal professionals working in the mental capacity field, there was training and information provided by training and educational organisations. The OPG provided most of the information for the public, but it was very much by way of an introduction to the Act. The gov.uk and Justice websites could be clearer and need tidying up, particularly as you need to know what you are looking for.

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5.2 Lay people are often unaware of their responsibilities when acting either as a Deputy or an Attorney. This is despite them being sent information via professionals or available on various web sites. The information does not resonate with them or they believe they are simply stepping into the incapacitated person’s shoes, rather than having to make best interest decisions. This has been demonstrated by recent cases that have been reported.

5.3 It would seem that there are gaps within the medical profession in terms of medical reports that are prepared that do not take account of the Act and its principles – a weakness that can also be found in general medical reports and matters relating to the Act. Again, this has been evidenced in reported judicial cases.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

6.1 Understanding in some areas is better that in others. In general we believe lawyers and some health and social care professionals have a good understanding, although there are still very significant gaps in knowledge.

6.2 The law is still very complex for the retirement or replacement of a mentally incapable trustee or director and where the incapacitated person has an express power of appointment or is a ‘Protector’ under a trust. There are many areas where flowcharts, perhaps in the Code of Practice would be of real benefit, supported by Practice Directions, rules and standard documentation.

6.3 A particular difficulty in day to day practice for professionals and lay people alike is the way in which financial institutions impose their own internal rules which can often be at variants with the law – in some cases being wrong, in some cases being much more restrictive, leading to frustration for the lay client, particularly in relation to the operation of joint accounts where the law is confused. A best practice note has been drafted by the financial and legal community but it is too early to say whether this will lead to a longer term change in approach.

6.4 Some health and social care professionals do not understand the current law and in particular on the interface between the Mental Health Act and the Mental Capacity Act and the implications of GJ v The Foundation Trust (2009) EWHC 2972 (Fam). The Code of Practice would benefit from having a flowchart for identifying whether care for mental health is to be provided under the Mental Health Act, the Mental Capacity Act or by way of a deprivation of liberty authorisation. Good practice checklists in the emergency ambulance service should be adopted more widely. Access the Code of Practice should be more clearly signposted to health and social care professionals.

6.5 Cross-border understanding of the Act is patchy, and guidance needs to be published.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
7.1 Knowledge of the Act is inconsistent. It is generally better known by those who work everyday with incapacitated adults, however professionals who occasionally touch on situations involving incapacitated people or the non-professional carer, they are unlikely to be familiar with the provisions of the Act. Overall the position has not changed for family carers on the basis that they are usually concerned for the best interest of the personal lacking capacity and will, in any event, have been acting within the general parameters of the Act. The reverse can also be said, where the Act can easily be ignored or avoided by ill informed, ignorant or the less scrupulous, for example by the use of pin numbers, joint accounts, signing authorities etc.

7.2 The section 5 defence is very valuable and gives assurance for non-professional carers, but there are cases where local authority social services departments have removed an incapacitated person from their home, against the wishes of the person’s family. If the family object, they are commonly told by social services, that they have authority to move the person and if the family do not like it, they can apply to the Court of Protection. This is a misuse and misrepresentation of the statutory protection against liability. More needs to be done to improve the awareness of the Act, for front line workers in health and social care environments.

8. Has the Act ushered in the expected, or any, change in the culture of care?

8.1 There is a greater understanding of the need to consider the interests and needs of the individual and to put their interests ahead of what might most suit the decision maker. However, on its own the Act is unlikely to make much difference in the context of the widely publicised shortcomings of the regulation and standards of care, which urgently need to be addressed.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

9.1 Experience suggests that the issue will usually be one that is more related to socio-economic rather than to race, gender or religion. The more affluent, and better educated are more likely to be familiar with the provisions of the Act and to act generally within the principles of the Act, than others where their overall situation perhaps makes them more likely to be unaware of the Act etc and to treat someone with a (mental disability) with a lack of overall dignity and respect. However, some ethnic groups may not feel the need to engage with the Act, as culturally they sort out problems within the family as incapacity is not seen as an obstacle to decision making, for example it may be perceived as irrelevant as others are responsible for making decision on their behalf, such as in the case of an arranged marriage.

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is
made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

10.1 With the emphasis on the decision specific nature of capacity we believe that the former blanket assumptions of capacity or incapacity are less frequent and those with some capacity are being encouraged to exercise it, in cases where those providing care, treatment, legal, and financial services are informed about the Act.

10.2 There is a greater degree of support for those requiring assistance in making decisions than before the Act. This is particularly the case where professionals – whether in the health sector, social services or legal profession are concerned. The introduction of the IMCA has also helped in this regard although the financial resources to make this generally available where required has been particularly constrained in recent years.

10.3 At a day-to-day level the means by which the authority is made may affect the quality of decision-making. The quality of decision making by attorneys under EPAs and LPAs, deputies (under the supervision of the OPG) and the Court was, in general, always high and remains so, but ‘general authority’, given its lack of independent supervision, was always open to abuse and still is. Even within the formal structure of deputyship and attorneyships, information and support given to the decision maker is varied and this must impact on the quality of decision-making. Case law would support this, where attorney and deputies have been removed because they made unacceptable levels of gifts, often in situations where they were unaware of what was acceptable.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

11.1 Lawyers frequently offer and make advance decisions for clients. Knowledge of them and their effect amongst health care professionals is still very patchy. There is a lack of easily accessible written information as to the interaction between and status of an health and welfare LPA which gives the attorney power to refuse life sustaining treatment, a ‘Do Not Resuscitate’ wish and advance decision. The recent case of an NHS Trust v D (2012) EWHC 885 (COP) shows that more needs to be done to make people aware of the statutory requirements of the Act.

12 Has the MCA fostered appropriate involvement of carers and families in decision-making?

12.1 In general carers and families were always involved in decision-making and we do not think the Act has made a great deal of difference.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?
13.1 Generally yes, but it is of concern that according to Department of Health statistics the number of referrals for safeguarding has decreased by 2% over the last year, where there is no evidence that people are any less at risk.

14 Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

14.1 There are still wide disparities in the rate of IMCA instructions across different local area, and it appears that in some areas the duties under the Act are still not well embedded. The duty to refer people who are eligible to IMCAs is still not understood in all parts of the health and social care sector. Much has depended upon the engagement with the legislation of the local authority and the level of funding it has provided.

15 Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

15.1 With increased pressure on local authority and other finances have meant that organisations that are offering this service are under particular financial pressures so that there must be a risk that the service is already or will in the future suffer for this reason.

15.2 Experience of IMCA’s is mixed. On occasions IMCA’s have been known to approach situations on quite biased terms, assuming the situation as relayed to them by the relevant public authority is correct, without seeking the views of family etc, and on one occasion this nearly led to the immediate removal of an individual from their family (which several months later having been in court, an independent expert recommended the exact opposite.) There are some very careful IMCA’s however who have been very proactive for the clients leading to efficient resolution of problems.

Deprivation of Liberty Safeguards

16 Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

16.1 The difficulties with deprivation of liberty translating in to practice continue to cause tensions between local authorities, care providers and the public, as documented in the CQC annual report. Reliance is being placed on the joint cases of Cheshire West and P and Q being heard in the Supreme Court later this year as solving the problem, however this is not guaranteed. Recent developments in case law around capacity and contact between P and others are already starting to cause problems (i.e. is the matter issue specific or person specific.) Now that the Act has been in force for several years and the practicalities of its working become clearer, work on the gaps and problem areas should be undertaken.

16.2 The state of the case law is a mess, professionals do not understand it. The assessments that are undertaken are routinely cut and paste jobs from previous authorisations and rubber stamped by local authorities, despite the comments in LB Hillingdon v Steven Neary (2011) EWHC 1377. The Supreme Court need to give
guidance in the upcoming cases about identifying deprivation of liberty, it is then for Parliament to look at the whole picture, the relevant case law and overhaul the system. Case law is a crucial way of obtaining insight into the kinds of cases/disputes that arise under DOLS, which were not available when they were implemented. It is too often forgotten the reason why the DOLS were brought in the first place (Bournewood) yet very clear ‘Bournewood type’ cases do not constitute a deprivation of liberty.

16.3 DOLS authorisation is not always appropriate and should never be used as a method to stifle a true welfare dispute about residence requiring resolution by the Court.

17 Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

17.1 We are concerned at the amount of judicial time and public money which is being spent on the minutiae of the safeguards which seems of little benefit to society in general. Whilst a compassionate and caring society must make appropriate provision the pendulum seems to have swung too far in the opposite direction.

17.2 Consideration should be given as to whether there should be a statutory definition to deprivation of liberty, which would at least go some way to making sure that there is consistency of decision-making, which is a significant problem in the operation of the DOLS regime.

The Court of Protection and the Office of the Public Guardian

18 Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

18.1.1 After initial teething problems for both organisations matters have, overall, improved. However, we would like to see the remaining recommendations of the Ad Hoc Court of Protection Rules Review Committee, Chaired by Mr Justice Charles in his July 2010 report to be taken forward at the earliest opportunity. This would improve efficiencies and speed of cases being processed. This is in addition to the other suggested changes contained in this submission.

18.2 One of the biggest problems arises from the volume of work that both the Court and the Office of the Public Guardian are experiencing. This means that the turnaround of work – particularly in the Court can take 7-9 weeks for an urgent application or 21 weeks for a non-urgent one, when the nature of the decision is such that time is of the essence in most cases, but are processed as if non-urgent.

18.3 The process is expensive, inefficient and inconsistent in practice. It is almost impossible to get through to the court by telephone, and if one can get through the information given is of limited use, with files and papers frequently being lost. The use of nominated officers for certain matters has speeded up the process a little but it is still taking too long to issue orders for a house purchase for instance or when dealing with disputed Power of Attorney matters.
18.4 There has also been inconsistency in the advice given or the terms of Court Orders where one would not have expected this to be the case. Deputyship Court Orders, for instance, for very similar cases can differ in their wording between Judges for no apparent reason.

18.5 One area of particular improvement has however been the ability for Deputies to make far more decisions on their own without having to go back to the Court for authority on a particular matter. This has made the system far more flexible and enabled decisions to be made more quickly. On the other hand it has left some Deputies feeling less supported and having to make decisions about which they feel less able to make.

19 What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision-making on matters of personal care and welfare?

19.1 There has been a steady increase in the number of people making Health and Welfare Lasting Powers of Attorney so as to be sure that their family, in particular, will be able to make relevant decisions on their behalf and to meaningfully and authoritatively engage with the likes of the local authority and medical services if and when they become unable to do so for themselves. On the other hand some lawyers have seen a decrease in the use of advance decisions as a result.

19.2 As the Health and Welfare LPA was a new concept for English Law their application is still evolving and the way in which health authorities and local authorities in particular engage with them has probably yet to be fully outworked, although they are now frequently asked for by care homes etc and are a key document for those dealing with health care. That said, the request is often perceived as a ‘tick box’ requirement, rather than a true understanding of how and when it operates, for example there is evidence that some care homes will treat the H&W LPA to be operative immediately, irrespective of the donor’s mental capacity. In the absence of case law on the operation of health and welfare LPAs, it would be useful if there were published case studies to educate and support health and social care decision makers.

20 What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

20.1 So far as LPAs are concerned the cost becomes more of an issue the longer LPAs are being registered. The present fee for registering one Power of Attorney is probably appropriate. However, for a couple who wish to make LPAs for both finance and health and welfare matters, a fee of £520 (£440 from 1st October 2013) is significant for what, in essence, is the same process each time. The client has also to weigh up carefully whether they think they will want to change the LPA at any time in the future. In that case a further fee of £130 (£110 from 1st October 2013) per LPA is due to cancel a registration and another £130 (£110 from 1st October 2013) per LPA to register the new document once created. A Health and Welfare LPA cannot be used until the donor has lost capacity to make the decision in question. A Finance
LPA however can be used immediately once registered. Many donors agree with registration on creation of the LPA but do not want Finance Attorneys to be able to act with immediate effect. Under the old Enduring Power of Attorney this balance was achieved by imposing a restriction that the EPA could not be used until registration at which point the donor was deemed to have lost capacity in any event. Although this can be written into the power, it causes administrative problems with financial institutions who cannot tell whether the donor has mental capacity to make a decision and are unsure who to accept instructions from.

20.2 The fee reduction is difficult to obtain in many cases, particularly where the evidence is provided for spouses where the application is treated as individual but their financial resources are jointly held.

20.3 The Court of Protection fee of £400 can be a serious barrier to some people making an application and can almost amount to disability discrimination on the basis that a mentally competent person would not have to pay the fee and ancillary costs to make the relevant decision for themselves. On the other hand there are obviously costs involved in processing cases and it also acts as a disincentive to spurious applications and so forth.

21 Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

21.1 The capital means testing that has been brought in for legal aid in welfare cases has already excluded many elderly individuals who own their own homes when they are made parties to cases, denying them access to justice. The majority of applicants are on benefits without capital so we have to wonder how much the LAA is saving by taking capital into account, as against the situation of having an elderly person party to proceedings concerning their spouse, who invariably is suffering from mental deterioration due to old age, having to choose between litigating a complex case alone, taking out loans on the equity in the home which they have worked their lives to obtain, or back down and allow the state to do as it will. Whilst the relative safeguards of the judiciary and the Official Solicitor are there to investigate all cases, if a case is not contested by the “offending” party, more often than not the case will be agreed, by default.

21.2 Family lawyers who have lost their legal aid contracts or are looking to branch out are looking to Court of Protection work to fill the gap. Whilst more specialists in any area is not a bad thing, legal aid from other areas permitting, there is a risk that there will be an increased number of inexperienced lawyers entering the market. This may have an impact on reapplying for legal aid contracts if there are more applicants for new contracts (as happened a few years ago with the previous mental health contract.) Only time will tell.

Regulation

22 Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?
22.1 As is clear from recent publicity, the CQC has not performed well and action is being taken to address this. Until the results of such action are available it is not possible to comment.

23 Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

23.1 There is no merit in duplicating the role the CQC is meant to perform.

Other legislation

24 How well is the relationship with the mental health system and legislation understood in practice?

24.1 We do not think that it is at all understood. See 6.4 above.

Devolved administrations and international context

25 Does the implementation of the Mental Capacity Act differ significantly in Wales?

25.1 No.

26 What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

26.1 In Scotland their power of attorneys are required to have attached a certificate by a doctor or a solicitor to confirm mental capacity and they do not have an objection process. This has created a simpler regime without the same level of bureaucracy that occurs in England.

26.2 Scotland has ratified the 2000 Hague Convention on the International Protection Adults and this should now be ratified for England and Wales.

27 Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

27.1 There is some concern that the MCA 2005 is not compatible with the UN Convention on the Rights of Persons with Disabilities and whether better provision should not be made for supported decision-making.

27.2 It is a real oddity that P does not need to be a party to Court of Protection proceedings, and there are doubts as to whether this can be Article 6 ECHR compliant. P is usually made a party in health and welfare proceedings, though, which then gives rise to a real problem caused by the fact that where (as in many cases) P has no one else who can act for him, the Official Solicitor is so overstretched that his waiting list to accept cases can be so long that it can be months before progress can be made in cases (and/or the courts have in desperation appointed people to act as

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Solicitors for the Elderly – Written evidence

Overview and context

1. To What Extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

Codification of the test of capacity has certainly, in relevant professional circles, raised awareness of the need to consider capacity more actively than was perhaps the case in the past. In particular the principle of a presumption of capacity and the requirement to assess capacity on a time specific and task specific basis has resulted in many more cases of individuals being able to manage some or all of their affairs that might not previously have been the case.

2. Which areas of the Act, if any, require amendment, and how?

The Act requires decisions made on behalf of someone who is incapable to be the least restrictive possible. In theory this could lead to very bureaucratic and unwieldy situations where the practical solution is the appointment of a Financial Deputy for an unlimited period and with general authority. Strict adherence to the Act could mean multiple applications for one off decisions with consequent cost, delays and Court time involved.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

Most difficulty however lies in the area of health and welfare, as has been demonstrated by recent cases – particularly when coupled with some of the previous decisions on tests of capacity for, for instance, marriage, contact, sexual relations and illnesses such as Anorexia.

The area of “best interests” is an area that needs reviewing.

Members have experienced that the outcome/decision can be very different in relation to the same decision where an individual is regarded as having capacity and able to make an unwise decision and where, if that individual, in respect of the same the same decision, lack capacity so that the decision was made in their best interest.

A “best interests” decision will often be more “cautious” than an unwise decision made by the individual themselves. Is that correct? Or should the “best interests” decision be the same as what the individual would have made if they had had capacity? Sometimes “best interests” decisions can be made with the views of an individual alone in mind and without setting that decision in the broader context of that individual’s family life etc.

There was a good article on this aspect in the Elder Law Journal (by Amelia Hughes of Monash University, Australia).

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It is also an area of the Law that is, at the moment, giving rise to a significant amount of litigation (relatively speaking). This may simply be an outworking of the fact that this is new legislation so that it will level off in due course. This has in turn resulted in a backlog of cases where the Official Solicitor is involved – partly for financial reasons but partly also because of “manpower”. We wonder if an alternative process could be devised to deal with these issues so as to enable decisions to be made more quickly, enabling individuals to get on with their lives and also releasing the time of officials and others to concentrate on other matters.

Implementation

4. To what extent have the five principle of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

The Act does in many ways set a very high bench mark as well as applying to very many ordinary day to day situations.

This can include care home staff, bank staff and others who may have little knowledge of or training the provisions of the Act but who are, day to day, making decisions that lie within the ambit of the Act. Medical staff and local authorities are also dealing, day to day, with the implications of the Act. Our experience as to the outworking of the Act has been varied across these disciplines and at times varied depending of who you are dealing with.

A particular problem is perhaps the time and therefore the financial implications for many organisations in seeking to fully and faithfully involve people with limited capacity to be involved in the decision making process. In these times of austerity this adds to budgetary and other pressures.

The general principle of presumed capacity and the ability to make “unwise decisions” does mean that vulnerable people are more likely to be financially or personally abused or put themselves or others at risk because capacity has not been assessed correctly. Decision are more likely to be made that a person has capacity to make the decision without seeking proper professional advice from an expert and can lead to wrong decision being made.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

Lawyers working in this area of law are fully aware of the provisions of the Act and supporting guidance.

However families are often not aware of the responsibilities laid on them by the Act and other legislation when acting either as a Deputy or an Attorney. This has also been demonstrated by recent cases that have been reported. It would seem that there are gaps within the medical profession in terms of medical

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reports that are prepared that do not take account of the Act and its principles – a weakness that can also be found in general medical reports and matters relating to the Act.

There has been a sustainable change made by the Act in dealing with persons who have limited capacity, certainly in the professional area but not in the lay/family area.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sections, such as health, social care, banking and others?

Please see above.

A particular difficulty in day to day practice for professionals and lay people alike is the way in which the Banks and other financial institutions have imposed their own internal regulations which can often be at variants with the law – in some cases being wrong, in some cases being much more restrictive, leading to particular frustration for the lay client. Some protocols have finally been established through the auspices of Solicitors for the Elderly and the like but these are still incomplete. It is particularly frustrating when lay people are given incorrect advice by (junior) bank staff which is then treated as absolutely correct though it often is not. Whilst the underlying aim of the Banks may be to protect their customer and reduce risk it has introduced greater levels of complexity and frustration.

Social Workers, on the ground, can also lack understanding of the provisions of the Act which can obviously be very stressful for families which health and welfare decisions are in question.

We also have come across health and social care professionals not understanding the current law on the interface between the Mental Health Act and the Mental Capacity Act and the implications of the GJ case particularly

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance been struck between protection of the carer and protection of the individual lacking capacity?

Our opinion is that the Act is not widely known or understood by the person directly affected, or if it is known perhaps it is ignored as being too complicated for them to fully understand.

The non-professional carer will often be another family member who will normally not be familiar with the provisions of the Act. Overall the position has probably not changed in this situation on the basis that family members who were previously concerned for the best interest of the personal lacking capacity will, in any event, have been acting within the general parameters of the Act.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
8. Has the Act ushered in the expected, or any change in the culture of care?

We believe that there is more of an understanding of the need to consider the interests and needs of the individual and it has put in place a legal framework to which care is to be expected.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black Ethnic groups, and gender?

We have no evidence or data to support any disproportionately.

If anything issues will be ones that are more related to socio-economic than to race, gender or religion. By this we mean that the more affluent, and probably therefore the more educated, are more likely to be familiar with the provisions of the Act and to act generally within the principles of the Act than others where their overall situation perhaps makes them more likely to be unaware of the Act etc and to treat someone with a (mental disability) with a lack of overall dignity and respect.

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made — ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection — affect the quality of decision making?

There is certainly a greater degree of support for those requiring assistance in making decisions now than before the Act. This is particularly the case where professionals — whether in the health sector, social services or legal profession are concerned.

At a day to day level we do not believe that the means by which the authority is made affects the quality of decision making. Where professionals are involved they would generally speaking have been more aware of the principles etc of the Act and therefore the process by which the eventual decision is reached is more likely to be as provided for by the Act than perhaps where decisions by lay individuals are involved who may well not be as familiar with all of the legal principles.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?

We have no evidence on this point.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
From our understanding this is mixed and will be dependant on the level involvement of the families and carers between them and whether parties are experienced enough to know the details and responsibilities of the MCA.

Professional Carers normally have some training with the MCA but the extent is surprising limited.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

We believe the role of an IMCA is extremely limited and very few cases will have an Advocate, but yes they have provided a voice for clients when there is no one else.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

Not known

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

With increased pressure on local authority and other finances this has meant that organisations that are offering this service are under particular financial pressures so that there must be a risk that the service is already or will in the future suffer for this reason. Generally speaking the quality of the service, where applicable, has been good.

Our experience of IMCA’s is mixed. We have known IMCA’s approach situations on quite biased terms, assuming the situation as relayed to them by the relevant public authority is correct, without seeking the views of family etc, and on one occasion this nearly led to the immediate removal of an individual from their family (which several months later having been in court, an independent expert recommended the exact opposite.) There are some very careful IMCA’s however who have been very proactive for the clients leading to efficient resolution of problems

The withdrawal of funding from and subsequent closing down of national group Action for Advocacy has, in our view, been a great loss as this group provided training and support on a national basis for advocates

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

The difficulties with deprivation of liberty translating in to practice continue to cause tensions between local authorities, care providers and the public, as documented in the CQC annual report. Reliance is being placed on the joint cases of Cheshire West and P and Q being heard in the Supreme Court later this
year as solving the problem, however this is not guaranteed. Recent developments in case law around capacity and contact between P and others are already starting to cause problems (issue specific or person specific.) Now that the Act has been in force for several years and the practicalities of its working become clearer, work on the gaps and problem areas should be undertaken. However these do appear to be discrete areas, and may not require an overhaul of the whole Act?.

The state of the case law is a mess, professionals do not understand it. The assessments that are undertaken are routinely cut and paste jobs from previous authorisations and rubber stamped by local authorities, despite the comments in Neary. The Supreme Court should give guidance in the upcoming cases about identifying deprivation of liberty, it is then for Parliament to look at the whole picture, the relevant case law and overhaul the system. Case law is a crucial way of obtaining insight into the kinds of cases/disputes that arise under DOLS, which we didn’t have when they were implemented. It is too often forgotten the reason why the DOLS were brought in in the first place (Bournewood) yet now, very clear Bournewood cases do not constitute a deprivation of liberty in many cases.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

Not Known

The Court of Protection

18. Are the Court of Protection and the Office of Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

After initial teething problems for both organisations matters have, overall, improved. Changes continue to be made to the processes and procedures which will hopefully lead to long term improvement but can lead to uncertainty in the meantime. There has also been inconsistency in the advice given or the terms of Court Orders where one would not have expected this to be the case. Deputyship Court Orders, for instance, for very similar cases can differ in their wording between Judges for no apparent reason.

In practice one of the biggest problems arises probably from the volume of work that both the Court and the Office of the Public Guardian are experiencing. This means that the turnaround of work – particularly in the Court which is much less “process driven” can take a long time.

The use of nominated officers for certain matters has speeded up the process a little but it is still taking too long to issue Orders for a house purchase for instance or when dealing with disputed Power of Attorney matters.

One area of particular improvement has however been the ability for Deputies to make far more decisions on their own without having to go back to the Court for authority on a particular matter. This has made the system far more flexible

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
and enabled decisions to be made more quickly. On the other hand it has left some Deputies feeling less supported and having to make decisions about which they feel less able to make.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

We are concerned that the OPG would like to make it easier to make a Lasting Power of Attorney (LPA) and that it is reasonably foreseeable that as a result, vulnerable people will experience financial abuse. There is a dash for ease and accessibility at the expense of care and protection.

Perhaps more consideration should be given with regard to safeguarding of individual by making the Certificate Provider a professional to sign off the document eg solicitor, social worker or a medical doctor when the online digital tool removes “wet signatures” to the documents.

It is insufficient for the Certificate Provider to be a layperson. The granting of a power of attorney of any description is an incredibly significant legal action and an LPA extends beyond mental incapacity which means that the legal ramifications are even more significant. The medico-legal concepts of capacity, legal presumptions, issue-specific, time-specific (to name but a few) are difficult for the practitioner let alone a layperson.

Adequate safeguards must be included for the donor of an LPA.

With regard to Health and Welfare Lasting Powers of Attorney so as to be sure that their family, in particular, will be able to make relevant decisions on their behalf and to meaningfully and authoritatively engage with the likes of the local authority and medical services if and when they become unable to do so for themselves. On the other hand our members have seen less use of advance directives or living wills as a result. As the Health and Welfare LPA was a new concept for English Law their application is still evolving and the way in which health authorities and local authorities in particular will engage with them has probably yet to be fully outworked. From our members experience we are unable to say how well prepared these organisations are to understand or engage with Health and Welfare Attorneys. Our members feedback is that they believe that charitable organisations that operate “in this space” have a good understanding on behalf of their clients and users.

20. What concerns, if any, are there regarding the costs associate with registering an LPA, or with making an application to the Court of Protection?

So far as LPAs are concerned the cost becomes more of an issue the longer LPAs are being registered. The present fee for registering one Power of Attorney is probably appropriate. However, for a couple who wish to make LPAs for both finance and health and welfare matters, a fee of £520 (£440 from 1st October 2013) is significant for what, in essence, is the same process each time. The client has also to weigh up carefully whether they think they will want
to change the LPA at any time in the future. In that case a further fee of £130 (£110 from 1st October 2013) per LPA is due to cancel a registration and another £130 (£110 from 1st October 2013) per LPA to register the new document once created. A Health and Welfare LPA cannot be used until the donor has lost capacity to make the decision in question. A Finance LPA however can be used immediately once registered.

Many donors agree with registration on creation of the LPA but do not want Finance Attorneys to be able to act with immediate effect but once registered the Donee could be able to deal with the affairs of the person without possibly their consent. But by delaying registration could not only impact possible future costs but also there will be a delay to get the document registered quickly in the situation of an emergency.

However, this must be weighed by the fact registration then allows for The Public Guardian to have full authority over the registered Power of Attorney in order to investigate circumstances of financial abuse.

The Court of Protection fee of £400 can also be a serious barrier to some people making an application and can almost amount to disability discrimination on the basis that a mentally competent person would not have to pay the fee and ancillary costs to make the relevant decision for themselves. On the other hand there are obviously costs involved in processing cases and it also acts as a disincentive to spurious applications and so forth.

The remission and exemption provisions in respect of LPA fees are helpful.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

The capital means testing that has been brought in for legal aid in welfare cases has already excluded many elderly individuals who own their own homes when they are made parties to cases, denying them access to justice. The majority of applicants are on benefits without capital so we have to wonder how much the LAA is saving by taking capital into account, as against the quite frankly disgraceful situation of having an elderly person party to proceedings concerning their spouse, who invariably is suffering from mental deterioration due to old age, having to choose between litigating a complex case alone, taking out loans on the equity in the home which they have worked their lives to obtain, or back down and allow the state to do as it will. Whilst the relative safeguards of the judiciary and the Official Solicitor are there to investigate all cases, if a case is not contested by the “offending” party, more often than not the case will be agreed, by default.

Family lawyers who have lost their legal aid contracts or are looking to branch out are looking to Court of Protection work to fill the gap. Whilst more specialists in any area is not a bad thing, legal aid from other areas permitting, there is a risk that there will be an increased number of inexperienced lawyers entering the market. This may have an impact on reapplying for legal aid
contracts if there are more applicants for new contracts (as happened a few years ago with the previous mental health contract.) Only time will tell.

Regulation

22. Is the role of the care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case of additional powers?

Not Known

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Yes we believe the Local Authorities should be fully involved in this area.

Other Legislations

24. How well is the relationship with the mental health system and legislation understood in practice?

Not Known

2 September 2013
This evidence is submitted on an individual basis though I am a Consultant Older Adult Psychiatrist with Oxleas NHSFT and I hold a Master’s degree in Mental Health Law with special interest in the MCA. I am also the medical lead MCA on my Trusts patient safety group and I run the DoLS refresher course as well as workshops on ‘MCA: key issues for clinicians’ within my trust.

I have completed and published an Audit on the ‘Fidelity of clinicians to the MCA’ and is in the process of re-auditing the same. The materials used for the audit and subsequent recommendations and actions (including flow charts and leaflets) are available on request.

Also, I took the lead role in conjunction with CSE and Health and Social Care Information Centre in re-designing the MCA folder in the current RoI (electronic patients record used extensively in the London region and perhaps beyond) to help improve the compliance of healthcare professionals with documentation as well as the prescriptions of the MCA.

Response to MCA house of Parliament Consultation:

By and large the MCA is a bold step at empowering individuals to make contemporaneous decisions about themselves and in certain instances decisions ‘stored’ up for the future (ADRT).

In cases on non-capacitous individuals, the MCA puts processes in place for their care.

I think it is excellent that the MCA puts the onus of capacity assessment on the person responsible for the action on behalf of the non-capacitous individual and that the final decision falls to them even where another ‘expert’ provides an opinion.

Adopting an alternative position of making capacity assessment the responsibility/preserve of a group of professionals e.g. psychiatrists would be unsustainable and would also make these professionals practice outside of their expertise bearing in mind that they will, in certain instances, not have the adequate/appropriate relevant information to give to the individual being assessed.

Some areas for improvement in my view:

1. I suppose it would be ideal if there is mandatory capacity assessment before an LPA or ADRT is created to ensure that individuals ‘know what they are doing’.

2. I also suggest that all ADRT’s are written or caused to be written when the decision is made or withdrawn (not only if it relates to life ending issues) to afford clarity of what the individual said/wanted (not hear say) and ease of implementation by those looking after them in future.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
**South Essex Partnership University NHS Foundation Trust (SEPT) – Written evidence**

**About our organisation:**

We are a large NHS organisation in the East of England. We employ approximately 7500 members of staff from all health and social care disciplines and provide community and mental health services across 4 counties, i.e. South and West Essex, Bedfordshire, Luton and Suffolk. Over the last two years we have been implementing a robust action plan to improve the implementation of the MCA and DoLS in our organisation. This project commenced in August 2011 following an audit which highlighted that practice in this area needed to be improved. Policies were rewritten and an intensive training and support programme was rolled out across the organisation, which was approved and supported by our Executive Team. This ensured a dramatic increase in the overall MCA and DoLS activity in our organisation.

As the graph below demonstrates, overall MCA and DoLS activity in 2010/2011 was 167. In August 2011 the MCA/DoLS action plan was implemented and this increased the overall activity in 2011/2012 to 394. This action plan was carried forward into 2012/2013 which ensured a further increase in activity to 673. Overall the activity during the span of the action plan has increased from 167 to 673, which equates to an overall increase of 403%:

**Figure 1:**

*Increase in MCA and DoLS activity since the implementation of the MCA/DoLS action plan*

*Figures presented in report to Executive Team in April 2013*

*Note: Further evidence of stats could be provided on request*
It is therefore safe to say that the action plan has definitely had a positive impact on the implementation of The MCA and DoLS across our organisation in the sense that it has dramatically increased activity in this area. Service users are being assessed under the MCA and DoLS is being applied more frequently.

The action plan is still not complete and the next phase consist of a further service improvement project to also improve the quality of the implementation of the MCA and DoLS. Our most recent audits have highlighted many areas of good practice, but there are of course areas that still need to be improved, especially in relation to how staff record assessments of capacity, best interests decisions and compliance with all of the principles of the MCA. This indicates that there is still much work that needs to be done. We know our staff are applying the MCA and DoLS when necessary, but we also want to ensure that they are doing this to the highest possible standard. We furthermore want to ensure full compliance with all the principles and processes of the MCA and DoLS. But above all, we want to ensure that our service users affected by the MCA and DoLS have the best possible outcomes from the process and that they are protected and enabled through it in the true spirit of the MCA.

We can bear witness to how important it is to have strong leadership as well as support from all levels to ensure successful implementation of the MCA and DoLS. We have invested a considerable amount of time and resources to get it right and we are all too well aware of the challenges our services face in relation to the MCA and DoLS. The greatest challenge by far has been to manage the cultural changes that are needed to ensure sustainable improvement in this area. MCA and DoLS are however high on our agenda and we will continue to strive for improvement and we will continue to focus on the most important factor, which is the real difference this legislation can make to the lives of people who may lack capacity, if it is understood and implemented effectively.

We will now provide as much evidence as we can in relation to the areas and questions in the call for evidence from the House of Lords. The evidence mostly relates to our experiences within SEPT. And although our journey has by no means been easy or without its challenges, it has without a doubt been a very positive experience and proof that if understood and applied correctly, the MCA and DoLS can work exceptionally well in practice.

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?
2. Which areas of the Act, if any, require amendment; and how?
3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

We see the Mental Capacity Act 2005 (MCA) is a vitally important piece of legislation, which in essence promotes a person centred approach. Its aim is to protect and empower people to make decisions for themselves where possible and to protect those who lack capacity to make decisions. If understood and applied correctly it can make a real difference to the lives of people who may lack capacity as it places the individual at the centre of any decision made in their best interests.

Where professionals truly understand the principles and processes of the MCA and apply it appropriately in the spirit that it was intended, those affected really are protected and

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
empowered to make decisions for themselves if they have capacity to do so, or if they lack capacity, decisions are made in their best interests with the person and their views and wishes at the centre of the decision making process. Relevant people, such as family or friends or others involved in their care, are also involved. In our organisation we have witnessed exceptionally good practice in this area, which provides concrete proof that, if applied correctly, the MCA can really make a difference and achieve its aims to the benefit of some of the most vulnerable people in society.

The core principles and processes of the MCA is appropriate and don’t need to be amended. It is a valuable, workable piece of legislation. But the key however is to apply it in the spirit that it was intended. What needs to be improved is professionals’ understanding of the MCA and how it should be applied in practice. There already is a legal duty on professionals to comply with the principles and processes of the MCA, but more needs to be done to hold them to account if they do not comply with these. Health, Social Care and other organisations, which employ these professionals, also need to be held to greater account. Employers definitely need more incentive to ensure that its employees understand and apply the MCA effectively. A legal duty to monitor the implementation of and compliance with the MCA could for example be places on organisations. In our organisation we have already taken this on board and we monitor compliance with the MCA, as well as DoLS, on a regular basis via a robust system. This has proved to be very useful and it has greatly improved our compliance in this field.

More emphasis needs to be placed on the legal duty to involve the person and their family/carers/friends. The best interests checklist already states that anyone making best interests decisions must consider the person’s views and wishes and consult with all relevant parties, including family or friends, but this doesn’t always happen. This can make the best interests decisions subsequently made unlawful, yet not all professionals understand this. We continue to raise awareness in this area and recent audits of our MCA paperwork have indicated that our staff are involving the person and their family/carers/friends appropriately in the decision making process.

The person and their family or friends do however need more rights and protection against poor decision making. More rights to challenge professionals’ decisions and a quicker way of appeal against or process of review of these decisions are also urgently needed. At the moment, if the person or family or others do not agree with a decision made by professionals, then they can either raise a complaint to the team involved or the organisation’s complaint department – which would be investigated internally and can take time – or they have to approach the Court of Protection – which could be costly and also long winded. Similar rights to what a person and their Nearest Relative have under the Mental Health Act are needed for those people and families affected by the MCA. A legal duty should also be placed on professionals to inform the person and their family of their rights and ways to complain, appeal or challenge decisions that are made under the MCA.

Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack

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South Essex Partnership University NHS Foundation Trust (SEPT) – Written evidence

capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

6. Is the Act widely known and understood by professionals required to implement it?

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

8. Has the Act ushered in the expected, or any, change in the culture of care?

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

Nationally there are worrying levels of misunderstanding of when to use the MCA. Research and literature raise concerns that significant levels of front line practice appeared to be in contravention with the fundamental principles of the MCA. Assessments of capacity may not always follow a rigorous process and do not always comply with the principles of the MCA. Best interests decisions made on behalf of those who lack capacity are not always carried out in line with the best interests framework of the MCA. The person and their family or friends are often not involved. The use of restraint and lack of consideration of the least restrictive principle is another concern – there is a tendency amongst professionals to make overly restrictive best interests decisions focussed on managing risk and not supporting autonomy. There are also concerns that staff are not aware of when lawful restraint might be moving into a deprivation of liberty that requires further authorisation under DoLS and these safeguards are either mis-used or under-used. And lastly, there is still much confusion around the role of the IMCA. More needs to be done nationally to recognise those eligible for IMCA services and to improve the referral rate accordingly.

Our latest audit within the organisation has however provided evidence that our staff are generally following the processes of assessing capacity and making best interests decisions and in many cases there was evidence that they are also following most of the principles of the MCA. When staff are concerned that a person might lack capacity to make a specific decision they do seem to assess this in line with the MCA and where the person was found to lack capacity, the best interests checklist was used to guide the decision making process. Our initial MCA/DoLS action plan seems to have ensured that this message was driven through and the increase of over 400% in overall activity over the last 3 years (see Figure 1, p1) is further evidence that the MCA is being applied in more cases. Our staff also seem to be maintaining the balance between enablement and protection and we have found very positive evidence that staff are supporting our service users to make their own decisions where they have been assessed as having capacity.

The audit has of course highlighted areas that could be improved, such as that staff were not always clearly recording compliance with all of the principles, such as what less restrictive options had been considered (in line with the least restrictive principle). Evidence to support capacity assessments and best interests decisions could also be improved in some cases. But we are currently addressing these issues further by amending the paperwork that is used to prompt staff to give this evidence and we are also focussing specifically on this and other areas that need to be improved in our MCA/DoLS training programme. We have In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
found that continuous audits and training and to support staff are essential to ensure effective implementation of the MCA and DoLS.

In relation to the issues of involving the person, family and friends and consideration of IMCAs, the recent audit showed that generally our staff are complying with these requirements. In most cases there was evidence that the person and family and friends were involved (although the exact context was not always that clear) and we furthermore found considerations for referrals to IMCA services in most cases audited (although we still would like to improve our overall referral rate).

The Department of Health did invest a considerable amount of time and resources into implementing the MCA in its early phases and they continue to provide guidance around this, but they have now very much left local implementation to local organisations. Professionals are all aware of the MCA, but how well they implement it varies greatly from one area to the next and this is not monitored by any central agency. The Department of Health’s initial implementation plan did raise awareness of the MCA, but more needs to be done now to ensure effective implementation of it across all areas. In many areas the initial implementation also didn’t lead to sustainable change. A reason for this might be that the cultural changes that would have been needed to ensure long term change were underestimated and therefore not addressed entirely by the initial implementation plan. Some professionals still struggle to make the shift between doing what they have always done and believe to be best, to acting and making decisions within the legal framework of the MCA. The outcome may be the same, but the right process is not always followed.

Families of those who lack capacity are also largely still unfamiliar with the MCA and they very much have to rely on professionals to gain a better understanding of it, which is difficult when professionals themselves don’t understand it all that well. Voluntary and third sector organisations, such as Age Concern and MENCAP, are much more proactive in providing information to families about the MCA. Many of these organisations have got useful information leaflets and other resources to help families understand the MCA better, but this is only available to families who get into contact with these services. The Department of Health also has useful information booklets for families, but how and when families access this is variable. In our organisation we re-enforce the importance of explaining the MCA and DoLS to families and we are planning on involving them in future training through our recovery colleges. We are also designing posters and information leaflets specifically aimed at improving families’ awareness and understanding of the MCA and DoLS. We feel much more needs to be done in relation to this, locally and nationally.

In our latest audit we have found no evidence that the provisions of the MCA affect any groups, such as ethnic minorities or a specific gender, disproportionately. It seems to be applied more in our elderly and learning disability services, but these are the services where you would expect it to be applied more frequently as this is where capacity might often be an issue.

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made
11. What evidence is there that advance decisions to refuse treatment are being made and followed?

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

Where the MCA is being applied correctly, those affected are being enabled and supported to make decisions for themselves to a much greater extent than they would have been in the past. This is due to the emphasis in the MCA that those who have capacity have the right and should be supported to make their own decisions, even if it is unwise or may involve some risk. Where professionals fully understand and apply this, those affected are truly enabled and supported to make more decisions for themselves. But in situations where the MCA is poorly applied or worse, applied to re-enforce the views of professionals, those affected are less able to make decisions for themselves. Some professionals do use the MCA in a very oppressive manner and will quote the best interests process as their authority to do so, even in cases where people do have capacity or where they lack capacity but could still be supported to participate in the process.

The means by which the decision is made (general authority, Lasting Power of Attorney, deputyship, Court of Protection) doesn’t seem to affect the quality of the decision as much as the knowledge of those making the decision. Where decision makers have a good understanding of the MCA, good quality decisions will naturally follow, as evident in our organisation. We have also found that the MCA has indeed fostered appropriate involvement of carers and families in decision-making processes in our services.

Advance decisions are being made more frequently and we have policies, procedures and paperwork in place that staff will use to aid our service users in the process. We are also in the process of developing ways to add an advance decision to a service user’s electronic records on our central database, which could be flagged up when the records are accessed. Our service users are actively encouraged by staff to make and record advance decision. Our Advance Decision Steering Group, who has been responsible for designed all our policies, procedures and paperwork in relation to this, is also led by service users.

The role of the Independent Mental Capacity Advocate (IMCA) has definitely succeeded in providing a voice for our service users, as well as an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf. We feel IMCAs are an invaluable resource, especially in complex cases, and our staff work well alongside them. In our recent audit we found considerations for referrals to IMCA services in most cases audited and, where appropriate, referrals seem to have been made. But our overall referral rate is still relatively low (5.8%), so we are continuing to raise awareness throughout our organisation about the benefits of the use of IMCAs to increase our referral rate to this

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service even further, in line with recent recommendations made by the Department of Health.

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?
17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

Yes, if applied when needed, DoLS can provide very valuable safeguards to those affected. But it is still poorly understood and greatly under-used. Professionals are not always aware of when lawful restraint might be moving into a deprivation of liberty that requires further authorisation under DoLS. It can also be used in the wrong circumstances, such as to authorise overly restrictive care regimes. There are furthermore great variations in the use of DoLS from one area to the next. We have done a considerable amount of work over the last 2 years as part of the overall MCA/DoLS action plan to improve staff’s understanding of when to use DoLS and we have subsequently seen a dramatic increase in the use of DoLS. Over the last 3 years, our requests for DoLS authorisations have increased 14 fold (1408%). When understood and used correctly the processes for authorisation and reviews are accessible and timely. Challenges of DoLS authorisations are however not always timely and could involve lengthy hearings in the Court of Protection. A quicker way to challenge decisions, such as what we have under the Mental Health Act, would be very useful.

The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?
19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?
20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?
21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

The roles of the Court of Protection and the Office of the Public Guardian are not sufficiently understood and accessible to all. If there are unresolvable conflicts around a best interests decision, then the Court of Protection should be approached, but this is often not done by professionals (making these decisions) and the burden if left to the family, which could be a very costly affair. Families are furthermore not aware that they can challenge these decisions or how to go about doing this, such as by approaching the Court of Protection.

The Court of Protection and the Office of the Public Guardian do operating effectively and successfully and when involved and they can be very helpful. But it can take a very long time for cases going to the Court of Protection to be heard. This needs to be improved. A different or quicker way to challenge decisions is definitely needed.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
We can’t fully comment on questions 19 to 21 as we have very little involvement with this. Generally we think more service users should make LPAs for welfare – this is still relatively rare.

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?
23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Yes the role of the CQC is appropriate, they are positively re-enforcing the use of the MCA and DoLS in all settings. But they could be given more powers to take action when they find that an organisation is non-compliant with the MCA or DoLS. Other regulators definitely do need to take more action in this area as well. The message needs to be re-enforced from all stakeholder, even commissioners have an important role to play as they can require more proof from service providers regarding compliance with the MCA and DoLS. Our commissioners are already requesting regular evidence in relation to MCA and DoLS compliance, which is re-enforcing the importance of it at all levels.

Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

The relationship between the MCA, DoLS, the Mental Health Act, Human Rights Act and other legislation in this field is very poorly understood in practice. Case Law in this field is also poorly understood and applied. More clarification is needed at national level to help professionals understand the above. We have again addressed this issue in our organisation through regular training and monitoring, but we would also benefit from clearer guidance at a national level. The MCA and DoLS Codes of Practice could for example also be amended to help all involved understand this complex relationship better.

Devolved administrations and international context

25. Does the implementation of the Mental Capacity Act differ significantly in Wales?
26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?
27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

We have no involvement in this context and therefore can’t comment on these questions.

4 September 2013
South West IMCA Group – Written evidence

South West IMCA Group – Written evidence

We have read the transcript of the evidence provided by Nicola Jones (The Law Society), Katie Johnston (Liberty), Professor Richard Jones and Kirsty Keywood (Manchester University) to the Select Committee on 25th June 2013. Our response relates to the areas identified by the committee.

Overview and context

Our general experience has been that the principles of the Act, definition of capacity and the best interest checklist can provide helpful and vital guidance in applying the Act – but only if they are known and applied. Generally, we have experienced poorest levels of knowledge and application within hospital settings.

Implementation

We would agree with Katie Johnston’s evidence to the select committee that “there is a lack of understanding among those who have to apply (the MCA) on the ground. The Act contains helpful principles but poor implementation has meant that there is patchy practice. The Act is generally poorly understood outside of Local Authority Adult Care Services.

Decision making

We would agree with Professor Jones’ evidence that the Act is rarely thought about or followed in day to day care provision.

We believe the IMCA role to be a necessary and appropriate safeguard that helps maintain a central focus on the person, clarifying issues of capacity, and informing best interest decision making. IMCAs routinely enable and support the maximisation of their clients’ involvement in decision making processes. The role is well understood by social care professionals, but can often be misunderstood by health professionals. This disparity can be traced back to disparities in training and implementation between health and social care. By adopting a balance sheet approach in their mandatory reports, IMCAs can clearly identify both the potential options and the relevant factors and probable weight of those factors to be weighed and applied by decision makers. This makes this advocacy role particularly helpful.

The IMCA role is poorly resourced and strictly boundaried. There is an opportunity to extend the role and better resource it. The IMCA service is well placed to meet the requirement for litigation friends for a person without litigation capacity – if appropriate resourcing were made available. Our experience is that advance directives are still rare.

Deprivation of Liberty Safeguards (DoLS)

In our view Professor Jones was correct to differentiate between the legislative eloquence and clarity of the Capacity Act and the DoLS regime which we agree “is hugely complex, voluminous, overly bureaucratic, difficult to understand and yet provides mentally incapacitated people with minimum safeguards.” The reason for this disparity may well be that the DoLS regime was a legislative ‘bolt-on’ to rectify the Article 5 non-compliance identified by the European Court.

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The lack of a statutory definition of deprivation is lamentable and could be rectified. Currently, practitioners need a comprehensive understanding of case law developments to gauge whether there is a deprivation. This sits uncomfortably with initial responsibility for diagnosing deprivation usually resting with care staff.

The DoLS safeguards are not as robust as safeguards under the MHA. A simple free appeals mechanism that is peripatetic, and on occasion automatic is absent. There is no second medical opinion safeguard.

**Court of Protection**

The process is cumbersome, remote, expensive, time consuming and not easy to access. It often involves numerous hearings. Since Legal Aid is means tested, the process of obtaining representation is not easy, is routinely expensive and often calls upon P’s often limited assets. LASPO will only exacerbate this situation.

It is often difficult in unbefriended cases to obtain a litigation friend. There is no routine funding built in for a paid litigation friend – although most IMCA services would be able find capacity to do so on a spot purchase basis. As Professor Jones suggests, an alternate simpler tribunal structure that is both flexible and where necessary peripatetic would be preferable.

Our experience is that welfare LPAs are rare.

**Mental Health Act overlap**

The precise delineation of two systems that can both apply to incapacitated people with mental disorder is often poorly understood and applied in practice. An updated Capacity Act code of practice could be a helpful resource – subject again to potential implementation and training problems.

30 August 2013
St Helen’s Council – Written evidence

Introduction
Due to a request for information from the House of Lords Select Committee on an inquiry into the Mental Capacity Act 2005 the following responses have been compiled.

Responses
1 To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1.1 The Act has succeeded in providing a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions about their care, treatment or support.

1.2 The Act formalizes and standardises the process for assessing capacity and subsequently making best interest decisions on behalf of the person who lacks capacity.

1.3 The Act ensures there is a consistent approach to decision making on behalf of a person who lacks capacity.

1.4 The Act clarifies the responsibilities of different individuals when making best interest decisions on behalf of a person who lacks capacity.

1.5 The Act raised awareness about the rights of people who lack capacity and how decisions must be made on their behalf therefore challenging individual practice.

1.6 The Act makes it very clear how and who should be involved in the decision-making process and makes the process for making best interest decisions transparent.

1.7 Families and friends are actively encouraged to be involved in the decision making process.

1.8 The Act allows staff to explain the reasons for their actions and provide literature.

1.9 The Act opened up the debate about the legal responsibilities for making decisions on behalf of people who lack capacity.

1.10 The code of practice is a useful accompaniment and provides clear guidance when applying the Act to everyday practice.

Areas For Consideration

1.11 There can sometimes be conflict and confusion about who is the decision maker in situations where best interest meetings are responsible for making a number of decisions. It would therefore be useful to update the code of practice to include relevant up to date case examples explaining the decision maker’s role in such situations.

1.12 When assessing capacity the time and decision specific criteria must be applied.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
1.13 Due to limited understanding of the Act terminologies such as capacity and best interest are misunderstood and used randomly to apply to situations, which do not meet the threshold of the Act.

1.14 More time is needed to embed the Act into practice.

2 Which areas of the Act, if any, require amendment; and how?

2.1 It is difficult to suggest amendments to the Act because the understanding and application of the Act in practice remains inconsistent. When all individuals, who have delegated decision-making responsibilities for people who lack capacity regularly apply the principles then any suggested amendments should happen at this time.

3 At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

3.1 The principles and definitions are appropriate and encapsulate the spirit of the Act. However, there is wide variation in both their application and understanding of how it relates to a person who lacks capacity.

Areas For Consideration

3.2 Principle 1 ‘A Presumption of Capacity’ careful thought must be given when applying this principle. It must not be used to evidence no action.

Principle Three: ‘Unwise decisions’. It is essential that any decisions made with regards to ‘unwise decisions’ are based on the capacity of the person and not open to interpretation by the assessor.

Implementation

4 To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

4.1 The principles are understood and staff adhere to them. However, in general how they impact on the day-to-day practices of all those individuals who care or support people who lack capacity requires further investigation.

4.2 The number of recorded capacity and best interest assessments and meetings that take place, which includes discussions, is an indication of the adherence to the principles of the act.

4.3 There is a view that the Act achieves a satisfactory balance between enablement and protection of the person who lacks capacity. However, there can sometimes be a conflict between the balance between enablement and protection.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The implementation plan was successful and has led to ensuring the Act is embedded into everyday practice. It helped to raise awareness amongst staff, service providers and families and carers. Having National and Regional leads to cascade information to identified specialist practitioners was extremely useful and assisted in the implementation of the Act. Information sharing forums were also set up which allowed discussions to take place about the use of the Act where a sharing of information took place. Individual projects were also funded which benefited all those individuals working with the Act to develop the wider understanding of the legislation and its impact on application. Awareness raising and application of the legislation is a continual need for staff working with people who lack capacity and is essential.

Training, Briefing sessions, policies and procedures, open days, Government literature, individual meetings were all part of the plan to ensure that both professionals and families were aware of the Act.

The implementation plan has assisted in ensuring that there has been a permanent change in the way capacity and best interest decisions are approached and recorded.

Areas For Consideration

Understanding and application of the Act in general is still inconsistent. Awareness raising there remains crucial if the Act is to be fully embedded and understood in practice.

Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

There is limited understanding about the Act amongst those who are directly affected by it. If carers understand and are aware of the principles of the Act they find it beneficial. The Act provides a good framework to ensure that the views of the person are considered and explored as opposed to making general assumptions that a person lacks capacity because they have a particular condition. The Act also ensures that when making best interest decisions and carrying out capacity assessments that carers views must be considered and taken into account with regards to any decisions made on behalf of the person. The Act also makes it a statutory responsibility to instruct an IMCA to support a person if they have no family or friends ensuring their views are represented by an independent person.

Has the Act ushered in the expected, or any, change in the culture of care?

Only those who understand and apply the Act to the caring regime bring about any changes in the culture of care.
7.2 The Act has formalized what was considered to be best practice.

7.3 There is greater clarity on the process for assessing capacity and making best interest decisions.

7.4 The Act has made individuals accountable in law for the decisions taken on behalf of the incapacitated person.

7.5 The Act introduced section 44, which has resulted in a number of prosecutions.

7.6 The Act ensured that the needs of the person are central to any decision making process.

7.7 The Act ensures that decisions around ‘End of Life; treatments or Advance Decisions must follow the guidance in the legislation.

**Decision Making**

8 Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

8.1 The recording and accountability for making time and decision specific capacity assessments is greater since the introduction of the Act.

9 What evidence is there that advance decisions to refuse treatment are being made and followed?

9.1 General knowledge and Awareness of Advance Decisions is patchy resulting in few being completed. However, there is evidence to suggest that in those situations where people have completed them they are being considered.

10 Has the MCA fostered appropriate involvement of carers and families in decision-making?

10.1 The Act has fostered the inclusion of families and carers in discussions made in the best interest of the person and in any discussions about capacity assessments.

11 Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no one to speak on their behalf?

11.1 When involved the IMCA has played a vital role in supporting the person.

**Area For Consideration**

11.2 The IMCA potentially has role to play regardless of whether the person has family or friends to support them. The Act should therefore reflect this.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
St Helen’s Council – Written evidence

12. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

12.1 The referrals to the IMCA are lower than expected.

13. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

13.1 The IMCAs are adequately resourced to carry out their role in relation the number of requests for their service.

Deprivation of Liberty Safeguards

14. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

14.1 The safeguards, when applied and authorisations sought, have afforded protection to those people who lack capacity and have been deprived of their liberty in either a care home or hospital. The authorisations have served to ensure that the persons situation and care arrangements are continually and carefully monitored and subject to scrutiny and review by the MA, the SB and any Relevant Persons Representative.

Areas For Consideration.

14.2 There continues to be a lack of understanding amongst MAs about when to and not to use the safeguards. There is no statutory definition about what constitutes a deprivation of liberty, which if in existence would assist MAs’

14.3 The terminology conjures up negative images of care. Many MAs do not believe the care they are providing a person is depriving them of their liberty. A change in the terminology may serve to encourage MAs to look more favourably on the safeguards and their use.

14.4 The DoLS process is bureaucratic, time consuming and costly.

14.5 MAs struggle completing the documentation. They find the documentation confusing and repetitive.

14.6 The code of practice is out of date. Consideration needs to be given to updating it with relevant case law examples.

15. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

15.1 The statute is very clear about the process to follow when requesting and assessing if a person is being deprived of their liberty.

Areas For Consideration

15.2 If there was in existence a system whereby a person could have a speedy appeal of an authorisation, which mirrored the system that existed under the Mental Health Act

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1983, then any DoLS challenges could review more easily, quickly and be cheaper than applying to the Court of Protection.

15.3 Is the Court of Protection adequately resourced to hear the cases put before them?

15.4 If MAs are not requesting authorisations because they do not perceive the care they are proving as depriving a person of their liberty then the protection afforded by the safeguards will not invoked.

15.5 There are often different opinions and conflicting views about what does or does not constitute a Deprivation of Liberty. This has been highlighted by recent case law, different judges and professionals opinions which had added to the confusion when attempting to assess whether a person is being deprived of their liberty or not.

15.6 The time frame for completing an assessment for a person subject to an Urgent Authorisation is only seven days. Consideration should be given to extending the time frame.

The Court of Protection and the Office of the Public Guardian

16 Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

16.1 There is confusion and misunderstanding about the Court of protection and the Office of the public guardian and when to access it.

16.2 In light of the confusion that surrounds the Court then there is a view that it is not accessible. In light of the above they are not operating effectively.

17 What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision-making on matters of personal care and welfare?

17.1 Many individuals are unclear about their purpose and function.

17.2 It is felt that they are to costly to take out and the paperwork if off putting.

17.3 Many people wonder how they will benefit from having a LPA.

18 What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

18.1 They are too expensive to register.

18.2 Individuals find completing the forms difficult.

18.3 Confusion about how they will benefit from having LPA.

Regulation

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
19  Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

19.1  CQC has limited regulatory powers, which limits their powers when looking at the MCA standards.

20  Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

20.1  It may be useful for health regulators to monitor the application and use of the Act in all health settings and with health professions.

**Other Legislation**

21  How well is the relationship with the mental health system and legislation understood in practice?

21.1  In general staff are aware of both Acts however there is confusion about when to apply the Mental Health Act 1983 and the Mental Capacity Act 2005.

**Devolved administrations and international context**

22  Does the implementation of the Mental Capacity Act differ significantly in Wales?

22.1  No

23  Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

23.1  Although most professionals are aware of the Act in practice the application of it bemuses some professionals and remains inconsistent.

2 September 2013
Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The Act is a good act which still requires a culture change in order to fully implement

2. Which areas of the Act, if any, require amendment; and how?

Consider greater emphasis on supported decision making in situations. Often with greater support people who may have been initially assessed as lacking capacity are able to make a decision but require a great deal of support to do so.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

Yes

Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

The implementation has been patchy. I get the impression that many healthcare professionals still practice a medical model where the doctor diagnoses the problem and prescribes a course of treatment with little involvement with the patient. Many patients still expect to be “done to” rather than being partners in their healthcare.

The balance between protection and empowerment appears to be more heavily weighted towards protection and this is understandable – most practitioners would feel more comfortable defending a decision to protect rather than being accused of being neglectful. Using an example of change of accommodation – many older people are moved from hospital to a care home when the hospital admission was deemed to be due to an inability to cope in their own home. In my experience the vast majority of people would say (when they have capacity) that they would prefer to accept the risks of independent living rather than to be moved to a care home. A true best interest decision would prioritise what the person would have wanted if they had capacity to make the decision.

Most serious case reviews that I am aware of include issues of interpretation and implementation of the MCA and this is evidence that the Act is not fully embedded in practice.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Businesses and providers of health and social care have a clear responsibility to ensure that their staff comply with the MCA. It would have been useful to have a centrally coordinated public information campaign to raise awareness of the Act amongst the general public. Many people do not understand their rights including rights to appoint LPAs and make advanced decisions to refuse treatment.

**Decision making**

1.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

It is difficult to know whether greater involvement with families and carers is a result of the MCA. There is anecdotal evidence of clinicians getting confused about the requirement to consult with families and carers to ascertain the likely views of the incapacitated person and instead thinking that carers and families are the decision makers.

**Deprivation of Liberty Safeguards**

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

Yes the safeguards themselves are adequate but see Q17

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

A statutory definition of what constitutes a deprivation should be considered in order to provide some clarity.

The Code of Practice states that an urgent authorisation should not be used where there is no expectation that a standard authorisation will be needed. In many hospital DoL cases it is unclear whether p is likely to require a DoLS for a very short period of time or for several weeks. They may for example regain capacity quickly or over a period of time or not at all. The [*Commissioner of Police for the Metropolis v ZH*](#) case decided that a deprivation of liberty can occur for a relatively short period of time and therefore hospital staff are keen to have a way of legitimising a relatively short DoL.

It is nearly impossible for p to challenge a DoLS without the support of their RPR. There are occasions where the RPR believes the DoLS is in the persons best interests but p does not. It would be incumbent on the care home / hospital to eventually take this to court but this is an expensive and time consuming process and the institution may be reluctant to do this. A system such as the mental health tribunal would be a simpler, more efficient and cost effective way of considering many appeals.

**The Court of Protection and the Office of the Public Guardian**

1. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
St Mary’s House – Written evidence

1. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

The costs are significant and often prohibitive.

1. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

**Regulation**

21. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

Inspectors do not always have sufficient knowledge of the Act. This is evidenced in a number of inspection reports. Whilst it would be unreasonable to expect all inspectors to have an expert knowledge of the act increased expertise and leadership in CQC would enhance their credibility. Better communication from CQC inspectors with health commissioners would be mutually beneficial in making judgements about healthcare providers compliance with the Act.

22. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

**Other legislation**

24. How well is the relationship with the mental health system and legislation understood in practice?

25. Variable. There have been a number of cases where I have suspected that the MHA should have been used rather than DoLS. This is particularly the case in the acute general hospital where mental assessors sometimes seem reluctant to use the MHA. It is difficult for the Supervisory Body to challenge the assessment of the Mental Health assessor

4 September 2013
Standing Commission of Carers – Written evidence

Introduction to the Standing Commission on Carers

The Standing Commission on Carers (SCOC) warmly welcomes the opportunity to contribute to the current consultation on the Mental Capacity Act.

The Department of Health established the Standing Commission on Carers in December 2007 at the request of the Prime Minister. The Standing Commission is an independent advisory body, providing expert advice to Ministers and the Carers Strategy Cross-Government Programme Board on progress in delivering the National Carers Strategy (a ten year Strategy published in 2008) and on other policy issues relating to carers and support for their roles. In 2009, the Standing Commission was formally constituted as a Non-Departmental Body, with Chair and members appointed by the Appointments Commission. Dame Philippa Russell has chaired both stages of the Standing Commission’s development and current role.

We have particularly welcomed this consultation because of the growing debate (and in many cases uncertainty) about the application of the Mental Capacity Act and, in particular, about its potential for safeguarding vulnerable people.

With regard to the House of Lords’ specific questions, we would like to comment as follows:

Has the Act made a difference to family carers - if so how?

- The MCA has made a significant difference to family carers. It sets out expectations about how everyone, including family carers, should assess capacity and make best interests decisions.
- It formalises the role of family carers when someone lacks capacity, recognising the important contribution they can make as substitute decision-makers and as consultees. The Code of Practice also places a duty upon health and social care staff to involve family carers at all stages.
- The MCA and the Code of Practice should give families confidence that learning disabled or other vulnerable relatives will have their capacity properly assessed and that the people in their lives will be acting and making decisions in their best interests.
- The MCA provides ways for family carers to hold health and social care staff (and others) to account for their actions, by challenging assessments of capacity and best interest decisions, DoLS applications and the actions of substitute decision-makers.
- The Court of Protection has shown itself to place a high value upon the maintenance of family relationships in the application of the MCA.

However, we are concerned that many family carers are not made aware of the MCA and how it applies to them. Therefore we see a need for additional resources and for information on their availability when a ‘best interests’ decision has to be made.

We note that that accessing the MCA can create challenges for families.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
For families of young people, it can be a shock to suddenly be confronted with a new way of making decisions for someone who lacks capacity when they reach adulthood (and many are unclear that most of the MCA applies from 16). Many family carers still assume wrongly that they will continue to have parental responsibility for a young adult and assume that they are the legal guardians of their relatives. In effect, they do not understand the MCA concept of guardianship.

Some family carers feel that the MCA is used by professionals to ‘get their own way’ and do not feel empowered to challenge actions and decisions made by professionals under the MCA;

Procedures for substitute decision-making (especially deputyship) are expensive and can appear complex;

The Court of Protection seems daunting and many families fear that it is expensive in terms of the implications for the individual’s assets. Some families also feel that the ‘best interests’ judgements of the Court of Protection do not pay sufficient attention to the views of the family about the likely wishes of their relative and money is not necessarily released for activities which the family feel would benefit that relative.

What are the good things about the Act - can you give examples?

- We warmly welcome the presumption of capacity. We consider that the decision-specific principle that underpins its application offers powerful protection to people who lack capacity.

- The presumption (linked to the above) that decisions under MCA will be evidence based. There are assumptions that there should be a care plan and care pathway and thereby assumptions that efforts will have been made prior to any formal procedures to engage and support the individual to have a good quality of life. We are hopeful that the duty set out in the Care Bill for local authorities to provide or facilitate the provision of information and advice services may raise awareness of MCA.

- The clear procedures for assessing capacity and making best interests decisions for someone who lacks capacity. The Code of Practice is a long and complex document, but it is very well written and offers good examples of how the Act should work in practice.

- The inclusion of criminal offences about mistreatment and neglect. This has enabled the Government to adopt a robust approach to dealing with the perpetrators of abuse at Winterbourne View.

- The possibility of independent advocacy (eg around decisions about health care, well-being, property etc). However, we are concerned that many families are totally unaware that the enduring power of attorney has been replaced and do not understand the role of the deputy (or deputies if there are dual issues, eg finance and health decisions to be made). CQC, in its report on the use of the MCA 2011/12 notes that 1 in 5 patients did not know of their right to have an independent mental health advocate and were generally unfamiliar with the MCA.

- With regard to the above, CQC also found that although PCTs (and now CCGs?) have had a legal duty to provide independent Mental Health Advocates since 2009 to all qualifying detained patients and patients subject to a community treatment order or guardianship, this has not always been the case. Regular access to independent Mental Health Advocates was a problem in over a quarter of the wards visited by CQC. This has particular implications for people with learning disabilities and their families (or people with dementia, when there is cognitive impairment) because there may be a range of
additional issues to be considered in helping them make the best decisions about treatment, discharge etc.

**What needs to be improved - why?**

- Ensuring that health and social care professionals understand their duties and obligations to involve family carers and recognise the value of the information, views and commitment that they offer. It is important to point out that family carers are usually best placed to;

  i) Provide information about a relative’s capacity, needs, wishes, preferences, previously expressed opinions etc;

  ii) Ensure that a best interests decision is turned into action, and;

  iii) Be the ‘eyes and ears’ to check that a relative’s best interests are being served.

  iv) Offer long-term interest in and support for the relative.

- CQC (cited above) found that carers generally did not feel that they received adequate information. They reported that police officers, approved mental health officers and clinical staff and others sometimes assumed that they had a level of knowledge about the MCA and local services that they did not have.

- We are concerned that there is often a lack of the promotion of simple, cost-effective ways to resolve disputes before they escalate to the Court of Protection. In many cases, invoking MCA procedures comes too late for sensible early decisions to be made.

- Because the MCA is often invoked in a crisis, it is important for carers to ensure that as far as possible their relative does have a care plan, a care pathway which sets out what he/she and the family want and what steps the relevant professionals have taken to achieve the goals set out in any plan before a challenge occurs. Good practice could include initiatives similar to the Passport for Health Care and Decision-making (St Richards Hospital) and the Dementia Passport (Surrey NHS and local authority).

- We also note that presumptions of incapacity may be made too easily. Many people with a learning disability, cognitive impairment etc. can still communicate their wishes and feelings (albeit not necessarily by formal speech). Family carers are the most likely to know how their relative communicates and to find ways of involving them in significant decisions about their care and support.

- More support and information are needed for family carers to ensure that they understand how the MCA applies to them – this is especially important for family carers of young adults. We welcome the role of organisations such as the National Family Carers Network, which has produced an excellent range of family-friendly materials to enable family carers to get the best out of the MCA for their relatives.

- DoLS procedures need to be simplified and clarified.

- It is important to ensure that all relevant professionals and staff have appropriate training in the use of the MCA. We note with some concern that the new Skills for Care unit on MCA awareness currently makes no specific reference to carers, friends or relatives (ie the people closest to the individual who may lack capacity and assistance in decision-making). Additionally (and in most cases) carers, relatives and
If you could make a key change to the legislation or the way it is implemented, what would it be?

We would be very cautious about suggesting amendments to a piece of legislation that is still relatively new. Instead, we would recommend that the focus remains on getting implementation right – ensuring that everyone involved understands the law and how it applies to them. One area of concern is around the local arrangements that are in place for monitoring implementation. Concerns have been expressed about the implications of the latest local authority budget reductions and about the involvement of key individuals including family carer representatives.

We hope that the CQC, in its annual report on MCA, can ensure that the examples (and the inspection visits) include learning disability. Post Winterbourne View, the issues are even more important. We would also welcome regular reports which are specific to particular populations, eg dementia, decisions around ‘right to treatment’ (or in some cases, the right to withdraw treatment).

In addition to CQC’s regular scrutiny, it would be helpful if Healthwatch could also monitor what is happening with regard to MCA (ie the experiences of particular groups of patients who are subject to MCA procedures and of course the views of their carers). Healthwatch has enormous potential inasmuch as it is both national and local and covers health and social care. CQC has tended to inspect and monitor MCA in health settings but of course people with community treatment orders will almost certainly have regular contact with social care services as well.

Involvement of family carers in ‘best interests’ decisions

As noted above, we are aware that families are in general involved in decision-making about ‘best interests’. However, we are also aware that there is insufficient clarity in some cases about how such best interests are interpreted and how the MCA might help. We cite the case of ‘Mr H’ (Health Service Ombudsman, July 16 2013). ‘Mr H’ has severe learning disabilities, behavioural difficulties, epilepsy and other health problems. His mother Mrs B requested a repeat prescription of midazolam in liquid form from her GP Practice because her son refused to take the tablet form and was having repeat seizures. The GP refused, saying that midazolam in liquid form was too expensive for his practice even if the young man was having repeat seizures because he would not take the medication in tablet form. The mother was told to find another practice which ‘had a bigger budget and would be happy to provide the medication’.

The Health Service Ombudsman investigated and concluded that the practice had firstly failed to consider their obligations under disability discrimination law and also failed to follow medical guidelines which set out that when prescribing medicine, doctors must ensure that the prescribing is appropriate and responsible and in the patient’s best interests. The Ombudsman further stated that doctors should, when appropriate establish the patient’s priorities, preferences and concerns and ‘discuss treatment options with the patient and carer’. Julie Mellor, the Health Service Ombudsman, stated that ‘this case is particularly worrying because the preference and concerns of this young man’s mother about his medication were ignored, as was the Mental Capacity Act in determining what those best interests were’.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Standing Commission of Carers – Written evidence

The above case is particularly relevant in the context of the Confidential Inquiry into premature deaths of people with learning disabilities, which similarly found a number of instances where invoking the MCA with regard to best interests could potentially have saved lives. Therefore, we would welcome a greater emphasis on training around the MCA for all health professionals. We were pleased to see that the Department of Health, responding to the Confidential Inquiry cited above, recommends that advice on the MCA should be available 24 hours a day to health and social care professionals. As Julie Mellor noted in her report on the case of Mr H, ‘The Department of Health’s response identified several areas of good practice made since 2010 which have included improvements in listening to patients and their families and also in following of the MCA by healthcare staff. But as the case of this young man clearly shows, there is still plenty more to do in these areas.’ We share her views that the proper understanding and use of MCA powers and duties is still ‘work in progress’.

What experience do you have with DOL assessments?

Although family carers are always consulted with regard to a DOL assessment, they are not always involved as fully as they would wish. Carers are not always aware that they can be appointed as Relevant Person Representatives, nor are they necessarily aware of what the role would entail. Local Authorities can of course appoint an IMCA to support the carer but we are aware that there are shortages of IMCAs in some areas and families may be uncertain about their role. We also note that DOL assessments usually take place at a time of crisis, when local support systems have broken down or there are real safeguarding risks. Carers’ views about the individual’s history; the trigger factor for the breakdown and the family perspective on any future action or support are all very relevant. We hope that the Care Bill’s emphasis on whole family assessment and the provision of information and advice will enable families to play a more proactive contribution to DOL assessments and to decisions about treatment and/or intervention.

As we have noted earlier, police, paramedics, adult social care services and the NHS may presume a greater knowledge than is the case about DOLs, their purpose and the steps for discharge. We would welcome better training for those likely to be involved in DOL situations with regard to working with families and seeing them as essential partners both in treatment and in a planned return to the community.

The role of the IMCA

We would like to conclude our submission with some comments on the role of the IMCA. This role is often pivotal to the effective deliver of the IMCA. We have welcomed the issues raised by the House of Lords in its committee sessions around this inquiry. We are aware that mandatory training is required for all IMCAs but agree with Jonathan Seker, in one of the witness sessions, that this ‘provides a floor rather than a ceiling for the level of understanding that people need to have.’ With greater complexities in terms of co-morbidities and long term conditions (and in decision making for specific groups of citizens such as people with learning disabilities, dementia, cognitive impairment through trauma etc) we also see the need for IMCAs with expertise in specific areas.

Conclusions

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Standing Commission has welcomed this Inquiry and endorses the role and functions of the MCA in protecting a wide range of vulnerable people. However, we are concerned that it is not always well understood by users/patients and carers. As noted above, we hope that the new duties around information and advice within the Care Bill will assist in informing families about the role of the MCA in its different facets. For example, many family carers are still unaware that the MCA can be invoked around a specific situation (eg in the recent case of the man with a learning disability who wanted a vasectomy). There is also concern about the financial implications of the MCA, with many families finding formal procedures though the Court of Protection expensive and cumbersome. Safeguarding is high on all our agendas at the current time, in the wake of Winterbourne View and the Mid-Staffordshire Inquiry). However, this consultation also highlights the importance of good practice and accurate information and advice at much earlier stages so that emerging issues can be resolved without recourse to MCA procedures and, very importantly, so that MCA procedures if invoked are evidence based and produce the best possible outcomes.

As a final comment, we are concerned that family carers are not always fully recognised and respected as integral to good decision making and outcomes. We hope that the training proposed by the Department of Health will underline the value of family carer viewpoints and expertise and their reciprocal expertise with that of the user or patient himself or herself.

We shall look forward to the outcomes of this Inquiry and are of course very happy to provide any supplementary evidence.

30 August 2013
Michael Stanley (Barnsley MBC/ PCT) – Written evidence

Please find my views and written response to your call for evidence which includes:

Background of witness

I am a career grade social worker with nearly 40 years experience during which I have worked in children's and adult services including mental health and disabilities.

I am an Approved Mental Health Professional (AMHP) under the Mental Health Act 1983 and have been a Best Interests Assessor (BIA) under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards since 1st April 2009.

A substantial part of my professional life has been working in Older People's Mental Health Services and prior to the implementation of the Mental Capacity Act 2005 on 1st April 2007, I had been using the British Medical Association and Law Societies Guidance on mental capacity for over two years in my every day work but significantly in my role as Team Manager/ Safeguarding Manager.

It was then with enthusiasm that I fully embraced the principles and Mental Capacity Act Code of Practice and the subsequent Deprivation of Liberty Safeguards.

My present post is Professional Development and Support Manager for Barnsley MBC but I am also the MCA/DOLS Lead officer for Barnsley Metropolitan Borough Council. I remain a Senior Safeguarding Manager.

Between 2007 – 2010 I was a member of the Yorkshire & Humber Health Improvement Partnership (YHIP) MCA/DOLs Regional Network and following the withdrawal by DoH of YHIP support and guidance, I became chair of the Yorkshire & Humber MCA/DOLS Regional Network of which there we still 20 active and committed members.

I have just completed my second term as chair of the Yorkshire & Humber MCA/DOLS Regional Network.

Although I work strategically, I also support all Adult Services on professional issues, with a specific remit for MCA/DOLS. As well as understanding the theory I have had the invaluable opportunity to develop the culture , implement the MCA/DOLs principles, practice and agendas at strategic, operational, service area, provider, team, individual and family level.

As well as having this strategic and operational responsibility I remain a practitioner as an Approved Mental Health Practitioner and Best Interests Assessor seeing, unique real people, service users, patients and their carers on a daily basis.

I do appreciate that so far you have interviewed a number of "expert" witnesses but with respect how many of them see the unique people this affects each day ensuring that their rights are protected under this legislation?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
It is therefore with this background and as a true Yorkshire man I respectfully offer and provide my down to earth and brief written evidence to the select committee on the following questions.

Overview and context

1. **To what extent has the MCA 2005 achieved its name?**

   To be frank it remains a work in progress. I never anticipated complete implementation but envisaged the need to embed a slow, time consuming culture change and that’s exactly what it is. There is still work to do and progress to be made.

2. **Which areas of the act if any require amendment and how?**

   I believe the Act and Code of Practice remains well regarded and needs no fundamental amendments. It perhaps needs fronting with a clearer message and the need for understanding of Human Rights issues and practice.

3. **At the core of MCA are its principles and definitions of capacity and best interests, are these appropriate**

   Yes of course they are. It’s how these are implemented and as a member of the Yorkshire network I am very aware of the variation in practice even occurring in this region as well as the issue of the national post code lottery.

   As an older social worker I have embraced and welcomed the principles, definitions of capacity and best interests as we have moved away from a very paternalistic, risk averse often medical model approach to a rights based risk management approach.

   Every day I have the opportunity to consider the needs, and support the legal, human rights and best interests of unique individuals.

Implementation

4. **To what extent have the five principles been implemented in front line practice etc.**

   It is a task in process. It appears generally well established in my area with professional colleagues, multi-disciplinary staff and voluntary agencies but needs further drilling down to carers and the public as a whole.

5. **How effective was the Governments implementation plan etc.**

   The initial support of Paul Gantly at DoH and YHIP was well received and welcomed. Their demise left a void resulting in many if not most of the Regional MCA/DOLS networks reducing their activity or ceasing to function.

   The Yorkshire & Humber MCA/DOLS Regional Network has remained throughout and is a strong influence both Regionally and locally.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
As a member of the Yorkshire & Humber MCA/DOLS Regional network I have also recently been involved with a small DoH & SCIE reference group in London developing MCA/DOLS Governance & Performance Standards which are due to be published in August 2013

Professional colleagues, agencies and providers are certainly now more aware of the Act, but marketing the message to others including families and carers is an ongoing task.

It didn't help that DoH ended the ring fenced MCADOLS budget and MCA/DOLS training was not deemed mandatory at a national level.

6. **Is the Act widely known and understood by professionals**

   Once again this is work in progress. Since 2007 as well as having a strong commitment to train (free training) and an ongoing training programme for Social Care and NHS staff we have also provided training to care homes, police, probation, ambulance service, dentist, pharmacists, local voluntary agencies and more recently to CQC Regional inspectors.

7. **Is the Act widely known and understood by those who are directly affected by it and by their non professional carers**

   In simple terms the answer is no not really, it's work in progress.

8. **Has the Act ushered in the expected or any change with the culture of care**

   We are seeing improving practices across all areas but it's work in progress and a slow culture change.

**Decision making**

11. **What evidence is there that advance decisions to refuse treatment are being made and followed**

   We have a strong commitment in Barnsley to an Advance Statements and Advance Decisions process and document designed by 6000 local people. Many AS/AD documents have been completed and there is recent evidence at the local A&E and in Palliative care with their links to End of Life Care Planning and Preferred Priority for Care that these are being understood, respected and upheld. This document has been also been used by other Local Authorities in the region.

12. **Has the MCA fostered appropriate involvement of carers and families in decision making**

   We are seeing evidence that this is the case especially in Best Interests discussions and formal Best Interests meetings.
13. **Has the role of IMCA succeeded in providing a voice for clients and additional safeguards etc.**

   We have nothing but praise for our IMCA service but there is a limited budget to provide this service.

14. **Has the level of referrals to MCA met expectation**

   No IMCA referrals especially for treatment issues are still low. Regional and Local variation is due to a lack of understanding about the role of IMCAs. This remains a work in progress.

**Deprivation of Liberty Safeguards**

16. **Are the safeguards in DOLs adequate**

   Adequate – yes – if there is a commitment to make it work.

   To be honest what's the alternative, leaving vulnerable people in care homes and hospital wards with no rights?

   DOLs is complex, bureaucratic difficult to manage and implement but it is not unworkable and does work in this area.

17. **Are the processes for authorisation review and challenge of DOLs sufficiently clear**

   They are in Barnsley but there are areas for improvement. Regionally practice is variable.

**Court of Protection**

18. **Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all. Are the operating effectively and successful**

   Accessible to all – of course not, as it can only respond to a small number of cases and costs do alienate the public, family, carers in seeking the jurisdiction of the court.

   LPAs and Deputyships are regarded as expensive.

**Regulation**

22. **Is the role of CQC in inspecting on the MCA standards adequate and appropriate**

   The CQC are significantly playing catch up in their understanding of MCA/DOLS issues I have only recently trained Regional CQC inspectors on these issues.

   I have a very positive relationship with my local CQC Inspectors and a commitment by us all to implement and maintain the highest standards of practice on both agendas.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The new DoH/SCIE Guidance of MCA/DOLS Governance and Performance Standards due to be published in August July 2013 should support CQC in their difficult role.

Other Legislation

24. **How well is the relationship with the mental health system and legislation understood in practice**

Mental Health v. Mental Capacity interface continues to causes confusion and debate every day.

I therefore, respectfully hope the Committee find my written evidence and very down to earth views of interest?

1 August 2013
Overview of Experience

I am a parent /stepfather to an adult with learning disabilities; I employ 4 staff / PA’s for my stepson through the ILF and direct payments. I also have experience of the MCA 2005; because my deceased Mother had Alzheimer’s and was in residential care. I am also an experienced volunteer adviser and Fellow of the Institute of Paralegals and retired Member of the Chartered Institute of Arbitrators. Therefore I have working knowledge /experience / expertise from all these perspectives as a carer, employer and volunteer adviser.

Overview and context

Q1 To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

A1 In practice my experience is that the MCA 2005 isn’t working very well in practice

Q2 Which areas of the Act, if any, require amendment; and how?

A2 I have concerns about the 3rd Principle:

“Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.”

The reason for this is that I feel there is a conflict between this principle and a duty of care in tort. I feel the principle is a good principle per se, in as much it should promote independence and a person’s individual personality and preferences. However it has been my experience that care homes and social workers interpret a person’s choice or unwise decision, over the duty of care .In other words care homes and social workers use this as a get out clause. Given that people with learning disabilities and elderly people sometimes need supervision in their choices, taking into consideration people with learning disabilities within the autistic spectrum, have rituals and like routine .Which for instance can sometimes make them want to dress inappropriately for the weather inter alia. For instance it may be a persons choice or unwise decision to go out dressed in summer clothing in the winter in freezing cold weather or vice versa .While this may be an unwise decision , and isn’t a prerequisite to assuming a person lacks capacity . Nevertheless it is an unwise decision in as much the person may get hypothermia, simply because they don’t have the mental capacity to understand the implications of such a decision. Therefore feel that this should somehow be explained in the Act and the Code of Practice. Or change unwise to reasonable managed risks or something similar. This should then put social workers and care home managers on notice that they must still take into account their duty of care in tort.

Q3 At the core of the MCA are its principles and definitions of capacity and best interest’s .Are these appropriate?

The principles are:

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
A3 Principle 1: A presumption of capacity.

**Principle 2:** Individuals being supported to make their own decisions a person must be given all practicable help before anyone treats them as not being able to make their own decisions.

**Principle 3:** Unwise decisions – people have the right to make decisions that others might regard as unwise or eccentric.

**Principle 4:** Best interests – anything done for on behalf of a person who lacks mental capacity must be done in their best interests.

**Principle 5:** Less restrictive options – someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person’s rights and freedoms of action, or whether there is a need to decide or act at all.

In my experience working with social worker’s, it has become apparent that individual social workers understanding of the Mental Capacity Act 2005 fluctuate and there is no consistency.

For instance we recently had a telephone call from a Social Worker to make an appointment to review my stepsons care package, consequently the first thing he said was “that he was going to do a capacity test and that he would be talking to our neighbours to find out about my stepsons capacity”. Clearly there was no presumption of capacity and didn’t take account of principle 2 either.

Furthermore certainly wouldn’t have found out from our neighbours whether my stepson had capacity, because they don’t know him well enough and don’t have an understanding of the test of capacity and no knowledge of the 5 principles. The assumption seems to be that if a person has learning disabilities, then they don’t have capacity to make their own decisions. However in principle, principle 3 allowing someone to make unwise decisions, particularly with a person with learning disabilities is difficult. For instance recently whilst my stepson is able to make specific decisions for example say what food and drink he likes. But has a problem with eating and tends to over fill his mouth and not to chew his food, consequently there is a propensity to choke. It might be said that under the MCA that this is an unwise decision, but nevertheless under the MCA if taken to the extreme his choice to make an unwise decision. This isn’t looking at caring holistically and specifically in my view doesn’t take into account a carer’s duty of care, over a person’s rights and freedoms. It is merely looking at the word unwise in isolation and should include the following test: the ability to use or weigh that information as part of the process of making the decision.

Again I had an experience with my mother, who was in a care home diagnosed with mild Alzheimer’s. In this case Social Worker’s cherry picked parts of the MCA, which worked to their advantage. For instance my mother was assessed has being at risk living on her own because of eccentric behaviour. The psychiatrist said my Mother had capacity to make a decision where she wanted to live. Social Worker’s persistently ignored, the decision my mother made that she wanted to return home instead they made her go into care against her will. But on another occasion, because of the Alzheimer’s my mother was found several times over.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
times with faeces on her hands while eating a sandwich, concealing food and toilet paper etc. This was reported to social services under safeguarding vulnerable adult’s procedure. But seemed to be brushed under the carpet by the care home manager and key worker on the grounds my mother had capacity to make that unwise decision. This appeared to be conveniently accepted by social services. But it was obvious to me that because of the Alzheimer’s she was unable to care for herself properly. In my view she was no better of in care than she would have been living in her own home. In deed a year after the first safeguarding vulnerable adult’s procedure, a different social worker found my mother in the same state as the previous year and carried out another safeguarding vulnerable adult procedure. Unfortunately I was given no information regard the outcome of the meeting between the social worker care home manager and key worker. Although the key worker disappeared from the care home about that time.

Furthermore the MCA wasn’t enabling a good quality of life or independence. In addition to this my mother passed away December 2010 and it was pointed out to me by the A&E doctor, that my mother had been badly neglected. It was obvious from what the hospital doctor told me, that my mother hadn’t been eating or drinking for quite some time and was dehydrated and anorexic inter alia. I am considering making a retrospective claim for clinical negligence or requesting the coroner’s court to look at the findings, subsequently sent out a letter to the care home manager requesting information. The following questions were:

1. Please provide an account of Mrs (person’s name) last two months. In particular; at what point did she become bed ridden? When the serious sores were were first noticed?

2. When did Mrs (person’s name) cease to take in (a) food and (b) liquids?

3. What assessment of Mrs. (person’s name) capacity to consent to medical treatment was made; (a) When Mrs (person’s name) bed sores were first noted; and (b) when she ceased to eat and/or drink? If Mrs (person’s name) was found to lack capacity in any of these areas, what decisions were taken in her best interests? What liaison was there with Social Services at this point? How were decisions minuted?

4. Please provide copies of Mrs (person’s name) daily notes from (care home) for the period from 26th October 2010 to her death.

 Needless to say the first request was received by recorded delivery after a month I had received no reply, a second letter was sent giving a caution, if there was no reply or a reply is written in an evasive or equivocal manner. Therefore I would conclude an adverse inference. However after a few weeks the second letter was returned unanswered saying no one of that name at this address. Therefore because of the care home silence, I am assuming that there are no notes that these procedures took place. Which I feel is further evidence that the MCA procedures are not being following. This is either because the staff are poorly trained or there are no procedures in place by the care home, to be followed in these situations. Therefore feel the CQC are failing badly in not ensuring these MCA procedures are being followed and staff are given training. Furthermore it raises the question why was this not picked up by the CQC for immediate remedial action? This is I feel more evidence that the MCA is not working as it should by all concerned i.e. Social Service’s, CQC and Care Home Managers, Staff.
Implementation

Q4 To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

A4 There certainly isn’t a satisfactory balance between enablement and protection. The only thing in my view is that it has allowed social services and the CQC to use the MCA to use principle 2 as a get out clause for very poor care. See previous examples of poor practice.

Q5 How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA/ Has it led to sustainable change?

A5 I work as a general adviser at the Citizens Advice Bureau and have had several clients come in for advice about the MCA and still have clients asking for advice in 2013. In my experience the medical professionals have used the MCA as a means to avoid caring for patients properly again using principle 2 as a get out clause, by stating a person with capacity has the right to make an unwise decision. However this doesn’t take into account the complexity of the decision being made and must not be looked at in isolation, the following test must be taken into account: the ability to use or weigh that information as part of the process of making the decision.

Furthermore patient’s relatives are at a disadvantage because they don’t understand the MCA consequently find it difficult to challenge medical professionals and social workers.

Q6 Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

A6 In my view the MCA is not widely understood by professionals. There appears to be no consistency in understanding with social workers the medical profession or bankers. They all seem to have separate understandings of the MCA and appear to have their own agenda’s, regard the MCA and DOL’s.

Q7 Is the Act widely known and understood by those who are directly affected by it and their non-professional carers? To what extent does the Act provide protection and reassurances for informal carer and protection of the individual lacking capacity?

A7 Again in my capacity as an adviser, it is my experience that the MCA is not widely understood by those affected by it and non professional carers

Q8 Has the Act ushered the expected, or and, change in the culture of care?

A8 The answer to this question is in my experience definitely not. My stepson was in care 15 years ago and my mother from 2008 until 2010 and my experience there was no visible change in the culture. There was still an institutionalised approach to care, instead of looking at a person as an individual, independent person.

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Q9 Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups and gender?

A9 Have no knowledge of different socio-economic groups. So I don’t feel I have the knowledge and experience to answer this question.

Decision making

Q10 Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – general authority, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

A10 In my view there has been no change in decision making in a residential care setting. In my mother’s case she certainly wasn’t enabled or supported to make decisions. In deed my stepson was in residential care, subsequently couldn’t see any difference in decision making and the culture. Residential care homes in my view do what is best for the owners and the bottom line is about making a profit not providing good quality care.

Q11 What evidence is there that advanced decisions to refuse treatment are being made and followed?

A11 I have not had any experience of this. So cannot answer this question.

Q12 Has the MCA fostered appropriate involvement of carers and families in decision making?

A12 The answer to this question is most definitely not. In my case the social workers totally ignored me. They didn’t take into account 57 years of knowledge of my mother’s likes and dislikes. They were more interested in avoiding accountability for themselves and the care home. The CQC were absolutely no good at all. They were invited to safeguarding vulnerable adult meetings, but couldn’t be bothered to turn up. In my view the CQC assessment isn’t fit for purpose. It is no more than a tick box exercise. They ask the residents if they are happy, which doesn’t take into account a vulnerable scared elderly person isn’t going to be critical as they have to suffer the consequences after the CQC have gone. The CQC certainly are not observant. They certainly shouldn’t do announced inspections. They should do unannounced inspections and they should be more often and the inspection should be more on observation, rather than a tick box completion based on residents written notes. Because if the manager has an understanding of the required standards they are going to put written policies in place to comply, but that doesn’t mean it happens in practice. It is no better than a yearly M.O.T on a car. For example there is liability on the owner of a car to maintain the vehicle after the M.O.T until it is due next. From my experience being a carer in a residential care setting, it is a poorly paid job, with very little training and prospects for continued professional development and many care homes employ foreign staff. In deed in my experience the majority of foreign staff couldn’t speak English and they certainly had no training in the MCA. Therefore any notes that the CQC took account of wouldn’t have been completed by the carer. Furthermore when I raised this with the...
assistant Director of Social Service’s and the Care Home Manager was accused of being racist. Which I am most certainly not. I was looking at it from a common sense point of view that if I couldn’t understand the carer, then what chance would a person who is confused with Alzheimer’s have,

Q13 Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

A13 I have no experienced of IMCA’s representing or safeguarding against abuse and exploitation. However I do feel that, care home managers, social workers and medical professionals would manipulate the information an IMCA would see.

Q14 Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

A14 I have no experience of referrals. So I don’t feel I have the experience to answer or offer evidence to this question.

Q15 Are IMCA’s adequately resourced and skills to assist in support or substituted decision making for people lacking capacity?

A15 I have no experience dealing with IMCA’s to comment on resources, skills in supporting decisions for people lacking capacity.

Deprivation of Liberty Safeguards

Q16 Are the safeguards in the Deprivation of Liberty Safeguards (DOLS) adequate?

A16 It is my view the safeguards are not adequate. This is because social workers and medical professionals ignore relatives and do what they think is in a person’s best interest, irrespective of whether the person has capacity and disregard the assessment and 5 principles. It is very difficult to safeguard a person’s liberty when the professionals who are supposed to uphold the principles and safeguard vulnerable people, when the professionals don’t have a consistent and a good understanding of the principles. Furthermore feel that principle 3 needs a radical rethink and amendments to make professionals more responsible and accountable. I would even go as far as saying there should be a statutory tort provision within the act if a professional is found in breach of the MCA principles and Code of Practice is proved. This in my opinion will stop individual social workers cherry picking parts of the act to their advantage and putting financial interests of local authorities and local NHS authorities first over the quality of care. I feel the common law of tort is difficult to prove, therefore isn’t a sufficient safeguard or deterrent. It would be much better if there was a statutory tort / criminal tort written into the MCA.

Q17 Are the processes for authorisation, review and challenging of DOLS sufficiently clear accessible and timely?

A17 I feel they do appear complicated to the lay person /carer . I feel it should be less formal or the lay person should be given more legal help. It appears that the official solicitor

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is not easily accessible for advice and doesn’t appear to have the resources to uphold individual’s rights.

The Court of Protection and the Office of the Public Guardian

Q18 Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to decision making on matters of personal care welfare?

A18 In my view they are not sufficiently understood and accessible to decision making on matters of personal care and welfare. In deed social workers again make this very difficult. For instance I requested a capacity test regard my mothers understanding of her care needs, because I thought the care home were not looking after my mother properly. They deliberately asked the medical professional to do a capacity test regard whether my mother had capacity to decide where she wanted to live, even though she didn’t originally want to stay at the care home. But she had been continually bullied by the care home and social workers over a period of a years until she said she wanted to stay. The social workers also knew that a specific decision about this would get the answer they wanted and was an easier test. They new very well that had the medical professional had concluded that my mother didn’t have the capacity to understand her care needs that I would have insisted on a best interests decision for my mother. Which in my view would be to have my mother moved and that it may cost more money. I have no doubt in my mind, that my mother would have failed the following tests:

- the ability to understand the information relevant to the decision
- the ability to retain that information
- the ability to use or weigh that information as part of the process of making the decision, and
- the ability to communicate the decision (whether by talking, using sign language or

If the decision over capacity was about her care needs. Therefore in my view the MCA doesn’t safeguard vulnerable adults, if social workers manipulate and cherry pick the MCA in practice.

Q19 What has been the impact of the introduction of Lasting Powers of Attorney (LPA) especially with regard to decision making on matters of personal care and welfare?

A19 This is very difficult for people like my stepson who has communication problems to make themselves understood sufficiently well enough for legal or medical profession to understand whether he has capacity or not. It is particularly difficult, because end of life decisions and advance decisions are implied in an LPA for welfare. In my view the only people that have sufficient understand of a persons understanding are the relatives and in some case’s PA’s that work long term with a person with learning disabilities. This is because medical professionals, social workers or solicitor may only come into contact with a person for very limited time. It is also difficult for a relative to give their opinion regard capacity, because there appears to be a propensity to assume that a relative may have an ulterior motive regard end of life decisions. In my view medical professional’s, social care and legal professionals should take much more notice of relatives on the issue of capacity. A relative is much more likely to understand whether a person has capacity, if they have communication problems. For instance my stepson refers to himself, as “you” rather than “me” when talking.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

1642
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

about himself. Therefore someone that doesn’t understand this would maybe think he doesn’t have the ability to understand and weigh things up. In deed when he has reviews with social workers we have to act as an interpreter. In deed we have had this problem in the past when he was in care. This is because caring is a poorly paid job and very little training and professional development. Therefore there is a high turnover of staff. Therefore it is impossible for staff to build up that kind of relationship and understanding of a persons needs. Furthermore when doing a capacity test, how a person reacts depends on the time of day and mood. This isn’t always taken into account. With regard to my stepson early mornings are not the best time and can sometimes be in a belligerent mood, subsequently if a capacity test was done under those circumstances, the person doing the capacity test probably wouldn’t get much sense out of him and conclude he didn’t have capacity. So long term knowledge of a person is essential to the outcome.

Q20 What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

A20 It is my understanding that costs involved with registering can be means tested, so that account is taken of a person’s income.

Q21 Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

A21 I have read both consultation documents from the FJC and MHLA and feel that the legal aid reforms will have a detrimental effect with regard to representation for people with or without capacity.

Regulations

Q22 Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

A22 I feel that the CQC is not fit for purpose inter alia, regard inspecting the MCA. The CQC needs to be radically reformed. It definitely needs additional powers. Not only does the CQC need more powers, but the willingness to use those powers and make an example of care homes that consistently perform badly, abuse and exploit residents and also neglects residents. The CQC also need to be more observant and more powers to investigate. They should also be able to investigate under cover. Perhaps there should be an ombudsman to oversee the CQC, which has draconian powers to make the CQC perform better.

Q23 Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

A22 I feel they should be acting in this area.

12 August 2013
Sussex Partnership NHS Foundation Trust – Written evidence

Introduction

1. Sussex Partnership NHS Foundation Trust (“SPFT”) provides mental health, learning disability, substance misuse and prison healthcare throughout Sussex, along with a range of specialist services across the South East of England including London, Kent, Medway and Hampshire. SPFT currently manages around 100 sites across the South East of England. SPFT staff operate within both the legislative frameworks of the Mental Health Act 1983 and the Mental Capacity Act 2005.

2. This response has been developed in consultation with staff across Sussex partnership NHS Foundation Trust.

To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

3. Generally the MCA, prior to addition of DOLS, achieved its aims well as a codification of the previous common law in relation to best interests decision making on behalf of vulnerable adults accumulated over many years. Amongst SPFT professionals the MCA has succeeded in raising awareness of the issues around mental capacity and prompted consideration of the issue of capacity in the decision making process.

4. The five principles of the MCA and the 2-stage test for capacity are generally well understood by professionals, however there have been practical examples since 2008 which indicate some professionals (clinicians and health and social care professionals) do not fully understand the complexities of the MCA and the code of practice. In particular the consideration of ‘best interests’, the use of restraint, the Deprivation of Liberty safeguards, the different mechanisms of enabling the individual to make decisions such as power of attorney, advance decisions and applications to the court of protection and, crucially, the interface between the MCA and the Mental Health Act (MHA) 1983.

At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

5. SPFT are generally agreed that the five principles entrenched in the MCA 2005 are appropriate. The principles explain clearly how the MCA should be implemented and how the assessment of capacity should be approached. The third principle (the right to make a “wrong” decision) is a useful reminder that practitioners should not conclude that an individual lacks capacity just because they arrive at a different decision from the practitioner.

6. The five principles are easily understood and the practical examples provided in the 2007 code of practice provide useful additional guidance for professionals involved in the decision making process.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
7. SPFT provides MCA training to all our staff to promote awareness and increase knowledge of the MCA and the five principles underlying its provisions. This training is mandatory and ensures trained staff do have a good understanding of the MCA 2005 immediately following completion of the course. However, Government’s implementation plan was insufficient to ensure all front line staff received appropriate training from their employers and little guidance was available on what training should involve.

8. As an organisation SPFT are aware that the delivery and quality of training is not consistent across third party organisations. SPFT regularly receive requests to provide MCA training to organisations who do not understand the provisions or application of the MCA 2005 and who have been operating without sufficient support and guidance since 2008.

Is the Act widely known and understood by professionals, those affected by it and non-professional carers?

9. Although knowledge of the five principles is generally good across clinicians, knowledge and understanding of the provisions of the MCA varies widely. SPFT provides MCA training to organisations and individuals across the South East of England. Amongst those professionals trained there is generally a good understanding of the MCA and its application. However of those professionals who have not attended training, understanding of the provisions of the MCA can be very poor. In particular there is often confusion around the interface between MCA and the MHA.

10. In the experience of SPFT staff, the complexities of the MCA are not understood by those directly affected by it and by non professional carers. Explanation by professionals who implement the MCA is usually required which can create significant confusion where the MCA is also not understood by the professional. There is also confusion around how much involvement friends and families of individuals should have in the decision making process. This confusion is evident amongst professionals as well as friends and families.

11. Professionals and carers are not sufficiently clear on how ‘best interests’ are determined. Particularly within SPFT where mental health is often also a consideration, the determination of best interests often conflates personal and public interests. Also, as stated above, it is not always clear who can be consulted in making a best interests decision.

Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past?

12. The codification of common law principles by the MCA is a welcomed advancement and has increased knowledge and awareness around the issue of capacity. As such the MCA has enabled and supported individuals to make decisions for themselves to a greater extent that in the past. However, the MCA has also placed a significant burden on staff who have little experience of helping individuals to make such
decisions. There is a risk that work pressures at times override ethical and legal principles because of a lack of understanding.

13. Additionally, the quality of decision making when making a decision in someone’s best interests has not necessarily been improved. The concept of ‘best interests’ has always been difficult for professionals to comprehend and this has not improved under the provisions of the MCA. There can be many different views of what is in the person’s best interests and many different considerations. The risk has always been that public interests are perceived as being in the person’s personal best interests.

Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

14. On the whole, IMCAs have been a valuable resource and do provide a voice for the individual. However, it has been the experience of SPFT that IMCAs vary in their skill and knowledge and this can have a significant impact on the individual who depends on the IMCA to ensure they are heard and to protect them from abuse/exploitation. There does not seem to be a consistent approach in the way IMCAs carry out their professional role.

Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

15. The insertion of these safeguards into the MCA via the MHA 2007 amendment resulted in the MCA acquiring a very complex and bureaucratic set of appendices. Ward and unit managers are now required to identify who will be affected by the DoLS by looking at the individuals circumstances and applying the 2-stage capacity test, establish whether a deprivation of liberty is or about to take place, grant urgent authorisation or apply for standard authorisation and notify the CQC. There is significant confusion at each of these stages and staff do not understand the complexities of these safeguards. Given that managers of care homes and those working in hospitals are expected to understand these, the Government is asked to review these provisions urgently. In particular, it is very difficult to identify when a deprivation of liberty has taken place and the organisation now has to draw guidance from the MCA, code of practice and the increasing body of case law building on this issue.

16. In the experience of SPFT the DoLS process is applied in a random and piecemeal way. Its implementation relies wholly on all staff understanding the Act sufficiently. SPFT provides half day DoLS specific training to staff but detailed and in depth training, which cannot realistically be provided, is required to give staff a practical understanding on how to apply the safeguards. Despite the provision of training, a lot of time is still being spent sorting out inappropriate referrals or inappropriate use of the MCA, particularly where there are mental health considerations. It is also the experience of SPFT that some residential care homes have patchy, or at times no, understanding of the safeguards. It is becoming increasingly apparent that the process for authorisation, review and challenge of DoLS is not sufficiently clear.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
How well is the relationship with the mental health system and legislation understood in practice?

17. Although there are professionals with a good understanding of the interface between the MCA and MHA, this is not consistent across all clinicians. The interface between MHA, MCA and DOLS is generally poorly understood. Although case law has provided some clarity around the priority of application where an individual meets the criteria for detention under the MHA there is still confusion about this in practice. Clinicians are reluctant to apply the MHA even where its application is wholly appropriate because of the seemingly restrictive nature of the provisions and the extremely vulnerable nature of the individual.

18. The principles of the two frameworks can often be conflated which can result in the inappropriate use of both pieces of legislation. For instance the consideration of whether an individual has the capacity to agree to detention under the MHA 1983.

2 September 2013

Submission to be found under Victoria Butler-Cole in Volume 1.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Dr Paul Swift, Toby Williamson, Dr Val Williams, Dr Geraldine Boyle, Dr Marcus Jepson and Dr Pauline Heslop (School for Policy Studies, University of Bristol) – Written evidence

Submission to be found under Dr Val Williams.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Advanced Decision Evaluation (ADE) in Bipolar Disorder Study Team, Institute of Mental Health, University of Nottingham – Written evidence

Introduction and Context

3. We welcome the opportunity to provide evidence to the Committee in its consideration of the Mental Capacity Act 2005.

4. The PARADES (Psychoeducation, Anxiety, Relapse, Advance Decision Evaluation and Suicidality) Study is a National Institute for Health Research (NIHR) funded research programme based at Lancaster, Manchester and Nottingham Universities looking at various aspects of the care and treatment of people with bipolar disorder. One aspect of this programme, the Advance Decision Evaluation (ADE), is specifically exploring the impact that the Mental Capacity Act is having on this group and how advance planning under the Mental Capacity Act might be influenced through specific information and training on the use of the Mental Capacity Act in relation to bipolar disorder. It is this area of our work that we felt would be of interest to the Committee in its consideration of the Mental Capacity Act 2005.

5. The ADE study has created a database of a representative sample of 650 psychiatrists from across England who have answered questions with regards to their training and awareness on the mental capacity act and 550 service users who live in England who have answered questions about their understanding, use and experience of the mental capacity act, particularly in relation to Advance Decisions (AD). We have also conducted in depth interviews with 24 patients, psychiatrists, carers and lawyers to understand the barriers and drivers to advance planning that operate for this group.

6. This large sample of professionals and patients/service users and in-depth interviews allows us to comment on areas with regards to training of professionals on the mental capacity act and ‘take up’ of advance decisions that members of the committee have asked questions about in earlier oral evidence session for which witnesses did not have or did know of any evidence.

7. The committee has heard evidence with regards to Deprivation of Liberty Safeguards (DoLS). This is more often used in the Learning Disability and Dementia care setting, examining the use of the Mental Capacity Act in a severe mental illness such as Bipolar Disorder offers a different perspective on its implementation and effectiveness and on the relationships between the Mental Health Act 2007 and the Mental Capacity Act. We have responded to some of the questions from the call for evidence, focusing on those issues that our study provides data that underpins our views.

8. The names of the authors of this report and their roles and affiliations including contact details appear at the end of this submission.

Bipolar Disorder and the mental capacity act

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
9. Bipolar disorder is a severe mental illness affecting 1-2% of the population. It is characterised by periods of moderate to severe depression and separate periods of mania (elated mood, over activity, reckless behaviour, overspending, over confidence). If symptoms are severe enough, both the mania and depression phases of the condition may result in a loss of capacity.

10. In between episodes of illness, the vast majority of people with bipolar disorder return to their normal capacity although some will continue to have some depressive symptoms or cycle between mild hypomania and mild depression. Therefore, persons with bipolar disorder may benefit from one of the advance decision making options available under the Mental Capacity Act.

11. The introduction of advance planning measures is in keeping with the objectives of the Law Commission of England and Wales, who, during the consultation process for the Mental Capacity Act, emphasised the need to empower and encourage people with mental disorders or impairments to make decisions for themselves (Law Commission of England and Wales, 1995). Advance planning helps to promote individual autonomy and further propagates the principle of non-discrimination because it dispels the notion that people with severe mental illness will never be able to make important decisions for themselves (Richardson Committee, 1999).

Key Issues

2. What evidence is there that advance decisions to refuse treatment are being made and followed?

Unfortunately we found poor uptake of advance decisions amongst people with Bipolar Disorder. Of our sample of 550 patients only 55 (10%) had made an Advance Decision. 66% of the sample had not heard of this prior to participation in the study. Of those who had heard about advance decisions, but had not made one, 10% cited being unsure about how to make one as the reason for not creating an Advance Decision and 12% felt that their doctor would make the right decisions for them and therefore did not feel it was necessary to make an advance decision.

In order for advance decisions to be followed, there needs to be a systematic process for the recording, storage and retrieval of this information at the time when the person who made the AD lost capacity. Our data suggests that this is not happening. 47% of our sample who had made an advance decision held it with themselves and had not shared this. Others stated that they had given a copy to a family member or friend or to the medical team involved with their care. There is no single system which holds Advance Decisions centrally. Practice within individual Trusts varies. We are therefore not confident that in emergency situations decision makers have an agreed pathway to determine the presence or lack of an Advance Decision.

Our survey of psychiatrists echoes the findings above. Only 15% of psychiatrists had patients with Bipolar Disorder who had made Advance Decisions. Although 81% of our sample of psychiatrists said they would discuss advance decisions if the patient or carer asked about this only 35% of the sample said that they would instigate these discussions. The most common reasons for not discussing AD include lack of time, lack of training and more
worryingly for 32% of our sample the view that it was not clinically relevant, and since the Mental Health Act allows for certain ADs to be overruled it was not worthwhile (10%). In our view this view is misguided although legally correct. Although research has shown that most Bipolar Disorder patients admitted to mental health wards lack capacity to make treatment decisions, it is not the case that all such patients are admitted under the mental health act. There is also usually a ‘grey period’ when a person is relapsing, before they are admitted, where they might be losing capacity to make certain decisions but do not meet the criteria to be detained under the Mental Health Act.

3. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers?

No- for the group of patients we surveyed and interviewed there is a lack of knowledge and awareness of the Act. This is exemplified by the poor uptake. As well as the 10% figure mentioned above for Advance Decisions, only 4% of our survey had made LPAs (Lasting Powers of Attorney). During the course of the research many patients expressed an interest in finding out more and making an Advance Decision/LPA which suggests a lack of awareness rather than apathy regarding the Act. Most patients and non-professional carers had not come across the Act. In our in-depth interviews the reasons that acted as drivers for knowledge became apparent. Some participants had heard about the Mental Capacity Act through the media and had related it specifically to the needs of people with dementia. It appears that the legislation has been more associated with conditions associated with a decline in cognitive abilities or with situations where there is an intellectual disability and the extent to which the Act could help those with conditions with relapsing-remitting conditions was not appreciated. Participants who were members of self-help groups, either within or outside of the NHS were more likely to be aware of the Act. There appears to be a lack of clear responsibility within statutory services in Health and Social Care on who should lead on making sure patients are aware of the Act and its provisions.

4. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

Yes and no: we believe that the act is well known but the degree of understanding and implementation is variable. 92% of professionals (psychiatrists) had received training on the Mental Capacity Act. Many psychiatrists had been to more than one session of training (79%). The training was largely delivered through the NHS Trusts that they worked in. The Mental Health Act approved clinician training course also provided a vehicle for training with 32% of participants reporting that they received some training on the Mental Capacity Act. However as the answer to question 1 demonstrates the awareness is not being translated into action.

5. How effective was the Government’s implementation plan? Has the Act ushered in the expected, or any, change in the culture of care?

Knowledge is power- the data above shows that the lack of knowledge has meant that the potential to empower patients and carers has not reached the level that could be hoped for. The implementation plan has been partially effective, in that the professionals have awareness of the ACT. However the constraints they have cited such as a lack of time, and a
sense that this might not be clinically relevant suggests that the implementation strategy has not demonstrated the priority that the Mental Capacity Act should be afforded. The lack of awareness in the patient group could be improved if the knowledge held by the professionals was shared. This is not occurring. Our data suggests that this is because information about planning for periods when a person might lose capacity is not a routine part of the clinical interview and because there is vacuum of responsibility as to who should be responsible for generating this awareness to patient groups. The separation of inpatient and outpatient care within secondary care mental health services has compounded this problem. Our data suggests that those involved with service user groups were more likely to have awareness of the provisions of the Act. However, our data also implies that once this awareness is generated there is often a lack of further information or follow-up about how to practically create an AD and where it should be stored. The lack of practical on-the-ground implementation has prevented a change in culture.

6. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender

We analysed our sample in terms of socio demographic factors such as age, educational level, ethnicity, employment, relationship status and membership of NHS service user groups in order to identify whether certain groups were more likely to use the Mental Capacity Act. We did not find a significant relationship between educational attainment and making an Advance Decision. We are currently analysing the other variables with a statistician and can make the findings available to the Committee in supplementary evidence if this would be helpful. Our qualitative interviews suggest that there might be cultural differences in how some groups approach issues around determining best interests when a family member or friend has lost capacity. Ethnic minority groups might not subscribe to the same extent to the view that an individual’s pre-determination of choice, in the event of losing capacity, is the right principle to ascertain best interests, relying more on the family as the decision making unit.

7. How well is the relationship with the mental health system and legislation understood in practice?

This is not well understood. We have heard a range of views and individual examples during the course of this research from professionals and patients that highlight the misunderstandings about which piece of legislation should be used and how the determination might be applied. Our finding that 10% of professionals felt that it was not worthwhile to discuss Advance Decisions because the Mental Health Act overrules these is significant. In interviews, we have been informed that there might be cases where DoLS might be the more appropriate pathway to be used however because the use of the Mental Health Act is more familiar and perceived as easier to apply, this might be more likely to be used. Similarly we have heard examples of patients’ Advance Decisions being overruled and at times not even considered because (they perceive) they were subject to the Mental Health Act. We are also aware of cases of excellent practice where practitioners choose to respect Advance Decisions (for reasonable periods of time) even if their patient is detained under the Mental Health Act and the refusal of treatment is contrary to the preferred management. There are no clear guidelines to help practitioners navigate between these two
pieces of legislation that at times clash during the care of some of the most unwell individuals.

Recommendations

Implementation strategy to address the lack of awareness in groups such as people with bipolar disorder who have relapsing-remitting conditions; this could be through individual Trust’s MCA lead; or through a ‘make every contact count’ approach in which the expectation is that issues around capacity are discussed at each appointment with a mental health professional for those conditions in which loss of capacity is a recognised or anticipated phase.

Sharing best practice between providers as to how the MCA has been implemented within their service.

Consideration should also be given to standardisation of the forms used for creating Advance Decisions. Clear pathways as to how these should be stored and accessed at times of urgency

Better training for service users, patients and carers

Within individual care providers pathways to ensure that issues around capacity are discussed with an appropriately trained individual

Guidelines for front-line professionals on the relationships between the Mental Health Act and Mental Capacity Act with an emphasis on best practice.

Ask commissioners and the Care Quality Commission to require evidence of the implementation of the above recommendations e.g. through CQUIN, CQC and commissioner inspection.

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In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Aire Centre – Written evidence

1. The AIRE Centre welcomes the opportunity to present written evidence to the House of Lords Select Committee on the Mental Capacity Act 2005.

2. The AIRE Centre is a law centre which has provided information advice and litigation assistance for 20 years to individuals on matters of European law, including on the Charter of Fundamental Rights of the European Union, the European Convention of Human Rights, the European Social Charter and the Revised European Social Charter.

3. The AIRE Centre has been granted permission by the Supreme Court (SC) to intervene in the case of P and Q and as is currently preparing that intervention. The case before the SC considers a quite narrow and specific and will focus judicially on what criteria must be met for it to be decided that a deprivation of liberty has occurred or is proposed. The scope of the call for evidence by this Committee is somewhat wider than the P and Q case.

4. The AIRE Centre is also working with the secretariat of Council of Europe’s Convention on Biomedicine and Human Rights on the drafting of a protocol to that Convention which will deal with the involuntary placement or involuntary treatment of persons with mental or physical disabilities.

5. The AIRE Centre’s Senior Lawyer recently participated in a conference organised by the Academy of Europe on law on the rights of person with disabilities in Europe.

6. The AIRE Centre’s knowledge and experience is limited to the applicable international legal standards rather than any direct experience or expertise involving contact with patients in situations in which mental capacity is being assessed. Our evidence is confined to those matters of which we have knowledge and should be read accordingly.

7. This evidence is drawn from research we have compiled from many published resources. The Committee will be aware of the four reports of the comparative studies undertaken by the EU Agency for Fundamental Rights in this field and in particular of the fourth of those reports Legal capacity of persons with intellectual disabilities and persons with mental health problems.

8. The Mental Disability Advocacy Centre in Budapest has also made a compilation of the case law relevant to mental disabilities of the European Convention on Human Rights (ECHR).

9. We will make some general remarks in response to your questions 1, 2 and 3 and then respond to questions 16 and 17 on the deprivation of liberty safeguards, and question 27 on the UN Convention on the Right of Persons with Disabilities.


305 Summaries of Mental Disability Cases Decided by the European Court of Human Rights

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General remarks
10. In the vast majority of cases the involuntary treatment and involuntary placement of people considered to be suffering from a mental disorder or to lack mental capacity are measures which are imposed (and carried out) for wholly laudable and acceptable reasons and in a humanitarian manner which respects human dignity. But, partly because of the serious infringement of personal autonomy entailed and partly because the measures make those to whom they are applied vulnerable and thus at risk of ill treatment, they must be applied with extreme caution and effective legal safeguards against misuse. (see para 19 below)

11. As the Committee is of course fully aware the situation of many people is complicated by the overlap between the two parallel but increasingly overlapping legal regimes which exist in the UK relation to the treatment of persons with mental health disorders – the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA), both as amended by the Mental Health Act 2007. 306 This call for evidence is focused on the MCA but we first would like to address the issue of the overlapping regimes.

The MHA Regime

12. The purpose of the MHA is to provide the statutory framework for the compulsory assessment care and treatment of people for their mental disorder when they are unable or unwilling to consent to that care and treatment and when it is necessary for that care and treatment to be given to protect themselves and others from harm. The key provisions regulate compulsory admission for assessment307 and assessment for treatment308. Under the MHA, certain categories of person with mental health disorders can be compulsorily detained (“sectioned”) if they meet the criteria set out in the statute. Importantly, some patients who are “sectioned” under the MHA may, despite their mental disorder, have the capacity to consent to treatment but are simply unwilling to do so.

13. People may lack capacity but fall wholly outside the scope of application of the MHA and are not susceptible to being “sectioned” if for example they have learning difficulties or suffer from some degree of dementia or are in persistent vegetative state or have a brain injury. For some people – and these are often the most complex group for the application of legal bright lines – their capacity may fluctuate and they may at all times have partial capacity.

14. The recent Report of the House of Commons Health Committee309 noted with concern that it appeared that a shortage of psychiatric beds meant that some people who needed

306 For example, a person with a degree of capacity who is lawfully detained under the MHA may lack capacity to make some decisions such as financial management which thus fall under the MCA

307 Section 2 of the Mental Health Act 1983

308 Section 3 of the Mental Health Act 1983

309 Post Legislative Scrutiny of the Mental Health Act 2007, First Report of Session 2013-14, 10 July 2013
The Aire Centre – Written evidence

... in-patient psychiatric treatment were having to be inappropriately “sectioned” in order to secure their admission to hospital.

15. The group of people who would prima facie fall under the MHA regime in the UK have, under the various regimes in place in different European jurisdictions, been the subject of most litigation before the European Court of Human Rights (ECtHR) and its case law reflects this. It historically focused only on deprivations of liberty or the infliction of inhuman or degrading treatment in relation to people who would in the UK have been “sectioned” under the MHA.

The MCA regime

16. The MCA is based wholly upon a capacity test. It only applies to those who are deemed to lack capacity. Its provisions do not apply to any persons who have the capacity to make their own decisions, even if they might otherwise fall within its scope. Those who retain the capacity to consent cannot be considered under the MCA. They can only be compulsorily treated if they fall within the scope of the relevant provisions of the MHA and have been assessed as lacking the capacity to consent.

17. The MCA is not in place to ensure those who require treatment can be forced to obtain it but only applies to those who do not have the capacity to consent. Significantly, the MCA itself contains a core principle requiring that a “person is not to be treated as unable to make a decision merely because he makes an unwise decision”310. The ECtHR has recently re-iterated that a person is entitled to refuse medical treatment even where it prolongs life311 and has emphasised that unless a person has been formally (wholly or partially, permanently or temporarily) deprived of his capacity to manage his own life he is at liberty to refuse medical treatment or social support if he so wishes, even if that treatment or support is in his best interests312.

18. The MCA operates a different regime for a different category of people in need from those who fall under the MHA, and the Deprivation of Liberty Safeguards regime (DOLS) under the MCA was intended to close the protection gap disclosed by the finding of the ECtHR of a violation of the ECHR in the case of HL v UK313, “the Bournewood gap”.

19. It is clear and well recognised that persons who are deprived of their liberty are more vulnerable to abuse than those who retain their autonomy and independence so that the protection of Article 3 ECHR (the prohibition on inhuman or degrading treatment) may

310 Section 1(4) of the Mental Capacity Act 2005
311 ECtHR, Pretty v UK, Application no. 2346/02, 29 April 2002 at para 64
312 ECtHR, Plesó v. Hungary, Application no. 41242/08, 2 October 2012 generally and specifically at para 62
313 ECtHR, HL v UK, Application no. 45508/99, 5 October 2004

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1658
The Aire Centre – Written evidence

be involved\textsuperscript{314}. Much of the discussion of the working of the MCA has thus surrounded the DOLS regime, which came into force in 2009 through the amendments made by the Mental Health Act 2007 in response to the “Bournewood gap” but it is important for the Committee to remember there are other international human rights standards which also apply to deprivations of liberty in this context.

\textbf{International authorities}

20. The international law context is significantly relevant to understanding the deprivation of liberty and its safeguards. “Deprivation of liberty” is a phrase that appears in international standards, each time with a different context and emphasis. A number of international institutions are concerned with the liberty and security of the person. The international perspective provides helpful insight which is valuable in formulating its meaning.

\textbf{ECHR}

21. Article 5 of the European Convention on Human Rights (ECHR) provides that everyone has a right to liberty and security of person. Liberty means physical liberty of person, not just a freedom to choose\textsuperscript{315}. The Article 5 right is qualified and so is subject to a number of exceptions, one of which is particularly relevant in this context: deprivation of liberty may be justified based on objective evidence of a medical condition constituting an ‘unsound mind’\textsuperscript{316}. For ease of reference it is useful to set out the relevant provisions of Article 5 of the ECHR (Right to liberty and security):

1. Everyone has the right to liberty and security of person. No-one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(a) the lawful detention of a person after conviction by a competent court;
(b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.


\textsuperscript{315} ECtHR, Engel v The Netherlands, Application no. 5100/71; 5101/71; 5102/71; 5354/72; 5370/72 at para 58

\textsuperscript{316} Article 5(1)(e) of the ECHR

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4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

22. From the relevant caselaw, the AIRE Centre has devised a five point test to be applied to ascertain whether there has been compliance with Article 5(1) of the ECHR:

a. Has there been a deprivation of liberty (as opposed to a restriction on freedom of movement or an interference with personal autonomy)? Only if there has been a deprivation of liberty must the other tests be met
b. Has the permitted exception under Article 5(1)(a)-(f) been identified? And was/will it be met? If the deprivation of liberty has not been for an expressly permitted purpose it is automatically unlawful
c. Was (or will it) be in accordance with national law?
d. Does the national law have the “quality of law” required under the ECHR? This requires it to be determined whether the law in is sufficiently precise, accessible, ascertainable and foreseeable for an individual to regulate his conduct by it? 317
e. Have alternatives which would constitute a less serious interference with personal autonomy than the deprivation of liberty been fully explored and rejected?

23. What constitutes a deprivation of liberty is discussed below (para 27 et seq). Generally, if a deprivation of liberty which is prima facie lawful under the criteria set out above has occurred or is proposed then the procedural safeguards of the provisions of Article 5 are triggered. They are precise and compliance is strictly required. Once it has been established that a deprivation of liberty has occurred or is proposed the procedural safeguards must be observed.

24. Article 5(1) sets out an exhaustive list of situations in which a deprivation of liberty is permitted. For a deprivation of liberty to be lawful it must fall within one of those situations. In the context of mental health, this is normally Article 5(1)(e) unsound mind (see below paras 33 et seq). As this exception suggests, the ECHR is reflective of a model of disability that places trust in the medical profession 318. This medical model of disability understands disability as rooted primarily in a person’s diagnosable impairments. The existence of such impairments may form the basis of a justification of an interference with a person’s liberty, subject to certain conditions and procedural safeguards.

25. The adoption of a relatively wide concept of ‘deprivation of liberty’ means that more measures restricting liberty are subject to procedural scrutiny and safeguards. Such scrutiny is required by Article 5(4) of the ECHR, even in cases where a deprivation of liberty is justified. The concept of ‘deprivation of liberty’ is the gateway to protection

317 See ECtHR, Sunday Times v. UK, Application no. 6538/74, 26 April 1979; ECtHR, Malone v. UK, Application no. 8691/79, 2 August 1984; ECtHR, Krušlin v. France, Application no. 11801/85, 24 April 1990; and ECtHR, Rotaru v. Romania, Application no. 28341/95, 4 May 2000

318 See ECtHR, Winterwerp v The Netherlands, Application no. 6301/73, 24 October 1979

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26. The deprivation of liberty must be in accordance with national law. This necessary clarification of the concept of the deprivation of liberty is what the Supreme Court is intending to provide in the pending case of P and Q. Once it is established that a deprivation of liberty has or will occur, then to comply with Article 5 it must be necessary and proportionate. The detention of an individual is such a serious measure that it is only justified where other, less severe, measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained.

The meaning of deprivation of liberty

27. Various institutions have assisted in shedding light on the meaning of the deprivation of liberty under Article 5 of the ECHR. The Fundamental Rights Agency’s (FRA) view of the wide scope of Article 5 in involuntary placement situations:

“The application of Article 5 is triggered not by whether or not a person is in fact restrained or detained, but instead by whether he or she is placed in an institution against his or her will and cannot leave without authorisation.”

28. The UN Working Group on Arbitrary Detention has put forward a similarly objectively framed conception of what amounts to a deprivation of liberty in a mental health context:

“Psychiatric detention as an administrative measure may be regarded as deprivation of liberty when the person concerned is placed in a closed establishment which he may not leave freely.”

29. The ECtHR has indicated that objective element of the concept of deprivation of liberty, which is the primary focus of the P&Q and Cheshire West cases currently pending before the Supreme Court, is met in respect of “confinement in a particular restricted space for a not negligible length of time.” The starting point must be the concrete situation. Key factors in determining whether a situation amounts to a deprivation of liberty, rather than merely a restriction on liberty include:

- the type of measures imposed;
- the duration of detention;

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319 UN General Assembly Resolution 43/173

320 FRA report 2012: Involuntary placement and involuntary treatment of persons with mental health problems, page 17

321 Report of the UN Working Group on Arbitrary Detention, Deliberation No. 7 on issues relating to psychiatric detention, E/CN.4/2005/6, 1 December 2004, paragraph 58(a)

322 Although we note the importance of consent as an issue more widely, as highlighted recently by the ECtHR in Plesó v Hungary, Application no. 41242/08, 02 October 2012

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The Aire Centre – Written evidence

- the effects and manner of implementation of the measures;323

30. In several recent cases, decided since HL, the Bournewood case, relating to detention on mental health grounds, the ECtHR has stated that “the key factor” in determining whether there was a deprivation of liberty was whether the management of the care homes in question exercised complete and effective control over the person’s treatment, care, residence and movement324. An important element of assessing that factor appears to have been whether or not a person is free to leave the placement in question without the management’s permission. Although duration is a relevant factor in determining whether there is a deprivation of liberty, nonetheless a deprivation can occur even if the detainee has been held only for a short period325.

**Purpose of Article 5 of the ECHR**

31. This relatively wide scope needs to be understood in light of the underlying purpose of Article 5 and its nature as a qualified right. No-one should be arbitrarily deprived of his or her liberty and any deprivation of liberty must be subject to judicial scrutiny. The ECtHR has recently re-affirmed:

“The Convention requirement for an act of deprivation of liberty to be amenable to independent judicial scrutiny is of fundamental importance in the context of the underlying purpose of Article 5 of the Convention to provide safeguards against arbitrariness.”326

**Article 5 and the MCA**

32. The MCA provides that deprivation of liberty has the same meaning as it does in Article 5 of the ECHR327. The safeguards against arbitrariness required by Article 5(4) are also provided for in the MCA. It gives authority to deprive a person of their liberty only in three circumstances: first, where the Court of Protection authorises it; second, where it is authorised under the Deprivation of Liberty Safeguards scheme set out in Schedule A1 of the MCA 2005; and third, in certain emergency cases on an interim basis pending court approval. These provisions attempt to ensure that deprivations of liberty of persons with mental health problems are subject to independent scrutiny. The breadth of the concept of ‘deprivation of liberty’ is likely to have a significant effect on how frequently it is necessary to seek such authority in future cases.328

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323 ECtHR, Guzzardi v. Italy, Application no. 7367/76, 06 November 1980, paragraph 92

324 See e.g. Mihailovs v. Latvia, App. No. 35939/10, 22 January 2013; DD v Lithuania, App. No. 13469/06, 14 February 2012; and Kedzior v Poland, App. No. 45026/07, 17 October 2012

325 ECtHR, Rantsev v. Cyprus and Russia, Application no. 25965/04, 07 January 2010, paragraph 317

326 ECtHR [GC], Stanev v. Bulgaria, Application no. 36760/06, 17 January 2012, paragraph 170

327 Section 64(5) of the MCA

328 See CC v KK and STCC [2012] EWHC 2136 (COP), Baker J. for an example of the application of the ‘relative normality’ test in a judgment that an elderly woman had not been deprived of her liberty when moved against her will into a nursing home.

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Unsound mind

33. The meaning of unsound mind within Article 5(1)(e) for the purposes of justifying a deprivation of liberty must be carefully construed.

34. A parallel can be drawn with an ECtHR ruling on the meaning of the term “alcoholics” also used in Article 5(1)(e). In the case of Litwa v Poland the ECtHR was called upon to consider whether the term “alcoholics” should include temporary episodes of drunkenness within its definition for the purposes of considering the lawfulness of deprivations of liberty under the ECHR. This was a subject of much debate and the ECtHR looked to the intention of the drafters of the ECHR in its travaux préparatoires. It concluded that it could be included.

35.

60. The Court observes that the word “alcoholics”, in its common usage, denotes persons who are addicted to alcohol. On the other hand, in Article 5 § 1 of the Convention this term is found in a context that includes a reference to several other categories of individuals, that is, persons spreading infectious diseases, persons of unsound mind, drug addicts and vagrants. There is a link between all those persons in that they may be deprived of their liberty either in order to be given medical treatment or because of considerations dictated by social policy, or on both medical and social grounds. It is therefore legitimate to conclude from this context that a predominant reason why the Convention allows the persons mentioned in paragraph 1 (e) of Article 5 to be deprived of their liberty is not only that they are dangerous for public safety but also that their own interests may necessitate their detention (see the Guzzardi v. Italy judgment of 6 November 1980, Series A no. 39, pp. 36-37, § 98 in fine).

a. 61. This ratio legis indicates how the term “alcoholics” should be understood in the light of the object and purpose of Article 5 § 1 (e) of the Convention. It indicates that the object and purpose of this provision cannot be interpreted as only allowing the detention of “alcoholics” in the limited sense of persons in a clinical state of “alcoholism”. The Court considers that, under Article 5 § 1 (e) of the Convention, persons who are not medically diagnosed as “alcoholics”, but whose conduct and behaviour under the influence of alcohol pose a threat to public order or themselves, can be taken into custody for the protection of the public or their own interests, such as their health or personal safety.

36. There were some separate opinions in Litwa. In one separate opinion, judge Bonello noted:

Article 5 § 1 (e) permits “the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts or vagrants”. These classifications share one common factor: they refer to continuing or habitual states of socially dangerous conditions or attitudes, but not to one-off, transient manifestations. A vagrant is a person who lives a life of vagrancy, not anyone who temporarily happens to have no fixed abode. Drug addiction, too, relates to a continuing situation, not to an isolated consumption of a prohibited substance.

329 ECtHR, Witold Litwa v. Poland, Application no. 26629/95, 4 April 2000

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The Aire Centre – Written evidence

substance. To be of unsound mind, again, represents a condition of extended impairment of mental processes, rather than any isolated bout of aberrant behaviour. (emphasis added)

37. By analogy with the approach taken by the majority in Litwa, consideration needs to be given to whether it is possible, for the purposes of justifying a deprivation of liberty, to consider that persons who temporarily lack mental capacity, wholly or partially and for whatever reason, can be considered as being of “unsound mind” in the same way that the Court found it possible to consider persons who were simply drunk to come within the classification of “alcoholics” for the purpose of their deprivation of liberty. If the concept of “unsound mind” is only applied to persons with diagnosable mental disorders, and is not applied to persons who, for whatever reason, de facto lack the mental capacity at the relevant time to consent to placement or treatment, some persons in need of treatment may fall outside the definition of “unsound mind” and may thus not be able to be lawfully deprived of their liberty however much this might be in their best interests. The approach that has been adopted in the UK, which has accepted a broad definition of unsound mind has not yet been tested in Strasbourg.

38. The connotations that a term such as “persons of unsound mind” in Article 5(1)(e) of the ECHR, had in 1950 may be wholly inappropriate to be applied to situations when the necessity of a deprivation of liberty is based on understanding the complex nature of many mental disorders, learning disabilities and conditions such as “locked in syndrome” which has evolved so far from that time. The important thing is that the ECtHR keeps pace with those developments, although in the interest of legal certainty, the ECtHR will always follow them rather than spearheading them.

39. Significantly, the ECHR is a “living instrument” and is to be interpreted in the light of the attitudes and conditions prevailing in the present day rather than those which prevailed 60 years ago when it was drafted. The changing attitudes to homosexuality, children born out of wedlock, transsexuals, conscientious objection to military service,

330 G v E & Ors [2010] EWCA Civ 822 (16 July 2010) at para 60

331 Protocol 16 to the ECHR was adopted by the Committee of Ministers in 2013 and is now open for signature and ratification. The Protocol, when in force, will permit the supreme courts of all contracting parties to it to refer “questions of principle relating to the interpretation or application of the rights and freedoms defined in the Convention or the Protocols thereto” – in a similar way to the possibility which exists under article 267 TFEU for references to be made to the CJEU. The ECtHR will thus be able to provide a national supreme court with guidance as to the interpretation to be given to a term such as ‘deprivation of liberty’ which the national supreme court will then be able to use to inform the decision which it takes on the particular facts of the case.

332 ECtHR, Tyrer v. UK, Application no. 5856/72, 25 April 1978 at para 31; ECtHR, Johnston v. Ireland, Application no. 9697/82, 18 December 1986 at para 53; ECtHR, Inze v. Austria, Application no. 8695/79, 28 October 1987

333 ECtHR, Dugeon v. UK, Application no. 7525/76, 22 October 1981; ECtHR, Schalk and Kopf v. Austria, Application no. 30141/04, 24 June 2010

334 ECtHR, Johnston v. Ireland, Application no. 9697/82, 18 December 1986 ECtHR, Inze v. Austria, Application no. 8695/79, 28 October 1987

335 ECtHR, Bayatyan v. Armenia, Application no. 23459/03, 7 July 2011

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corporal punishment in schools, rape in marriage and the death penalty have all been reflected in the Court's case law. Concepts such as the right private life found in Article 8(2) of the ECHR have expanded to include such matters as moral and physical integrity. The Contracting Parties to the ECHR are obliged under Article 53 to apply the ECHR in a manner consistent with any other international obligations now binding on a state, even if those obligations did not exist at the time of the Conventions drafting and adoption, for example the Convention on the Rights of the Child or the Convention on the Rights of Persons with Disabilities.

40. Lack of capacity whether clinically or legally determined will often be partial and a person who is for example incapable of managing his or her financial affairs is often quite capable of making choices relating to food, clothing, TV programmes or even more serious matters. Under the ECHR, a "mentally ill" person can bring a case to Strasbourg even if they would be required to act through their guardian in the domestic courts and the concept of "partial guardianship" is common across Europe.

41. However Article 1 of the ECHR requires the state to take the necessary steps to prevent a harm of which it knew or ought to have known and reconciling that duty with personal autonomy in situations where capacity is in doubt is a great challenge.

42. A deprivation of liberty imposed on a person adjudged to be of "unsound mind" must still be necessary and proportionate to comply with Article 5(1) and must be subject to the procedural safeguards inherent in that article as well as to the review specified under Art 5(4).

43. The ECtHR has considered this:

68. In ordering the applicant's psychiatric detention, no in-depth consideration was given to the rational or irrational character of his choice to refuse hospitalisation, to the actual nature of the envisaged involuntary treatment or to the medical benefits which could be achieved through that treatment, or to the possibilities of applying a period of observation or requiring the applicant to pursue outpatient care. In this connection, the Court finds it regrettable that no weight whatsoever was attributed to the applicant's non-consent, although his legal capacity had not been removed, for example by placing him under guardianship. (emphasis added)

It cannot therefore be said that the decision to deprive the applicant of his liberty was based on an assessment of all the relevant factors including the therapeutic prospects or the viability of less invasive alternatives, as required also by the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care......

336 ECtHR, Öcalan v. Turkey, Application no. 46221/99, 12 May 2005

337 See for example ECtHR, Kiss v. Hungary, Application no. 38832/06, 20 May 2010 and FRA Report on the Legal capacity of persons with intellectual disabilities and persons with mental health problems

338 ECtHR, Osman v. UK, Application no. 23452/94, 28 October 1998; and ECtHR, Z v UK, Application no. 29392/95, 10 May 2001

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The Court would note in this connection that the national law does not provide in this case for alternatives such as the postponement of a decision pending observation ......

69. It follows from the above that the Court is not persuaded that the applicant’s mental disorder was of a kind or degree warranting compulsory confinement. Therefore his detention fell short of the conditions assumed by Article 5 § 1 (e) of the Convention. There has thus been a violation of that provision.

**Detailed assessment of the ECtHR on the deprivation of liberty and restrictions on liberty**

44. The ECtHR recently affirmed that the difference between deprivation of liberty and restrictions on liberty of movement (the latter being governed by Article 2 of Protocol No. 4) is merely one of degree or intensity, and not one of nature or substance. In order to determine whether someone has been deprived of his liberty, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.

45. The focus of the ECtHR in these affirmations appears to be on objectively determinable restrictive measures that are sufficiently intense to amount to a deprivation of liberty. The key factors they point to are elements that are likely to present themselves from the perspective of the person affected. There is no obvious indication here that the reason, purpose or motive of the person implementing a restrictive measure is a relevant factor for this purpose. The focus is on the measures themselves.

46. In *H.M. v Switzerland* the Court seemed to take into account an authority’s ostensibly benevolent reasons for moving an elderly lady into a care home from her own home, where the hygiene and living conditions were poor when considering whether she had been deprived of her liberty. In more recent cases the Court seems to have interpreted the *H.M* case as turning on the issue of consent. A similar interpretation of *H.M.* emerges from the more recent Grand Chamber judgment in *Stanev*.

47. That case law of the ECtHR has evolved in this respect is clear from the unanimous Grand Chamber judgment in *Creangă v Romania*:

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339 ECtHR, Plesó v. Hungary, Application no. 4124/08, 2 October 2012 at paras 68 and 69

340 The UK is not a party to this Protocol

341 Stanev v Bulgaria, App. No. 36760/06, Grand Chamber, 17 January 2012, paragraph 115

342 H.M. v Switzerland, App. No. 39187/98, 26.02.02, paragraph 48; although the view of the majority was subject to a strong dissenting judgment from Judge Loucaides


344 Stanev v Bulgaria, App. No. 36760/06, Grand Chamber, 17 January 2012, paragraph 130-131

345 Creangă v Romania, App. No. 29226/03, Grand Chamber, 23 February 2012, paragraph 93

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“The Court notes that ..... the purpose of the presence of individuals at police stations, or the fact that the parties concerned had not asked to be able to leave, were considered to be decisive factors... The case-law has evolved since then as the purpose of measures by the authorities depriving applicants of their liberty no longer appears decisive for the Court’s assessment of whether there has in fact been a deprivation of liberty. To date, the Court has taken this into account only at a later stage of its analysis, when examining the compatibility of the measure with Article 5 § 1 of the Convention.”

48. Shortly after Creangă, the Grand Chamber (with six of the same judges sitting) delivered its judgment in Austin v UK, (the “kettling” case) with three dissensions. The Grand Chamber in Austin found that it could have regard to the specific context and circumstances of restrictive measures imposed in determining whether they amount to a deprivation of liberty. The Creanga judgment makes clear that an authority’s motive or object is not relevant to the question of whether there has been a deprivation of liberty:

“Indeed, it is clear from the Court’s case-law that an underlying public interest motive, for example to protect the community against a perceived threat emanating from an individual, has no bearing on the question whether that person has been deprived of his liberty, although it might be relevant to the subsequent inquiry whether the deprivation of liberty was justified under one of the subparagraphs of Article 5 § 1…. The same is true where the object is to protect, treat or care in some way for the person taken into confinement, unless that person has validly consented to what would otherwise be a deprivation of liberty.” (emphasis added)

49. The focus of recent cases, such as Stanev, on the details of the measures themselves suggests that reason and purpose should not be relevant factors in determining whether there is a deprivation of liberty. A woman with dementia placed in a care home without her consent question may have been deprived of her liberty. Such a deprivation of liberty may be justifiable. Whether a particular measure amounts to a deprivation of liberty is different from whether it is justified. As a matter of legal principle, two quite separate and distinct questions: Has there been a deprivation of liberty? And, if so, can it be justified?”

50. Recent case law supports this statement and suggests that the authorities’ reasons or motives for imposing measures restricting liberty are relevant to whether or not those measures are justifiable rather than to whether they amount to a deprivation of liberty. In X v Finland the Court stated:

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347 Ibid., paragraph 59

348 Ibid., paragraph 58

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“One general principle established in the case-law is that detention will be “arbitrary” where, despite complying with the letter of national law, there has been an element of bad faith or deception on the part of the authorities.”

One might add that nor can it be for administrative convenience (see para 52 below)

51. The caselaw of the ECtHR seems now to have reached the point where a benevolent purpose or aim should not a relevant factor in determining whether a measure amounts to a deprivation of liberty even though it may be more likely to justify it provided that it falls within one of the permitted exceptions

Restrictions on freedom of movement

52. The UK is not a party to the fourth protocol to the ECHR which regulates restrictions on freedom of movement. Article 2(3) of the Protocol permits restrictions to be placed on the right to liberty of movement where necessary, among other things, for the maintenance of public order, the prevention of crime or the protection of the rights and freedoms of others. It is however a party to the UN International Covenant on Civil and Political Rights (ICCPR) Art 12 of which prohibits unlawful restrictions on freedoms of movement and the ECtHR has emphasised the role of the ICCPR:

“The European Convention on Human Rights does not apply in a vacuum, but in conjunction with the other international fundamental rights protection instruments. In that regard, with reference to the United Nations, Article 9 of the International Covenant on Civil and Political Rights – which prohibits arbitrary arrest or detention and applies to all cases of deprivation of liberty, including in the context of immigration controls – has been interpreted by the Human Rights Committee’s case-law to mean that detention must not simply be lawful, but must also not have been imposed on grounds of administrative expediency (see Hugo van Alphen v. the Netherlands, Communication no. 305/1988, CCPR/C/39/D/305/1988 (1990)). In addition, it must satisfy the requirements of necessity and proportionality…”

53. Article 12 of the ICCPR protects the right to freedom of movement (see general Comment 27) and applies to less severe restrictions on movement than those prohibited Article 9 (deprivation of liberty). Importantly, restrictions on freedom of movement under Art 2 of Protocol 4 are not subject to the same rigorous controls as must be applied under Art 5 to deprivations of liberty. Since measures adopted in the UK in this field cannot be subject to the scrutiny of the ECtHR under Art 2 prot 4 as restrictions on freedom of movement the individuals subjected to such measures would risk being left without any ECHR protection if their situations were not characterised as deprivations of liberty.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

349 X v Finland, application no. 34806/04, Chamber Judgment, 3 July, paragraph 147

350 ECtHR, Saadi v. UK, Application no. 13229/03, 29 January 2008 in the Joint dissenting opinion

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54. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("CPT") organises visits to places of detention in European states in order to assess how persons deprived of their liberty are treated in them. These places include psychiatric hospitals, social care homes and other institutions relating to mental health. Following a period of visiting the institutions within a state the CPT provides it with a detailed written report detailing instances of deprivation of liberty detailing its findings and recommendations.

55. There have been some instances in the CPT country reports in which it has set out its opinion on the existence of a deprivation of liberty based on its factual findings. In these instances it has construed the meaning of deprivation of liberty relatively broadly. In its assessment of supported homes in Albania, it considered that the voluntary admission of patients, who were allowed to leave during the day with a curfew, were still deprived of their liberty because their family or the police would be called to enable their return, if they had not returned by an agreed time\footnote{Report to the Albanian Government on the visit to Albania carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 10 to 21 May 2010, Strasbourg 20 March 2012, CPT/Inf (2012) 11 at para 130}. The CPT also considers there to be a deprivation of liberty where patients are held in a hospital and stopped from leaving because there were not appropriate social welfare institutions to which they could be moved\footnote{Report to the Austrian Government on the visit to Austria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 15 to 25 February 2009, Strasbourg 11 March 2010, CPT/Inf (2010) 5 at para 152}.

56. In its consideration of deprivations of liberty, the CPT has also considered the manner in which it is possible to leave an institution. It has suggested that there still existed a deprivation of liberty of a person where they were gently but firmly prevented from leaving an institution, where they had tried to do so\footnote{Report to the German Government on the visit to Germany carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 20 November to 2 December 2005, Strasbourg 18 April 2007, CPT/Inf (2007) 18 at para 180}. It also considers that there is a deprivation of liberty where a person could be able to leave but due to their mental capacity they are unable to interpret the mechanism for doing so, meaning they are unable to leave the institution in which they are detained. Specifically, in its evaluation of a nursing home in Liechtenstein patients were free to leave through the entrance door, which was operated by a keycode. Written instructions on how to operate this were next to the door, but some persons were unable to comprehend these owing to their mental capacity (although others could). The CPT considered this to constitute a deprivation of their liberty\footnote{Report to the Government of the Principality of Liechtenstein on the visit to Liechtenstein carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 5 to 9 February 2007, Strasbourg 3 July 2008, CPT/Inf (2008) 20 at para 70}.

Other Council of Europe mechanisms

\footnote{Report to the Albanian Government on the visit to Albania carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 10 to 21 May 2010, Strasbourg 20 March 2012, CPT/Inf (2012) 11 at para 130}
\footnote{Report to the Austrian Government on the visit to Austria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 15 to 25 February 2009, Strasbourg 11 March 2010, CPT/Inf (2010) 5 at para 152}
\footnote{Report to the German Government on the visit to Germany carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 20 November to 2 December 2005, Strasbourg 18 April 2007, CPT/Inf (2007) 18 at para 180}
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57. International standards indicate that a careful balancing exercise may be required when applying restrictive measures to persons with mental disorder. The Council of Europe have recommended, in connection with the legal protection of incapable adults, that any protection measures taken should interfere with the legal capacity, rights and freedoms of the person concerned to the minimum extent which is consistent with achieving the purpose of the intervention. More recently, it has recommended that Member States adopt a principle of least restriction in the following terms:

“Persons with mental disorder should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others.”

58. The Council of Europe Committee of Ministers has more recently complemented this recommendation with a checklist for Member States. It includes the following expansion on the meaning of the principle of least restriction:

“People with mental disorder should be cared for in the way and in the setting that least restricts their liberty and ability to live a normal life and to participate in the life of the community. This principle must be continuously balanced against the need to provide appropriate treatment (subject to consent provisions) and the protection of their health and safety and the safety of others.”

59. This suggests that it will often be expected that people with mental disorder will properly have restrictions imposed on their liberty. Arguably, it points away from the idea that persons with disability inherently have limited liberty, so that it is relatively unlikely that measures will amount to restrictions on liberty. It might be argued that a wide understanding of ‘deprivation of liberty’ would lead to the application of additional safeguards that promote the principle of least restriction.

60. The Council of Europe standards on involuntary placement suggest that a high degree of protection is promoted in respect of persons with mental disorder placed against their will. The Committee of Ministers has made recommendations in relation to involuntary placement situations where a person with a mental disorder either refuses to consent or objects to a placement. (There is a separate provision applying to persons who do not object and are unable to consent to a placement.) It recommends that, except in limited exceptional circumstances, a person should only be subject to involuntary placement if and so long as all of the following conditions are met:

355 Recommendation No. R (99) 4 of the Committee of Ministers of the Council of Europe on principles concerning the legal protection of incapable adults (adopted on 23 February 1999), Principle 6 § 2

356 Recommendation No. REC(2004)10 of the Committee of Ministers of the Council of Europe to member States concerning the protection of human rights and dignity of persons with mental disorder, Article 8

357 Recommendation CM/Rec(2009)3 of the Committee of Ministers to member states on monitoring the protection of human rights and dignity of persons with mental disorder (Adopted by the Committee of Ministers on 20 May 2009 at the 1057th meeting of the Ministers’ Deputies)

358 Recommendation No. REC(2004)10 of the Committee of Ministers of the Council of Europe to member States concerning the protection of human rights and dignity of persons with mental disorder, Article 26

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The Aire Centre – Written evidence

(i) the person has a mental disorder;
(ii) the person’s condition represents a significant risk of serious harm to his or her health or to other persons;
(iii) the placement includes a therapeutic purpose;
(iv) no less restrictive means of providing appropriate care are available; and
(v) the opinion of the person concerned has been taken into consideration.\textsuperscript{359}

61. Notably, the existence of a mental disorder is an important element in the justification of an involuntary placement according to this Recommendation. It is possible, in light of an assessment of the particular situation, that a person who is seriously disabled by a mental disorder and is unable to care for him or herself may also be viewed as putting his or her health at risk.\textsuperscript{360} This is reflective of a medical model of understanding disability, similar to that put forward by the ECHR.

European Parliament

62. Comments of the European Parliament that “any restriction of personal freedoms should be avoided, with particular reference to physical containment”\textsuperscript{361} suggest that they support a wide interpretation of the right to liberty in the context of persons with mental health issues.

The UN Working Group on Arbitrary Detention

63. There is some evidence that the United Nations’ approach before the introduction of the Convention on the Rights of Persons with Disabilities (considered further below) is reflective of a medical model of disability. See the following extract from a report of the Working Group on Arbitrary Detention:

“Various factors may give rise to deprive of his liberty someone, showing the signs of mental illness: to conduct a medical examination whether or not that person is in fact suffering from mental illness, and if so, to identify the nature of the illness. If his mental illness is established, deprivation of liberty may be motivated by the need of medical treatment, to which the patient is unwilling to subject himself. In addition, in some cases confinement of psychiatric patients in closed institutions may prove necessary to prevent the harm which the patient might cause to others or to himself.”\textsuperscript{362}

\begin{footnotes}
\item[359] Recommendation No. REC(2004)10 of the Committee of Ministers of the Council of Europe to member States concerning the protection of human rights and dignity of persons with mental disorder, Article 17 § 1
\item[360] Explanatory Notes to Recommendation No. REC(2004)10, paragraph 131
\end{footnotes}

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64. This approach requires the establishment of a medical diagnosis and, if such a diagnosis is forthcoming, enables a consideration of whether a deprivation of liberty may be necessary.

65. After this passage the Working Group go on to consider the important protections in place to safeguard individuals who are deprived of their liberty, including the safeguard of regular independent review. It adopts an interpretation of ‘deprivation of liberty’ that seems to attempt to ensure that these safeguards apply in certain objectively determinable concrete circumstances. The Working Group states:

“Psychiatric detention as an administrative measure may be regarded as deprivation of liberty when the person concerned is placed in a closed establishment which he may not leave freely.”

66. Notably, this test does not appear to take into account as a factor the degree of severity of the person’s impairment or the ‘normality’ of their life in the establishment.

**The UN Convention on the Rights of Persons with Disabilities (CRPD)**

67. The CRPD, which entered into force on 3 May 2008, is the most important international standard in relation to the understanding of contemporary attitudes towards the right to liberty in a mental health context. It addresses the right to liberty directly in its application to persons with disabilities and, although it does not form part of UK domestic law, it was ratified by the UK in 2009 together with its optional protocol permitting individuals to bring petitions asserting that its provisions had been violated. It is also a key part of the relevant international law context and has been recognised by the ECtHR as part of a European and worldwide consensus on the need to protect people with disabilities from discriminatory treatment. (article 53 of the ECHR requires ECHR provisions to be applied in conformity with a state’s other international obligations) As such, the CRPD merits some detailed consideration in the context of formulating a test of what amounts to a ‘deprivation of liberty’.

**Application of the CRPD to persons with mental health problems**

68. Article 1 of the CRPD provides a non-exhaustive definition of disability as follows:

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

69. The EU Fundamental Rights Agency (FRA) have concluded from this:

363 Ibid., paragraph 58

364 Ibid., paragraph 58(a)

365 Glor v Switzerland, App. No. 13444/04, 30 April 2009, paragraph 53

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“The scope [of the CRPD] embraces without doubt persons with mental health problems, at least in situations when these problems are longer lasting in nature.”366

The social model of disability

70. In contrast to the medical model of disability which previously pertained, the CRPD promotes a social model of disability, which understands disability as arising out of the interaction of personal impairments and social, physical and attitudinal barriers.367 The potential benefits of this model in driving positive change have been widely recognised. There is, for example, an important shift towards understanding disabled persons as active subjects and away from an attitude of objectification.

71. In light of the CRPD, the Council of Europe (CoE) Commissioner for Human Rights368 has recognised the value of this approach:

“[the social model of disability] recognises that people are not limited in their choices because of any inherent feature or condition of the person him or herself, but by the social and physical environment in which they live. In enabling environments, things are not done to a person, but rather people are supported, just like anyone else, to make independent and autonomous (and in some cases supported) decisions.”369

72. However, it has also been noted that the social model is not without its challenges and limitations: there will be times when the conditions or impairments of a person with disabilities will be such that they cannot be equalised by supportive social responses, particularly given the fact that state and private obligations in that regard are not unlimited.370 It is not yet wholly clear how the CRPD will be interpreted in relation to these issues, but it clearly marks an important shift.

The Committee on the Rights of Persons with Disabilities

73. The Committee on the Rights of Persons with Disabilities is the CRPD’s supervisory body and will play an important part in the interpretation of the CRPD. All State parties are required to report to it every four years on progress towards implementation. There is also an additional optional protocol providing for petitions to the CRPD, which enables the Committee to deal with alleged breaches of the CRPD.

The right to liberty in the CRPD


367 See the non-exhaustive definition of disability in Article 1 of the UN CRPD.

368 The Council of Europe Committee of Ministers has also indicated a move to the social model: see Rec (2006) 5, section 2.2

369 Council of Europe Commissioner for Human Rights paper: The right of people with disabilities to live independently and be included in the community, [CommDH/IssuePaper(2012)3]


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74. Article 14 of the CRPD relates to liberty and security of person. It raises important issues around the right to liberty of disabled people, including potential conflicts with other international standards and with UK domestic law. Article 14 reads as follows:

- “1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
  - (a) Enjoy the right to liberty and security of person;
  - (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

- 2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.”

75. At least three key points emerge from Article 14 that may help to understand the meaning of ‘deprivation of liberty’ in the context of disability:

- Persons with disabilities should enjoy the right to liberty on an equal basis with others.
- The existence of a disability should in no case justify a deprivation of liberty.
- Any deprivation of liberty should be met with proper safeguards.

**Interpreting and understanding Article 14 of the CRPD**

76. Article 14 appears potentially to conflict with the ECHR’s justification of detention of persons of unsound mind. Indeed, the UN High Commissioner for Human Rights has referred to this provision as a radical departure from the ECHR’s approach. It may be attractive to interpret ‘deprivation of liberty’ narrowly in order to lessen the scope of any such conflict. However, Article 14 does not require that persons with mental health problems may never be detained. The Reporting Guidelines on Article 14 for State parties of the CRPD state:

“This article ensures that persons with disabilities enjoy the right to liberty and personal security, and are not deprived of their liberty, unlawfully or arbitrarily, on the basis of the existence of a disability.”

77. This could be read as indicating that a deprivation of liberty on the basis of a disability that is not unlawful or arbitrary may therefore be justifiable.

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371 For a discussion of this potential conflict and its consequences in international law, see Philip Fennell and Urfan Khaliq, Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law, E.H.R.L.R. 2011, 6, 662-674

372 UN High Commissioner for Human Rights Annual Report, A/HRC//10/48 (26 January 2009), paragraph 48

373 Here is a link to the Reporting Guidelines: http://www.ohchr.org/Documents/HRBodies/CRPD/CRPD-C-2-3.pdf

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
78. However, there remains a potential conflict with both UK and other international standards in the requirement that the existence of a disability should in no case justify a deprivation of liberty. The interpretation of this provision by the Committee on the Rights of Persons with Disabilities will be very important in determining whether this conflict is real. To date, the indications are that it is. For example, the Committee in the Concluding Observations on Spain recommend that Spain “repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability”. Furthermore, in its Concluding Observations on Tunisia the Committee expressed concern “that having a disability, including an intellectual or psychosocial disability, can constitute a basis for the deprivation of liberty under current legislation” before recommending the repeal of that legislation. Similar concerns about the permissibility of deprivation of liberty on the grounds of disability are expressed in the Concluding Observations on Peru and China.

79. The UN High Commissioner for Human Rights has pointed out that proposals were made during the drafting of the CRPD to prohibit deprivations of liberty based solely on disability. Those proposals were rejected. The High Commissioner deduces that this means that a deprivation of liberty cannot be justified on the basis of a combination of grounds, one of which is the presence of a mental or intellectual disability. The High Commissioner concludes:

“This should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.”

CDBI on the CRPD

80. The Council of Europe Steering Committee on Bioethics (CDBI) has adopted a Declaration the main purpose of which is to clarify certain Articles of the CRPD, including Article 14. The CDBI analysed whether Article 14 is “compatible with the possibility to subject under certain conditions a person who has a mental disorder of a

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374 The Concluding Observations of the Committee on the Rights of Persons with Disabilities on Spain (CRPD/C/ESP/CO/1 (19 October 2011)), paragraph 36

375 The Concluding Observations of the Committee on the Rights of Persons with Disabilities on Tunisia (CRPD/C/TUN/CO/1 (13 May 2011)), paragraph 24-25

376 The Concluding Observations of the Committee on the Rights of Persons with Disabilities on Peru (CRPD/C/PER/CO/1 (16-20 April 2012)), paragraph 28-29

377 The Concluding Observations of the Committee on the Rights of Persons with Disabilities on China (CRPD/C/CHN/CO/1 (17-28 September 2012)), paragraph 23-24

378 UN High Commissioner for Human Rights Annual Report, A/HRC//10/48 (26 January 2009), paragraph 48

379 UN High Commissioner for Human Rights Annual Report, A/HRC//10/48 (26 January 2009), paragraph 49

380 CDBI, Abridged report on the 41st plenary meeting (Strasbourg, 2-4 November 2011), paragraph 20

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
serious nature to involuntary placement or involuntary treatment, as foreseen in other national and international texts.”

The CDBI gathered information on discussions that had been held at national level and concluded that:

“the existence of a disability may not justify in itself a deprivation of liberty or an involuntary treatment. Involuntary treatment or placement may only be justified, in connection with a mental disorder of a serious nature, if from the absence of treatment or placement serious harm is likely to result to the person’s health or to a third party.” (Emphasis added)

81. This Statement seems slightly ambiguous as to whether a justification based on prevention of harm may require the existence of a “mental disorder” as a pre-condition to its application. Such a pre-condition arguably discriminates against disabled people. However, it might be argued on the other hand that it reduces the scope for the political abuse that might arise from a general power of preventive detention exercisable without the need to show any connection with a mental disorder.

82. These debates indicate the evolving changes occurring in relation to deprivation of liberty laws for disabled persons. There appears to be an important shift underway towards a thoroughgoing principle of equal treatment of persons with disabilities, including mental health problems, and a move away from the making of potentially discriminatory distinctions based on the existence of a disability. These debates and the potential changes they herald may be significant factors in the attempt to understand the meaning of ‘deprivation of liberty’ itself.

Oviedo Convention on Human Rights and Biomedicine

83. The Council of Europe is starting work in 2013 on an additional protocol to the Oviedo Convention. The protocol will relate to the involuntary treatment or involuntary placement of persons with mental disabilities.

The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

381 Statement on the United Nations Convention on the Rights of Persons with Disabilities adopted by the CDBI at its 41st meeting (2-4 November 2011), paragraph 1

382 Ibid. paragraph 2

383 (adopted by General Assembly, resolution 46/119 of 17 December 1991)
The Aire Centre – Written evidence

84. The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (adopted by General Assembly, resolution 46/119 of 17 December 1991) contain the following passage:

Principle 16 – Involuntary admission

“I. A person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient’s personal representative, if any, and, unless the patient objects, to the patient’s family.

3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.”

Article 8 of the ECHR (the right to respect for private life)

85 There are many situations which arise under ss 5 and 6 of the MCA which do not normally involve the deprivation of liberty and do not therefore attract the protection of the DOLS regime or of Article 5 ECHR. But this can be a grey area as some of these acts may involve a temporary deprivation of liberty. There is also a fine line to be drawn between the kind of restriction of liberty – particularly in the context of applying restraints under S6 of the MCA – and a deprivation of liberty which demands the full implements of DOLS.

The importance in ECHR law of making the distinction between acts which constitute a deprivation of liberty and those which constitute an interference with personal autonomy is that the provisions of Article 5 and Article 8 are very different. The applicable ECHR standards under Article 5 and other international standards applicable to the deprivation of liberty are set out above.

The “private life” rubric of Article 8 has been held to include the right to “moral and physical integrity” which is seen as encompassing not only physical and psychological well

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being but also personal autonomy. Appropriately for the present exercise these concepts emerged in a case which concerned the abuse of a person with learning disabilities in an institution. The Court found that the ill-treatment fell short of inhuman and degrading treatment, but considered that the injury to the applicant’s “moral and physical integrity” required the protection of the ECHR.

A six point test (analogous to that required by article 5(1)) above should be applied to all cases falling within the scope of Article 8

(i) Was there a protected right engaged — such as the right to moral and physical integrity or personal autonomy?
(ii) Was there an interference with that right (or is one proposed)?
(iii) Was it (or would it be) in accordance with national law?
(iv) Is the national law in question sufficiently clear, precise and foreseeable (see in addition to the cases cited above in relation to deprivations of liberty – see e.g. Hashman and Harrup v UK 1999, Chorrerr v Austria 1993)
(v) Did it pursue one of the legitimate aims set out in art 8(2) which one? The protection of health? The economic well being of the country?
(vi) Was it proportionate to the legitimate aim pursued? Had less intrusive alternatives been considered and valid reasons given for rejecting them?

The more serious an interference with personal autonomy the greater the justification that will have to be shown but in any case concerning an interference with these rights Article 8 requires that there must be “inherent procedural safeguards” in place and observed. It flows from this that the more serious the interference the stronger the inherent procedural safeguards will need to be. Those safeguards must also — in ECHR terminology — be “practical and effective not theoretical and illusory”. The seriousness of certain decisions leads to the view that formal safeguards replicating or analogous to the DOLS regime — must be in place for those acts. This is already reflected in the Code of Practice.

The Code of Practice.

6.18 Some treatment decisions are so serious that the court has to make them — unless the person has previously made a Lasting Power of Attorney appointing an attorney to make such healthcare decisions for them (see chapter 7) or they have made a valid advance decision to refuse the proposed treatment (see chapter 9). The Court of Protection must be asked to make decisions relating to:
* the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from a patient in a permanent vegetative state (PVS)
* cases where it is proposed that a person who lacks capacity to consent should donate an organ or bone marrow to another person

384 The finding that a rape did not constitute a violation of Article 3 has been much criticised

385 X and Y v Netherlands 1985

386 Artico v Italy 1980

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The Aire Centre – Written evidence

- the proposed non-therapeutic sterilisation of a person who lacks capacity to consent (for example, for contraceptive purposes)
- cases where there is a dispute about whether a particular treatment will be in a person’s best interests.

But many other “s5 acts” may entail significant interferences with personal autonomy and it is less clear if the appropriate level of mandatory “inherent procedural safeguards” required by Art 8 ECHR exists in relation to other “s5 acts” including significant decisions such as a change of residence and health care and treatment not falling within the scope of para 6.18 of the Code of practice.

S6 governs the use of restraints and enables carers and others to restrain individuals as a proportionate response to the likelihood of the person suffering harm in order to prevent this harm. Unfortunately the use of such restraints may not only be an infringement of the person’s dignity protected under the private life rubric of Article 8 but may, if sufficiently severe, come close to the threshold of severity required for Article 3 (inhuman and degrading treatment) to be engaged. In such circumstances it is unclear whether the kind of informal unqualified assessments of incapacity (see below) permitted under the act will be sufficiently rigorous to be Article 8 compliant, much less ensure that illtreatment in breach of Article 3 does not occur.

It is of note that the relevant sections of both the Act and the Code of Practice focus on the protection from liability which the decision maker has, and not on what protection the person alleged to lack capacity has against inappropriate decisions being taken about them, or inappropriate treatment being inflicted on them.

The assessment of mental capacity and the ECHR

S2 of the MCA sets out those people who are deemed to lack capacity but the assessment of whether an individual has capacity is largely guided by the Code of Practice. A non-consensual decision to carry out certain s5 acts must be preceded by an ad hoc assessment of capacity relative to that act. The inability to consent to a particular s5 act must not be taken as a general inability to make other decisions or to consent to other acts.

In the case of Shtukaturov v Russia the Court noted

94. ... the existence of a mental disorder, even a serious one, cannot be the sole reason to justify full incapacitation. By analogy with the cases concerning deprivation of liberty, in order to justify full incapacitation the mental disorder must be “of a kind or degree” warranting such a measure (see, mutatis mutandis, Winterwerp, cited above, § 39)

It considered that the medical report on Mr S did not analyse the degree of the applicant’s incapacity in sufficient detail. In line with the approach taken in Shtukaturov, the ECtHR In Sykora v Cz 23419/07 2012 has also stated the following:

103. Any deprivation or limitation of legal capacity must be based on sufficiently reliable and conclusive evidence. An expert medical report should explain what kind of actions the applicant is unable to understand or control and what the consequences of his illness are for his social life,
health, pecuniary interests, and so on. The degree of the applicant’s incapacity should be addressed
in sufficient detail by the medical reports (see also Shtukaturov, cited above, §§ 93-94). 387

Under the Act assessments of incapacity do not have to be made by expert medical
professional or contained in medical reports but can be made by e.g. carers or careworkers
who “do not have to be experts in assessing capacity” 388 They do not usually need to
follow formal processes, such as involving a qualified professional to make the assessment
but can make such an assessment on the basis of a “reasonable belief” that the person
lacks the capacity to make the decision or consent to the action in question and have
objective reasons for holding that belief.

It is unclear whether in the light of the statements made by the Court in Shtukaturov and
Sykora these informal assessments made by unqualified carers would stand scrutiny if
Strasbourg were asked to consider them.

Conclusions

The AIRE centre hopes that these brief comments will assist the Committee in assessing
whether the implementation of the MCA practice complies with the UK’s international
obligation

6 September 2013

387 ECtHR, Sykora v Czech Republic, Application no. 23419/07, 22 November 2012

388 Code of practice 4.44

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submissions.
The Brain Injury Rehabilitation Trust – Written evidence

The Brain Injury Rehabilitation Trust (BIRT), part of the Disabilities Trust has been providing excellence in brain injury rehabilitation for over 20 years. We offer a continuum of rehabilitation that can meet the needs of an individual at any stage in their rehabilitation at one of our 12 UK centres. Our continuum provides the following options:

- Specialist Acute Assessment and Rehabilitation
- Specialist Independent Hospitals
- Specialist Neurobehavioural Assessment and Rehabilitation
- Transitional Living Options
- Near Reach Houses
- Specialist Continuing Rehabilitation
- Community Services

Through the Brain Injury Rehabilitation Trust (BIRT), other organisations and individual professionals in the brain injury sector we have collated our views into a summary document for the House of Lords Committee. The group responded to the three main questions published in the document entitled, ‘Select Committee on the Mental Capacity Act 2005, call for evidence.’

These include:

Professor Michael Oddy, Director of Clinical Services, BIRT

Dr Camilla Herbert, Consultant in Neuropsychology and Rehabilitation, BIRT

Martyn Rose, Consultant in Neuropsychiatric Rehabilitation, Co-founder of Headway and member of United Kingdom Acquired Brain Injury Forum (UKABIF).

Alex Ruck Keene, Barrister, 39 Essex Street Chambers

Dr Howard F Jackson, B.Sc., M.Clin.Psychol, Ph.D., AFBPS., Clinical Psychologist, Consultant Clinical Neuropsychologist Clinical Director, Transitional Rehabilitation Units (TRU)

Prof Huw Williams, Associate Professor of Clinical Neuropsychology University of Exeter

Mark Holloway DipSW MA, Brain Injury Case Manager, Headfirst

Anna Headley, Director of Autism, Learning Disability and Education at the Disabilities Trust

To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The MCA has raised awareness of the rights of individuals to make choices and has provided a framework for making decisions on behalf of those who are not capable of making that particular decision. We believe there is further work to be done on raising awareness in the

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Brain Injury Rehabilitation Trust – Written evidence

general public and in some areas of professional practice about who is entitled to make decisions on someone’s behalf. The concept of ‘next of kin' continues to be used as a short hand for 'decision maker,’ and we believe these can be significantly different roles. Nevertheless the legal framework of best interest decision making is in place and this is a positive development.” BIRT

“We believe that the MCA, as it stands, does not recognise the context in which decisions are being made. The impact of cognitive impairments after ABI, are particularly notable in ambiguous, unstructured situations, where a rapid response may be demanded, where poor influences are prominent or where opportunities for immediate gratification or social contact are available. Thus, the Mental Capacity Act currently disregards the context in which decisions are being made. Many of our clients perform extremely well in terms of formal interviews. They can appear intellectually able in this setting, but have severe problems outside of this formal structured environment. Individuals with such fluctuating capacity based on their biological or neuropsychological impairments are currently not well addressed within the Act. Dr Howard Jackson

Whilst we applaud the general tenet in the MCA that all assessments should be 'decision specific', we question the validity of this ideal. We contest that in reality, decisions are not isolated but rather inter-related. A recurring inter-relation regards the Mental Capacity of our clients to decide where they live. On the surface this seems simple enough, and most if not all our ABI clients past and present, could say which part of the world they would like to live in. However, moving house may require moving rehabilitation or support provider, the decision for which the client lacks capacity. Thus the place of accommodation becomes dependent on the support services available. Dr Howard F Jackson

We have concerns that the best interests procedure and process is rarely carried out correctly with the pertinent people present or with due notification. Moreover, we are concerned regarding the appointed decision maker. Clearly this cannot be the provider such as ourselves. Often it is the commissioner who is the decision maker. TRU could not be the decision maker because of potential vested interest. However, the same may be said of the commissioners. A close relative or friend (with capacity) therefore should have the over-riding right to be the decision maker and act in the individual’s best interests. Whilst there are possible complications, this would bring the MCA closer in line with the Mental Health Act for which such complications are already laid down in legislation.” Dr Howard F Jackson

2. Which areas of the Act, if any, require amendment and how?

“The relationship between the Deprivation of Liberty Safeguards (DoLS) procedures and the Mental Health Act (MHA) requires clarification and amendment. Our understanding is that DoLS procedures can be used in a mental health context if the patient does not meet the criteria for detention under the MHA. There is a lack of clarity as to the overlap between the two Acts, and this has an impact on their use in mental health settings and in some cases has resulted in a reluctance to use of DoLS in non mental health settings. BIRT

The process of applying for deputyship or Power of Attorney is slow and expensive, and there are particular difficulties identifying support for this process for people who have no family to take this forward. It is also a cumbersome mechanism for those with very limited funds to manage. Whilst there needs to be a robust system in place in order to ensure

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adequate protection, the system is not sufficiently responsive or flexible to cope with individuals needs.” *BIRT*

“…the question of whether there should be a statutory definition to deprivation of liberty, as has been mooted in Scotland. For my part, I would suggest that this would at least some way to making sure that there is consistency of decision-making, which is a significant problem in the operation of the DOLS regime provided for under Schedule A1 to the MCA 2005.” *Alex Ruck Keene*

“We would like to draw comparison between the safeguards of the Mental Health Act (where most assessments must be carried out by 2 practitioners (specified as section 12 approved medical doctors) and an approved mental health professional. While we endorse the principle of wider representation of professionals for the MCA, the clear requirement for more than one assessment in the MHA appears an important safeguard against a polarised, uninformed or incompetent single assessor (as may be the case in a capacity assessment).” *Dr Howard Jackson*

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

“We believe that principles 2, 4 and 5 are appropriate. In our view the assessment of capacity remains problematic and there have been issues with an increased number of false negatives. We believe this is in part due to the explicit presumption of capacity (principle one) and the emphasis on individuals retaining the right to make ‘eccentric or unwise’ decisions (principle 3). For example, those with a brain injury who have executive disorder lack the ability to foresee the consequences of their actions or to relate their understanding of this to the actual decision, therefore they make a number of unwise decisions but are sometimes still judged to have capacity. *BIRT*

Defining the capacity question or decision is highly variable and can lead to differences in the outcome. The more general the question, (for example can an individual manage their financial affairs?) the harder it can be to assess according to the functional tests. If the question is highly specific (for example does this person have the capacity to open a bank account with no overdraft facility?), then the assessment is more straightforward.” *BIRT*
“There are real difficulties in applying the provisions of the MCA 05 to those who have suffered acquired brain injuries and in consequence, are suffering from problems of either lack of insight or loss of higher executive functions.” Alex Ruck Keene

“…injuries to the frontal parts of the brain and their rich interconnections, referred to as executive functions, underpin mental capacity, judgement and decision making. The problems arising from such common injuries include impulsivity, suggestibility, impaired initiative, impaired awareness, planning, memory, estimation, consequential thinking and abstraction. The effects of these impairments are often not obvious in general conversation or even in structured interview. However in everyday life they can severely affect mental capacity but are often not viewed as symptoms of “mental disorder” so that abnormal reasoning is often attributed to “unwise decisions” alone.” Dr Howard Jackson

“Many professionals involved in assessing individuals under the MCA may have little understanding of the nature of the cognitive impairments found in people with ABI.” Professor Huw Williams

“Loss of insight following acquired brain injury is common and is a confounding factor for assessment. This difficulty arises because this group often has high IQ, sound plausible and, in the context of a conversation lead by a third party, can often be supported to understand, retain and weigh up information. The issues arise however because this "good decision making" or even "unwise decision making" is extrinsically environmentally governed. The difficulty comes with the use of the information outside of this setting. The process of assessment creating a false sense of capacity, particularly where the assessor is reliant upon a snapshot or self-report, sometimes without corroborative evidence. It is the structured assessment that acts as the compensatory strategy that the brain injured person requires to be enabled to make decisions. What is being assessed therefore is the stated decision that a brain injured person is supported to make rather than the actual functional behaviour outside of the assessment setting.” Mark Holloway

“Many people after a traumatic brain injury (TBI) are impulsive, have impaired insight into their problems and/or deny difficulties. Others may not understand, but are sufficiently socially able to know when to nod their head as if they have understood…the fact that intellect may be retained, but executive function severely compromised is overlooked.” Martyn Rose

3 September 2013
The Challenging Behaviour Foundation – Written evidence

About the CBF:

The Challenging Behaviour Foundation is a small but national charity which provides information and support to individuals with severe learning disabilities and their families and carers – as well as professionals working with those individuals. See www.challengingbehaviour.org.uk

Individuals with severe learning disabilities need support with everyday tasks such as feeding and dressing, and often have no verbal communication skills. Challenging behaviour is behaviour likely to put the individual or others at risk. It includes aggressive behaviour, self injurious behaviour, disruptive and destructive behaviour and stereotyped behaviour. It typically results in exclusion and restrictive practices, and many individuals are denied access to ordinary community facilities which most of us take for granted.

Individuals with severe learning disabilities and behaviour described as challenging are therefore doubly disadvantaged. Indeed they have been described as one of the most marginalised groups in our society. The terrible abuse exposed by Panorama of individuals at Winterbourne View demonstrated their vulnerability and how society and the systems designed to protect them can result in serious harm when they are out of sight and out of mind.

Overview & Context

1. The Mental Capacity Act (2005) (MCA) should be very significant in promoting and protecting the rights of individuals with learning disabilities whose behaviour is described as challenging. However, our experience at the CBF is:

   • Most families who contact us are not aware of the Act or its significance
   • Many families describe experiences for their relative where the MCA has not been adhered to, and decisions have been made without reference to the Act
   • Many support workers and others (e.g. care managers) are unaware of the MCA, and how it should influence their practice.

2. It is the implementation of the Act that requires attention.

3. It is the view of the CBF that the principles and definitions within the MCA of capacity and best interest are appropriate.

Implementation

4. The experience of the CBF is that there has been, at best, patchy implementation of the principles of the MCA. Our evidence for this is anecdotal, from the families we support, but reflects the findings from the Review of Learning Disability services carried out by CQC post Winterbourne View.

“When my son attended the A&E department, he needed a blood test to check his red blood cell count but he was non-compliant. I had to explain to hospital staff about the process whereby we

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
could take a blood sample, and that we would need to follow the MCA. The Doctor went away and looked on the internet – he came back and said “The Best Interest process doesn’t apply here. If you want to follow that, your son will have to be admitted.”

“We asked staff about their knowledge of and experience with the MCA and DoLS. Responses were variable. We acknowledge the complexity of this area but, where there was confusion, we would expect providers to have more effective internal and external mechanisms to provide advice and support.”

5. The Government’s implementation plan has been ineffective. There is either little awareness of, or poor attention to the MCA. There are no consequences for those who do not adhere to the MCA.

“People seem to be allowed to make decisions for people with no penalties attached to not evaluating capacity or assessing best interest. People do not whistle blow, abuse is covered up, constantly swept under the carpet. Abuse should not be covered up, we should not have to resort to the media, to hidden cameras.”

6. The Act is not widely known and understood by professionals required to implement it. There is variation across different sectors and different areas of the country.

“The MCA would probably be adequate if people implemented it, if people understood it, but we have ignorance from medical professionals, from Local Authorities, providers, and support staff. Look at Margaret Flynn and Pauline Heslop when they went in to the House of Lords they talked all about the MCA and whether it was adequate, they said that if people used it properly it would be and I agree”.

“My son had to go to an out of area specialist hospital for treatment. In stark contrast to all our previous experiences, the staff there were fully aware of the MCA, and had a clear process that they followed, involving me fully.”

“I had a letter from a care manager telling me she was assessing my son for continuing care funding, that she would fill in the form and send it to me to sign. I pointed out that it was likely he lacked the capacity to consent to the assessment, and that we needed to follow the MCA. She wrote back and said she would ask her manager - I haven’t heard back.”

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390 Care Quality Commission (2012) Learning disability services inspection programme: National overview

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
7. Most families we support have no awareness of the MCA or its implications for their relative.
8. The view of the CBF is that although the MCA has huge potential to change the culture of care, as yet this has not happened.
9. The CBF is not in a position to comment on this. However, it would support research into application of the MCA for those with more complex needs to ensure that this group of individuals, who are vulnerable due to their inability to “have a voice” are benefitting from the MCA as they should.

Decision making

10. The CBF have found that those affected by the Act are not being enabled or supported to make decisions for themselves or in their best interests.

“Best interest meetings were not used to support decisions about important issues relating to treatment, health, personal care and family involvement.” 395

“My son was stopped from attending activities and maintaining important relationships. On two occasions I went to my son’s house and found he was being locked in. If it is necessary to lock the front door for safety reasons clearly the decisions should have been made using best interest principles and fully documented.” 396

11. The CBF does not have evidence about this issue.
12. The experience of the CBF is that most families are either not included, or their involvement is tokenistic.

“Relatives were not routinely involved in decisions…” 397

“We were not consulted by the IMCA who was involved in helping decide where my daughter should live. I know my daughter better than anyone and it was clear that she was not happy where she was living and the provider were not meeting her needs. There is a marked difference in representing the views of a person who can talk compared with a person who is unable to talk and presents with very challenging behaviours. It is vital that family carers of this group are consulted to get a balanced view of what really is in the person’s best interests.” 398

“It is scary to think that people responsible for informing very important decisions about vulnerable peoples’ lives are not following protocols and routinely consulting with the family of a person who is unable to speak up for themselves. Surely this is how people end up living in inappropriate placements, like Winterbourne View, where their safety, autonomy and dignity are likely to be severely compromised.” 399

395 Care Quality Commission (2012) Learning disability services inspection programme: National overview
397 Care Quality Commission (2012) Learning disability services inspection programme: National overview
399 The Challenging Behaviour Foundation (2013) Communication with staff: Archives

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
13. The experience of the CBF is that the involvement of IMCAs is variable. Due to their limited time allocated per person, it is not always possible for them to consult appropriately with those who know the person well. In addition, it takes time to understand and get to know an individual with complex needs.

“The IMCA didn’t go into my daughter’s background to inform their decision making or talk to our family. My daughter has very complex needs. You need to understand her needs and her history and get feedback on this from those who know her best. IMCA’s should take time to spend with the person and their families to ensure they truly understand what decision will be in her best interests.”

400

14. The CBF has no evidence on this issue

15. The view of the CBF is that resources and skills for IMCAs to support this particular client group are variable.

“An IMCA’s position is surely to speak out objectively on the person they have been appointed to represent. I am unsure how they consulted my daughter, who has a severe learning disability and is non-verbal.”

401

16. In the experience of The Challenging Behaviour Foundation the Deprivation of Liberty Safeguards (DoLS) are not adequate. DoLS are often used inappropriately for people with severe learning disabilities who display behaviour described as

DoLS


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challenging, when what is actually needed is skilled and experienced professionals to provide appropriate specialist support. The least restrictive alternative is often not explored fully enough, making us question the skills and experience of Best Interests Assessors.

“My son has been with his new care provider for six months. We are on the second DoLS authorisation to allow the provider to implement more restrictive interventions when my son’s challenging behaviour escalates to a point that he and the staff are at risk of harm. Specifically, that they be allowed to use upwards of 6 members of staff to hold my son in order for staff to get out of his space safely. I have observed this and whilst I am not unhappy with how they do this I don’t see the benefit of this in the long term.” 404

“Challenging behaviour won’t go away by merely implementing restrictive approaches to managing behaviour. In our experience our son is no better off for having a DoLS. Those involved in deciding on rulings for people who display challenging behaviour need to be highly skilled specialists who understand that reactive strategies for dealing with behaviour are inefficient at teaching the person better ways to get their needs met.” 405

“We don’t thinks DoLS is the answer for our son, when there are other factors contributing to his behaviour. What he needs is increased level of involvement from other professional services and for his support staff to work on improving their rapport and understanding of him and his needs.” 406

“We spoke to an IMCA to challenge the initial rulings suggested and asked that two other rulings be stipulated within the authorisation document; that our son needs to be supported to access the community more and engage more with support staff. We asked for those points to be included in the DoLS. They were included but have not been adhered to by the home.” 407

17. The CBF has found that the processes for authorisation, review and challenging of DoLS are not sufficiently clear, accessible or timely. Rulings made under DoLS have been in some cases highly and unnecessarily restrictive and are often left in place and renewed over long periods of time, in which there is no marked improvement to the person’s behaviour or quality of life.

“The use of Deprivation of Liberty safeguards was poorly managed resulting in unnecessary restrictions on others.” 408

“Providers were sometimes unclear about the use of Deprivation of Liberty and the safeguards needed, and those that were unclear did not have internal or external mechanisms in place to address that knowledge gap.” 409

408 Care Quality Commission (2012) Learning disability services inspection programme: National overview

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
“The use of deprivation of liberties and the safeguards needed are not well understood, reported and lessons learned.” 410

“Understanding the MCA and DoLS was a minefield until we spoke to Charlie [family support worker-CBF] who enlightened us and we got our solicitor. There are only a few specialist solicitors…it is frightening. It can be stressful for parents even when you get your head around it, it is still stressful”. 411

“Our son’s DoLS authorisation is renewed every 3 months. I think the first application was rushed and rulings not thought through properly. We don’t want the DoLS order being reinstated every 3 months.” 412

Court of Protection and OPG

18. The Court of Protection and Office of the Public Guardian are not sufficiently understood and accessible to all.

“The two websites are separate and don’t link to each other, the forms are confusing and CBF staff found that the CoP phone line was unwelcoming and unhelpful. An example of how the CoP and OPG are ineffective is that staff are not trained in understanding behaviour, the needs of individuals who display challenging behaviour, and what appropriate support looks like. This means that they may back or approve overly restrictive interventions”. 413

19. The CBF has no evidence on this issue.
20. The CBF have identified concerns regarding family entitlement to representation and the cost associated with applying to become a deputy.

“I was put off becoming a deputy by the cost, it can be quite expensive. You have your child’s best interests at heart…you should be able to have a say without having to pay to go to court”. 414

It has been found that legal aid available is not sufficient for families to be adequately represented in court. The eligibility criteria for legal aid do not take into account additional outgoings such as loan payments, which can make it impossible for family carers to afford legal costs.

Regulation

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409 Care Quality Commission (2012) Learning disability services inspection programme: National overview

410 Care Quality Commission (2012) Learning disability services inspection programme: National overview


413 Clare, I. Redley, M. Keeling, A. Wagner, A. Wheeler, J. Gunn, M. & Holland, A. (2013) ‘Understanding The Interface Between The Mental Capacity Act’s Deprivation Of Liberty Safeguards (Mca-Dols) and The Mental Health Act (Mha)’ University of Cambridge


In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
21. The role of the CQC in inspecting on the MCA powers is inadequate. Despite the findings of the Learning Disability Review in 2012, there is no evidence of action being taken to address the deficits in understanding, implementation and reporting.

22. It would be helpful to have more robust regulation that results in the MCA being used appropriately to deliver good outcomes for individuals.

Other legislation

23. The relationship with other legislation such as the Mental Health Act and the Human Rights Act is not well understood. 415

30 August 2013

415 Clare, I. Redley, M. Keeling, A. Wagner, A. Wheeler, J. Gunn, M. & Holland, A. (2013) ‘Understanding The Interface Between The Mental Capacity Act’s Deprivation Of Liberty Safeguards (Mca-Dols) and The Mental Health Act (Mha)’ University of Cambridge

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The College of Emergency Medicine – Written evidence

1. INTRODUCTION

This evidence is limited to the application of the Mental Capacity Act (MCA or the “Act”) in the Emergency Department (ED).

Before the Act came into force there was variation in the management of non-psychiatric patients who were incapable of making decisions regarding treatment. These patients were vulnerable to medical paternalism if not managed by appropriately skilled staff.

In 2007, the MCA was developed to co-ordinate & simplify the law about the care & treatment of all people who lack capacity. It provides a clear set of guidance for use by all staff at all times. There is evidence that the Act has provided a legal framework which if implemented properly gives the staff the confidence that they are practicing in the patient’s best interests and that the patient’s wishes have been taken into consideration.

2. To what extent have the five principles of the MCA been implemented in frontline practice? (Q4)

To illustrate this, reference would be made to a specific example pertaining to a patient who was detained under the Mental Capacity Act about 2 months ago in an emergency department.

Mr P was a 45 year-old gentleman brought to the hospital by the Ambulance. He was found wandering the streets and appeared to be under the influence of alcohol.

He had sustained a deep cut to the forehead which was actively bleeding.

He was not orientated in time or place. He was not able to focus his attention on the interview for more than a couple of minutes. Following a full clinical assessment a decision was made by the doctor to admit Mr P to the observation ward of the emergency department overnight for management of his head injury which would include suturing of the wound.

Soon after the assessment, he became aggressive to staff and threatened to leave the department. A formal capacity assessment was undertaken.

Mr P was not able to understand in simple language what the intervention was, it’s nature and purpose and why it was being proposed. He was not able to retain the information given to him. He was considered therefore, to be incapable of consenting to, or refusing, the proposed intervention at that stage.

The staff believed that it was necessary to detain Mr P to prevent harm to him and the detention was considered proportionate to the likelihood and seriousness of the harm.

It was however recognised that his condition was likely to improve and that his ability to consent to treatment should be reviewed. The standard form for documenting Mental Capacity assessment was completed and signed.

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Neuro-observations were performed on Mr P as appropriate and several hours later, the doctor was called to re-assess Mr P as he was calm and more cooperative. A formal assessment was done and he was deemed to have capacity to make an informed decision. He was then discharged from the unit despite not having a responsible adult at home to watch him and bring him back to hospital if indicated.

Applying the principles of the MCA to the above scenario:

1. Mr P was assumed to have capacity to make the decision to remain in hospital for management of his head injury until it was established that he lacked capacity.

2. Mr P was not treated as unable to make a decision until all practicable steps to help him to do so, had been taken without success.

3. He was not regarded as unable to make a decision purely because he made what appeared to the staff to be an unwise decision.

4. The decision made on behalf of Mr P was made in his best interests. Steps were taken by staff to prevent serious deterioration in physical wellbeing. Also, as far as reasonably practicable, all steps were taken to improve his ability to participate as fully as possible in any care given to him.

5. Before the decision to detain Mr P, regard was had to whether the purpose for which it needed could be as effectively achieved in a way that was less restrictive of his rights and freedom of action.

In addition, it could be inferred from the above case that the ED staff:

1. Were aware that capacity assessment is decision specific and time specific.

2. Had knowledge and skills required to deal with issues relating to the fluctuation of capacity in decision-making.

3. Were aware that in addition to providing care and acting in patient's best interests, they also need to think of patients as active participants in their care.

4. Were aware that control or restraint of patients who are considered a risk to themselves is used as a last resort.

3. Is the Act widely known and understood by professionals required to implement it? (Q7)

In some acute hospitals, to raise awareness, a general training on the Mental Capacity Act is provided as part of the induction programme for all clinical staff. In addition to this, to improve understanding, it is a statutory requirement for staff that have regular contact with patients to undertake more specific and directed training on the MCA every year. (Part of the “Annual Mandatory Training Programme”). The regular update in these hospitals is designed to ensure that frontline staff is equipped with the knowledge and skills required to interpret and implement the Act.

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At a recent feedback session, trainees in Emergency Medicine in some hospitals have highlighted this topic as an area in which they have little training. So the Act is not widely known and understood by all professionals required to implement it.

The MCA is part of the curriculum at Membership and fellowship examination stage of the college exams, and so is incorporated into the speciality culture.

4. Has the Act ushered in the expected, or any, change in the culture of care? (Q8)

There is evidence that the Act has been embedded within some multidisciplinary hospital policies and procedures that have had positive impact on how health practitioners care and treat their patients when they are unable to make informed decisions for themselves.

Evidence to demonstrate the impact the MCA legislation has had on clinical practice in some Acute Trusts

1. Incorporating best practice in line with the Mental Capacity Act 2005 into the development of a Trust-wide “Consent Policy” for adults who lack or may lack the capacity to consent to investigation or treatment.

2. Incorporating the MCA principles into the development of “Control and Restraint Guidance” for use in the emergency department.

3. “Information Leaflet on restraint in the ED” for carers and family of patients who require a short stay in hospital and are being cared for in the observation ward of the Emergency Department. This is for patients who have had temporary loss of capacity due to some form of substance misuse or minor brain injury but do require a period of observation, investigation, treatment or further evaluation which they are unable to consent to.

4. MCA principles have been incorporated into the “Advanced Care Planning Policy”

5. Incorporating the MCA principles into clinical care admission documents from ED.

5. Which areas of the Act, if any, require amendment? (Q2)

Challenges in the implementation of the Act

1. Lack of definition for deprivation of liberty in the Act or Code of Practice. Currently, the difference between “Restriction of Liberty” and “Deprivation of Liberty” is merely one of degree or intensity, not of nature or substance, and the final decision is made by the court based on the facts of each case. It is particularly worrying to know that “cumulations” of restrictions could amount to deprivation of liberty.

2. Difficulty with assessment of capacity in patients with learning disability. This is mainly due to problems with communication and difficulty knowing what their views and preferences are. There is also the problem of them consenting to a procedure without understanding the impact of the consequences of their decision.

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On the other hand, in a strange environment, especially after a long wait to be seen by a clinician, they may be distressed and display signs of challenging behaviour and be assessed as not having capacity to make a decision.

3. Absence of an objective test for ability to “weigh up information” to arrive at a “choice” in the assessment of capacity. This element relies heavily on the practitioner to make a subjective judgement on the comprehension of data, which can be challenging in a patient whom you have just met.

4. Presumption of capacity until proven otherwise. We often have to make judgements about whether a patient has capacity on very incomplete information. The best example of this is when a patient after taking an overdose absconds before they have been assessed by a clinician and staff have to decide whether to bring them back or not.

Presumption of capacity until proven otherwise can make it difficult to persuade the police to bring them back. Perhaps a degree of “leeway”, where capacity is uncertain, would be helpful.

6. To what extent has the Mental Capacity Act (MCA) achieved its aims? (Q1)
Is there a satisfactory balance between enablement and protection?

Evidence gathered anecdotally indicates that the provisions of the Act are being applied as intended in the emergency department. The ED staff deal with a wide range of patients and the principle-based approach to the Mental Capacity Act offers flexibility. They find the Act a really useful piece of legislation.

The MCA is commonly applied in the ED for decisions related to interventions that require control and restraint. These are situations where it is essential to achieve a balance between the patient’s rights to exercise their choice and the practitioner’s duty to act in a proportionate manner to protect the patient from the harm that may arise from their choice. The Act provides an effective framework for dealing with such situations, and has been seen by staff as being very important in helping resolve such conflicts.

When providing care or treatment for patients who lack capacity, in their best interest in a proportional manner, staff are confident that the care can be provided without incurring legal liability. This includes actions that would otherwise result in civil wrong, like giving an injection.

7. CONCLUSION

ED staff, by nature of their work, are faced with circumstances that require the application of the Mental Capacity Act on a daily basis. There is evidence that the understanding of the MCA legislation has led to the awareness amongst staff that in addition to providing care and acting in patients best interests, they also need to think of patients as active participants in their care i.e. balance between empowerment and protection.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
There is anecdotal evidence to show that the principles of the Act are being applied as intended in most emergency departments. Regular training is required in all hospitals to improve understanding and help staff understand how the Act can be used as a tool for improving care.

29 August 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The College of Social Work – Written evidence

The College of Social Work (TCSW) exists to uphold the agreed professional standards and promote the profession and the benefits it brings to the general public, media and policy makers. This document was produced in response to the Lords Committee on the Mental Capacity Act 2005 call for written evidence, and expresses the views of the College of Social Work in relation to aspects of the Act and its implementation.

The College is led by and accountable to its members, and as such this response was produced, following a call for evidence, in conjunction with members of its Mental Health and Adults Faculties, frontline social workers and our policy champion volunteers.

Like colleges for other professions, our role is to:

- Hold the standards for the profession and support and enable our members to meet those standards
- Be the voice of the profession to policy makers and the media, ensuring that our members speak up for the profession
- Be led by and accountable to our members – the profession. We do this in order to improve the outcomes for the people served by our profession.

A) Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

Respondents to our call for evidence unanimously regard the Mental Capacity Act (MCA) as a good piece of legislation, with some going so far to describe it as ‘vital’. Its enactment has fundamentally altered the legal landscape, and in principle guards against the prospect of decisions being made on behalf of an individual that is not in their best interest. The new framework is very much in the spirit of social work, fitting well with the principles of empowerment while addressing issues of inequality. Through the Act, social workers are helping ensure that people who may lack capacity continue to have their rights protected.

As such, the Act should have brought forth a complex shift in culture, tipping the balance towards the individual, and embedding in practice a person-centred approach which enshrines the principle of self-determination and thereby respects the choices of people with capacity. The Act, in principle at least, was unanimously regarded by the respondents as empowering for individuals.

However, application of the Act has been patchy, and there is a fear among the respondents that professionals are not adhering to its five principles, and that this misapplication may owe to a lack of understanding which critically undermines its spirit and intentions. As such, while good practice does exist, there is tangible evidence that the cultural shift required to embed the MCA in practice has failed to materialise consistently across England, and as such has left huge geographical variations in understanding and application.
2. Which areas of the Act, if any, require amendment; and how?

Respondents were largely of the view that the core principles and process of the MCA do not need to be amended, describing it as a valuable, workable piece of legislation. However, professional understanding of the Act and how it should be applied in practice is in serious need of improvement.

Criticism is levelled at the Code of Practice with respondents calling for its revision. The Code does not adequately answer questions such as

- Who should actually assess capacity?
- What to do if decisions are not reached?
- How might decisions be challenged effectively?

The College of Social Work believes that social workers should be given specific responsibilities to carry out assessments where complex needs have been identified or have the potential to develop. In our work around the Care Bill we have proposed setting out in regulations reference to ‘complex cases’ which only social workers would be qualified to undertake. These would take in instances where a person is subject to legislation or national guidance, including people requiring assessment, support planning and review under the MCA and Mental Health Act. Social workers should take lead roles as Best Interests Assessors and in cases where a person is at risk of losing their liberty or freedom to act as they choose.

In our forthcoming Advice Note on the role and tasks of social workers, we have been arguing that a registered social worker should always be both responsible for dealing directly with clients and for overseeing cases where:

- There is a requirement for the assessment or review of an individual with complex social care needs.
- There is a requirement for the assessment or review of a carer looking after a person with complex social care needs.

Respondents were also concerned that individuals and families are not consistently and sufficiently informed of their rights, and have queried why there is no duty on statutory agencies to provide information.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

The principles are favourably looked upon by respondents. The emphasis on ‘presumption of capacity’ and ‘best-interests’ were seen to adhere to the basic tenets of social work, and fundamental to helping support an individual’s well-being.

The ‘unwise decision’ principle was also well-regarded, with respondents noting that applying it can have the benefit of forcing professionals to step back and fully appreciate the needs and wishes of the individual. However, there was also acknowledgement that these principles could be disregarded in practice, leading to practitioners over-intervening. This, one respondent argued, could have a corrosive or even catastrophic impact.

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One respondent did state that the definition for ‘regaining capacity’ should be expanded, arguing that good person centred care can enable a person with dementia to regain or develop capacity in areas of daily life, and that paragraph 5.28 of the Code of Practice (which mentions learning difficulties but not dementia) should be amended to reflect this. This is a crucial point worthy of serious consideration by the Committee.

**B) Implementation**

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

The MCA Code of Practice states that everyone working with and/or caring for adults who may lack capacity must comply with these five principles and processes, however there is a large body of evidence, including recent narrative submissions from our members which suggests a considerable degree of variation in implementation and compliance.

An assessment the Mental Health Foundation capacity audit toolkit found worrying levels of misunderstanding amongst staff of when to apply the MCA, and significant levels of practice appeared to be in contravention of the five fundamental principles. These findings are echoed in the Care Quality Commission’s March 2013 assessment of DOLs. The report found that there is still a lack of understanding of the Act among staff in hospitals and care homes which has resulted in decisions being made that do not necessarily adhere to the best interests principle. The CQC states in the report that:

“The use of the phrase ‘best interests’ does not always appear to signal that there has been a process of best-interests decision making in accordance with the MCA”

Similar conclusions are being reached by frontline professionals. An October 2012 article published by Community Care *Where social workers are going wrong on the Mental Capacity Act* written by College of Social Work member Elmari Bishop suggested that practitioners were being driven by risk-averse practice, with the ‘duty to care’ and ‘responsibility to manage risk’ had gained precedence over the duty to ‘empower and support person to make their own decisions.’

This imbalance between enablement and protection is also highlighted by Williams et al (2012) who found professionals struggling between empowering the individual to make decisions themselves, which might carry risks, and making decisions on their behalf that were restrictive, but on the face of it, better ensured the individual’s safety.

One of the fundamental issues in good MCA practice is to ensure practitioners use a clear, deliberative process which includes the gathering of evidence in reaching their decision both about capacity and about best interests. Only through the application of such a process and the gathering of evidence can decisions be defensible and be likely to adhere to best practice and principles. The importance of applying full, due assessment process, properly documented and standardised (within the context – e.g. a hospital applying a consistent protocol across all wards), is obviously greatest for the more significant decisions.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity

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know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

While the Department of Health did invest considerable time and resources into implementing the MCA in the early phases, this has now largely been left to local bodies and the retreat of any central oversight and monitoring has resulted in huge variations across different areas.

Furthermore, while there is recognition of early investment in materials and training to raise understanding among professionals, there has been insufficient guidance on how the various aspects of the Act might be implemented in practice and a lack of on-going coordination of learning and feedback at a national level.

This deficiency is particularly highlighted by one of the respondents to our call to evidence who was directly involved in training staff during the implementation process. They explained:

“I think an assumption was made that all that was need for successful implementation was for staff to be told that the Act was what principles, assessments, roles and decision making process were involved. It became quickly clear that this was not the case.”

They highlight a study that looked at the implementation work for DOLs.

“In one region a small piece of research was conducted by a trainee psychologist with managers of homes for learning disabilities. It showed that not all staff who had received MCA training could recall the five principles, and those who did weren’t able to recall them in sufficient detail.”

This forced the trainer to adapt their methods.

“After the first year of delivering this training I changed emphasis from refreshing knowledge of the MCA to exploring how staff might put it into practice. This has been positively received by health and social care professionals and managers of care homes and hospitals.”

It was worth emphasising that while the trainer’s adoption of different methods has led to changes in practice in one region, there is no guarantee that similar shifts are occurring across other parts of the country.

This lack of understanding has implications for the families of individuals affected by the Act, many of whom are reliant on professionals for advice. Voluntary and third sector agencies such as Mencap and Age UK are therefore playing a huge role in filling the gap, and have produced useful materials and resources that explain the Act and the rights it grants to individuals and families. However, it is worth noting that without appropriate signposting from professionals, it is not always guaranteed that families will come across the information.

6. Is the Act widely known and understood by professionals required to implement it?

As stated, while the MCA is widely known among professionals, it is not always sufficiently understood and applied. There are areas of exceptionally good practice which demonstrates that the MCA, if properly applied, can have a profound impact upon the vulnerable people it
set out to empower and protect. It is perhaps true to say that many statutory professionals, who should uphold the law and its application to protect citizens' rights, have been shown to be too often adrift compared to some voluntary organisations and advocacy groups in respect of the MCA. This would not be tolerated for, for instance, the Mental Health Act (MHA), and, whilst acknowledging the different history and scope of the MHA, the comparison in terms of degree of implementation resources and follow up on embedding between the 2007 MHA amendments and the 2005 MCA is salutary.

C) How does this differ across different sectors, such as health, social care, banking and others?

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

The March 2013 CQC reported highlighted that friends and/or family are often excluded from the decision making process, with practitioners sometimes failing to maximise people's capacity or help them make their own decisions.

The issue of application of the MCA in family/informal caring situations is very complex and is often not at all well understood by carers. It will be helpful to ensure the new duties towards/rights of carers in upcoming community care legislation cross reference with any improvements in guidance and other implementation support for the MCA – i.e. making the responsibility to include carers and family members more clear, and promoting the sharing of information about the Act, about rights for services users and carer and responsibilities of informal carers.

8. Has the Act ushered in the expected, or any, change in the culture of care?

Long standing cultural attitudes are proving difficult to shift. In the past professionals have tended to favour protection over empowerment, and in spite of the aspirations outlined in the MCA, the Act is still being used to protect and manage risk rather than enable individuals to make their own decisions. For instance care homes are often seen as the best option for individuals, and decisions are made without proper regard for home care or greater involvement of the family. Two Community Care magazine articles, Care home or care home: why client's best interests must decide and social workers must stop defying the Mental Capacity Act by resorting to care homes written again by College of Social Work member Elmari Bishop illustrate the dilemma. She says:

“...the MCA's least restrictive option principle would require evidence that care at home, as the less restrictive option, has been tried and failed or that is would be a totally unrealistic option, before recommendation of a care home placement is made.”

And:

“A Deprivation of Liberty Safeguards (Dols) authorisation, which is often used in such cases, does not give you 'permission' to refuse for a person to return home or to remove a person from home in the first instance, especially where there is family involved who wants to look after the person.”

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As it stands, the culture of protecting rather enabling is still prevalent across some areas of the country. This has still not been adequately addressed.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

DOLs Data published by the Health and Social Care Information Centre in August 2013 has indicated that application rates vary substantially with each ethnic group. The report stated that:

“Rates were highest among the white population (with 30.4 applications per 100,000 people) and lowest among the Asian and Asian British population (8.0 per 100,000 people). In part, these differences may reflect differences in age structure between ethnic groups. The 2011 Census found, for example, that among the White and White British population aged 18 and over, 77% were aged between 18 and 64, whilst 3% were aged 85 and over. In contrast, the age structure of the comparable Asian and Asian British population is more youthful, with 92% aged between 18-64 and 1% aged 85 and over.”

This message was repeated by some of our respondents, with one calling for a campaign to raise the profile of the MCA. More widely, respondents also noted that services such as interpretation were not as readily accessible under the MCA as they would be under the Mental Health Act, with access to specialist IMCA services in first languages other than English likely to be limited.

D) Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

The MCA has, in principle at least, allowed for greater participation by enabling service users, families and carers to take on a greater decision making role. The extension of Lasting Power of Attorney and the Court of Protection to health and welfare has also been a good development.

However, as previously stated, the experience of practitioners dealing with the Court of Protection hasn’t been unanimously positive. One respondent to our call to evidence cited feedback from a number of practitioners described the Court of Protection as ‘frustratingly slow and ineffective,’ which made challenging decisions difficult. The same respondent suggested that this may even put practitioners off from involving the court.

Echoing points made earlier in the submission, the capacity for involving individuals, carers and families in decision making was very much dependent on professionals fully understanding and applying the Act appropriately. Crucially, where it is poorly applied, especially where it was being used to reinforce the entrenched cultural practices, the MCA has had the adverse effect, and instead restricted the capacity of individuals to make decisions for themselves.

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12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

Again, respondents to our call for evidence emphasised that while the Act provides the legal framework, embedding a culture that will foster the appropriate involvement of carers and families in decision making is dependent on shifting cultural attitudes in practice. Overall, this has not happened to a sufficient degree, with respondents noting that professional opinion (for instance that of a Doctor) still carrying undue weight even when this decision is not necessarily in the spirit of a conducive, well informed, person centred approach. This has therefore adversely impacted the involvement of families and carers. As stated previously in this submission, putting a duty on statutory agencies to inform the families and/or carers of their rights under the Act might better guarantee their involvement and cross-referencing this with new duties towards carers and family members in the Care Bill may be useful.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

The increasing role of IMCAs has been warmly received by respondents, and the general consensus is that they provide a vital safeguarding function. There is an appreciation among those working alongside IMCAs of the knowledge and experience they bring to the process, and also recognition that this knowledge and experience is growing. One respondent to our call for evidence stated:

“Some of the best IMCAs I have worked with have also practised as lawyers, social workers or independent advocates - this has added to their effectiveness in supporting people who may lack capacity.”

However there was a sense among respondents that practitioners, carers and sometimes the IMCAs themselves are not always completely clear about what the different potential roles defined in the MCA entails. There is also variability in the quality of IMCAs and the monitoring framework for their practice and quality needs to be very well governed with better guidance.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

The evidence suggests that the number of referrals to IMCAs is still relatively low. The most recent data on this was published by the Department of Health in February 2013. While the data indicated that there was an overall increase in referrals from the previous year, and overall the numbers have more doubled in five years, there are still wide disparities in the rate of IMCA instructions across different local areas, and these variations cannot wholly be explained by population differences.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

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Building on the findings of the findings of Radley et al (2008) and Manthorpe and Martineau (2010), research conducted by Williams et al (2012) has determined that there is still considerable confusion regarding the role of the IMCA. While acknowledging the valuable support and safeguards advocates can provide, the authors indicate there is room for greater clarity and dissemination of their fundamental purpose. This has led to a situation whereby practitioners, carers and IMCAs are not always clear of the roles set out under the MCA, as one respondent to our call for evidence noted:

“There needs to be greater clarity regarding the role of the IMCA and what they can and cannot do in relation to support an individual and their family. I am aware of a situation where the IMCA was asked to act as a litigation friend for the individual, but the IMCA organisation as they felt it was outside of their jurisdiction. This could be a contractual issue with the service, but clearer guidance would help resolve disputes of this nature.”

This has been acknowledged by the Government to an extent. The February 2013 Department of Health annual report evaluating IMCAs recommends that commissioners, local authorities, health organisations and any other body sharing duties of care could do more to promote the role of IMCAs and ensure that referrals continue to increase. However, it is vital that these rises are consistent across the whole of the country and the regional disparities are ironed out.

The organisations which are funded to act as IMCA providers tend to be small voluntary organisations and as such are very reliant on local government funding. The pressure put on local authority budgets may explain why promotion of IMCAs has been inconsistent across different areas. With further cuts outlined in the latest spending review, this situation is unlikely to change in the near future.

It may be timely to consider whether greater clarity about links between IMCA and IMHA services can be promoted. Local Authorities have taken on commissioning responsibility for the latter now, (along with hospital DOLS supervisory body responsibility). Some LSSAs do not yet fully appreciate the differences and similarities between these different forms of advocacy and streamlining may improve provision of both.

E) Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

This is an area that demands extensive scrutiny. There are numerous documented examples of people’s liberty being restricted inappropriately, and many professionals have expressed their unease regarding the application and implementation of DOLs.

A post-legislative scrutiny report of the Mental Health Act 2007 published in August 2013 illustrates some of these issues. The report found that care providers did not know when they were exceeding powers and when to apply for DOLs authorisation, that there was a lack of understanding amongst providers and care staff regarding the meaning of ‘DOLs in practice’ and, echoing other points made in this submission, there was a resistance to apply DOLs because of the complex processes and ‘widespread anxiety and defensive regarding care standards in practice.’ The CQC has also reported confusion amongst staff as to the legal status of patients.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Another important finding highlighted the absence of a standard definition of DOLs that has hampered the ability of staff to properly interpret the guidance. Respondents to our call for evidence have stated that different professionals have different views about what constitutes restraint or deprivation, and this distinction appears to be causing confusion for providers. This point was reiterated by Dr Julie Chambers of the Royal College of Psychiatrists in a Committee oral evidence session. She acknowledged that the Government could do more to lead practitioners, and suggested that the definition could be clearer. The Government has to some extent already acknowledged this, stating in a memorandum produced for Committee in July 2012 that:

“The terminology (deprivation) is sometimes thought to be an obstacle... A more positive description may result in a larger number of care homes putting forward their residents for safeguards.”

Professionals have also raised concerns regarding the training and expertise of Best Interest Assessors given the complexity of the MCA/MHA/DOLs interface. One respondent to our call for evidence stated:

“Considering the decisions Best Interest Assessors (BIA) are required to make, it is strange that the role appears to be considered inferior to that of the Approved Mental Health Professional (AMHP), with it requiring considerably less training. For example, the BIA qualifying module runs over six taught days over five months on a 30 credit module - the comparable AMHP course runs for six months, including a practice placement, on a 100 credit module.”

The College of Social Work launched a new framework in March 2013 to formalise the standards expected of BIAs. The framework was developed by social work experts, and followed an extensive consultation into the capabilities required for the role, and focussed on six key areas which linked to the guiding principles of MCA. This was the first attempt to apply a set of standards that focussed on best practice rather than legal rules, and grants BIAs a clear set of expectations to apply to their practice. The BIAs capabilities framework can be mapped to the Professional Capabilities Framework, which was set out by the Social Work Reform Board and is now owned by the College of Social Work. The Department of Health has yet to put the framework into action.

Disparities in the number of applications across different regions also continues to be an issue, as highlighted in the Mental Capacity Act Deprivation of Liberty Safeguards Assessments published by the Health and Social Care Information Centre in August 2013. The rate of applications completed per 100,000 across England was 28.3. In the East Midlands it was 48.6 (highest), the South West was 37.7 (second highest), while in Yorkshire it was 22.8 (second lowest), and London it was 14.1 (lowest). In total, 55.1% of all applications were granted in England. The highest rate of granted applications was in London (58.3%), while the North West saw the lowest (50.4%).

17. Are the processes for authorisation, review and challenge of DoLs sufficiently clear, accessible and timely?

Respondents regard the DOLs process overly bureaucratic and in urgent need of simplification and in particular have called for a review of the forms to reduce their size and improve their clarity. A strong social work presence would be hugely beneficial in terms of better relating the forms to practice.

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The process for challenge is also insufficient. The Relevant Person’s Representative role relies on a family member or friend having a detailed understanding of DOLs which, for reasons touched on above, is very unlikely, and has therefore led to the increased use of Section 39D IMCAs. As noted elsewhere, challenges are not always timely and can involve lengthy hearings in the Court of Protection. Respondents called for a quicker system, similar to what is available under the Mental Health Act, to be incorporated into the process.

F) The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

While technically they are both important bodies within the MCA context, the roles of the Court of Protection and the Office of the Public Guardian are not sufficiently understood, nor are they accessible to all. If there are unresolvable conflicts around a best interest decision, then guidance states that professionals should approach the Court of Protection. The overall response to our call for evidence suggests that there are many occasions where this does not happen.

This might be explained by poor perceptions of the two institutions by many professionals. The Court of Protection was described as ‘expensive, laborious and slow’ by respondents to our call for evidence, with many noting the length of time the court takes to make arrangements and access resources.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

There are concerns that people can download the form from the internet and get Lasting Power of Attorney, granting them decision making powers over a person’s welfare. While any application requires a signature and an independent witness, Lasting Power of Attorney could potentially be set up by a determined person who has their own interests rather than the care of an individual in mind. One respondent noted that people are increasingly using the internet route given the cost of solicitors, and because legal aid is no longer available to them.

G) Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

Respondents to our call for evidence had mixed views regarding the CQC. On the one hand it was recognised that the body had a role to play for positively reinforcing the use of the MCA and DOLs. However, while acknowledging that theoretically the CQC was well-placed to regulate, some felt that staff at the CQC had insufficient knowledge of the MCA to act appropriately.
It is also evident that the CQC could have a more constructive role in ensuring the provisions of the MHA and MCA are brought together in mental health settings in their MHA ‘Commission’ role. These two pieces of legislation do not always fit together well – e.g. the language is different for similar concepts and the legal/rights foundations and history of the two pieces of legislation are different. New guidance on the MCA should recognise this and the CQC could have a key role in clarifying how mental health organisations should demonstrate excellent practice when both legislative frameworks are potentially in play. – see also section 24

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Having a registration process for those acting as Best Interest Assessors could be one way of monitoring and regulating standards as recommended by the College of Social Work. Similarly, recognition of the roles of both AMHP and Best Interest Assessors in professional practice would be a useful adjunct to professional registration e.g. with the Health and Care Professions Council.

The importance of MCA training in qualifying and post-qualifying curricula for all key professions could be much better recognised and promoted.

H) Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

There is considerable confusion and discussion regarding the interface between the MCA, DOLs and the Mental Health Act. While some legal judgements have clarified this (e.g. G v The Foundation Trust (2009) EWHC 2972 Fam) while others have added to the complexity (e.g. Cheshire West and Chester Council v P (2011) EWCA Civ 1257). As one respondent noted:

“The AMHPS and BIAs I train all find the interface between the MCA, DOLs and the Mental Health Act unnecessarily confusing and complex, resulting in the need to fund training from specialists in mental health law to support their understanding.”

Respondents also reported perceptions that the MCA only affects people with mental health difficulties and/or serious mental ill-health. This has led to assumptions of the MCA being specialist mental health law. This can lead to professionals and non-professionals not taking sufficient notice of the MCA.

3 September 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Disabilities Trust welcomes the House of Lord’s review of the Mental Capacity Act 2005. Further to our submission through BIRT and other external organisations and individuals from the brain injury sector we also attach a summary of opinion collated at service manager level across our divisions.

This includes staff at:

- Autism Spectrum Partners (ASP)
- The Brain Injury Rehabilitation Trust (BIRT)
- Disability Lifestyles (DL)
- Community Services
- The Disabilities Trust Foundation

Staff were asked about the following three issues in relation to the MCA 05:

1. Training
2. The role of the advocate
3. Specialist knowledge of conditions for assessors

Training and accreditation

Staff agreed that more training for those that assess the mental capability of a service user would be a positive step, they also felt it should be more consistent and for those from the local authority, specialist training of the most prevalent conditions in their area must be considered.

“It is a big responsibility and correct assessment process is crucial.”

“I believe that those making decisions should be trained, there are some decisions made at times that we (the staff) would question.”

“Yes it is a huge responsibility and needs to be right.”

“An accredited certificate may be useful but this would depend on what capacity is being assessed. I would not want to get to a position where decisions can’t be made because a ‘trained capacity assessor,’ isn’t available.”

“Currently the capacity decision is too 'black and white' and does not allow for grey areas such as those related to 'poor decisions.' For example, we have a service user who has been deemed to have capacity, but one of her issues is that her phone causes her anxiety. Sometimes she will ask us to keep it for her overnight (when anxiety occurs). However, if she asks for the phone back we are not allowed to remind her of our prior agreement (as she is deemed to have capacity) so we have to give her the phone which will then cause anxiety. At times her anxiety has led to such a high level of aggression we have had to call the police and section her.”

The Advocate

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The Disabilities Trust – Written evidence

The fourth principle of the Mental Capacity Act 05 refers to the role of the advocate and the absolute need for any decision to be made in the best interest of the service user. This principle is shared across the Disabilities Trust and we work hard to make sure it is implemented at every level. We asked our staff who is “best placed to be the appointed decision maker, in cases where the service user is judged not to have mental capacity.” The answers were mixed, with some stressing the importance of a group decision made between family, external and internal professionals. Others felt that the Service, our professionals, the local authority and the families of the service user could be subjective and have their own agenda and a neutral advocate (from an external service) would be best placed. All stressed, that it also depended on the decision that needed to be made, for example having major heart surgery or selecting and paying for an item of clothing would require different groups of professionals to assess capacity.

“Where major decisions are being made I would prefer this to remain as a group decision involving social workers, support agencies, family etc. Within a community setting the statutory authorities in some cases are well-placed to make these decisions.”

“families are often too overawed by the situation and just want ‘normality back,’ rather than looking at best interest, however all parties [to an extent] should be involved in the process.”

“I believe a neutral party, because all other stakeholders are coming at the capacity issue with their own agenda. Friends, family and the professionals can get very bogged down in the decision to be made rather than the person’s capacity to make the decision, particularly if they feel the person is making an unwise decision.”

“We hold a clinic once a month with our local advocacy, service users and staff are encouraged to discuss capacity at these sessions.”

Specialist Knowledge

Across our services we asked if staff considered that someone’s capacity hadn’t been judged properly because the assessor didn’t have specialist knowledge of the service user’s condition.

“I think external people that have been to the unit do not fully understand the cognitive impact of brain injury and although we (BIRT staff) have completed the capacity assessments, we have been questioned about the result…there is [also] a lack of understanding that if someone has the capacity to consent to treatment for example, this does not necessarily mean they have capacity to make decisions about their finance.”

“We are working with an individual who before coming to our service was judged to have capacity for her wellbeing. However when her anxiety is high, we have questioned this judgement. It causes issues with planning, supporting staff and risk assessment because if we do this, then external professionals question why we are doing this if she has capacity.”

“Our experience is that local authority staff, usually social workers are not trained to make capacity assessments particularly when someone has cognitive deficit due to brain injury. We also find that social workers use “capacity,” as a means of avoiding responsibility for

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service users. We have examples where our clinicians assess a lack of capacity and social workers assess as having capacity.

“In my experience GP and hospital doctors really don’t appear to have much of an understanding of the importance of this or the fact its decision specific and they can’t just make sweeping statements.”

3 September 2013
Together for Mental Wellbeing – Written evidence

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

1.1. Excluding DoLS, the MCA when used and applied, has been exceptional in upholding the rights of incapacitated and vulnerable people; however this only happens when the Act is understood and used properly by relevant professionals. Where the Act is not used, partially used or misunderstood then its aims are not achieved, therefore the main issue is still the lack of consistent implementation amongst professionals who ought to be using it.

2. Which areas of the Act, if any, require amendment; and how?

2.1. It is of concern to IMCAs, that their ‘independence’ is not genuine, as long as they continue to be funded and contracted by local authorities. Often ‘MCA Coordinators’, arguably the professional counterparts in the local authorities to IMCAs in terms of knowledge and experience, are advisors or even more involved, with commissioning of IMCA services; the risk is that where IMCA services prove to be challenging for the local authority, as their remit sometimes necessitates, this may bias the commissioning process. An acute example, is where an IMCA service challenges a Supervisory Body (e.g. their commissioning local authority) over a DoLS authorisation via the Court of Protection. The legal proceedings may be very long and acrimonious, and possibly resulting in a huge financial cost or penalty for the commissioning local authority. (Also note that the MCA Coordinator is often the Local Authority’s ‘expert’ and formal advisor in relation to DoLS).

2.2. The commissioning and resourcing (or lack of thereof) of IMCA services by local authorities, can realistically jeopardise the ability of IMCA services to provide meaningful challenges to best interests decisions made by the local authority. Specifically if the IMCA service, either feels the pressure not to challenge too hard to avoid jeopardising their chances of re-tendering their contract or by not having the resources to initiate their own Court of Protection proceedings or act as a Litigation Friend. There is a conflict of interests which should be removed by having an independent source of funding for IMCA.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

3.1. The MCA Principles and definitions of Best Interests are appropriate and fit for purpose (although the 1st Principle is sometimes misapplied by decision makers meaning that appropriate capacity assessments are not carried out).

3.2. Further clarification and elaboration on ‘capacity’ would greatly help practitioners as even experienced MCA-practitioners sometimes still grapple with assessing various components of the two-stage test. For example, when does psychological ‘denial’ which all people may experience or demonstrate, become differentiated from a lack...
of capacity due to insufficient understanding of relevant facts? When does an addiction, of whatever sort, demonstrate a lack of capacity due to an inability to use or weigh relevant information, as a result of an overriding addictive impulse? Or are the ‘usual’ addictions considered habits of ‘unwise decisions’, since they are conspicuously not mentioned in the Code of Practice.

3.3. An updated Code of Practice which incorporates up to date capacity case law to help elaborate capacity would be helpful.

Implementation Together for Mental Wellbeing – Written evidence

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

6.1. As IMCAs, we work with a tremendous range of professionals, commonly across several local authorities, and so we are uniquely placed to compare and contrast use and implementation of the Act amongst differing professionals and areas.

6.2. As a general rule, Approved Mental Health Professionals (AMHPs), and in particular, those also qualified as DoLS Best Interest Assessors (BIAs), appear to understand the Act best (most evidently BIAs who are AMHPs by background appear to be the best BIAs). One can speculate that their AMHP practice in using their legal thinking skills to apply the MHA, helps them to work with incapacitated clients using the MCA. Also commonly competent, are social workers who specialise working with older adults and people with learning disabilities. Less competent are health care professionals, such as nurses and doctors. Least knowledgeable and practised are GPs, which is most concerning since Clinical Commissioning Groups are now beginning to use their powers and meet their responsibilities.

6.3. Of course, the ranking given above is a generalisation and there are always ‘champions’ of MCA practice within each profession. The importance of these champions, in demonstrating and disseminating MCA practice cannot be overstated.

6.4. Specifically in relation to hospital Trusts and their employees, they are generally behind their social work colleagues in knowledge and practice. The correct use of the Act within the context of medical consent is often missing, with doctors still adopting the pre-MCA ‘two-signature’ practice of achieving ‘consent’ for patients lacking capacity. Training senior clinicians, in relation to the Act, appears ad hoc and widely fragmented dependent on the specialty. In addition, the usual route through the hospital system for serious medical treatments, is not conducive for best interests meetings, often needed for complex cases such as those for patients with learning disabilities: there is often neither the time nor the appetite, on the part of the decision makers, for convening such meetings. It appears that such decision makers, feel their remit is solely to make the ‘medical best interests’ decision, thereby negating the need to consider holistic best interests, as described by the MCA. Of course, the best clinicians, adapt their practice (or were already practicing in this inclusive manner) to practice MCA decision-making.

6.5. Where Trusts have turned a corner and a ‘tipping point’ reached, in terms of awareness and practice, this has been, as commonly the case, due to senior staff
with the necessary influence and power within the Trust championing the Act and its use. Where such tipping points have been reached, evidence of improvement has been demonstrated in accelerating rates of ‘serious medical treatment’ IMCA instructions; however there are still many more patients ‘outside’ of MCA practice by virtue of being outpatients and not inpatients.

Decision making

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

13.1. We have each been IMCAs since the inception of the service in 2007 and in total having worked in over 10 local authorities with many hundreds of cases. We have seen hurdles and barriers overcome, in the implementation of the Act within the health and social care system, and often IMCAs have been integral to this implementation at a local and national strategic level. Working at the ‘coal-face’ of the Act, has given us a great appreciation of its benefits and the importance of advocacy for the most vulnerable. At times, the role of the IMCA, feels like being a ‘MCA Evangelist’. MCA Coordinators and Leads, who similarly work wholly within the Act, often have the same dedication to the Act.

13.2. Decision makers, in the vast majority of cases, act in the person’s best interests and as such it may sometimes appear that IMCA involvement and their contribution is simply a formality as the same decision would have been arrived at without an IMCA involved; however it must be remembered that, beyond giving the oft-missing information about the person’s wishes, feelings, values and beliefs, IMCAs more commonly provide valuable safeguards on behalf of the service user by 1) asking questions 2) ascertaining capacity has been assessed and the conclusion appears correct 3) using their expert knowledge of the Act and MCA practice experience in guiding other professionals within decision-making and 4) helping to uphold ECHR Rights for the client within the context of DoLS. At other times, working as an IMCA, goes beyond the explicit safeguards of the Act, for example, being the sole visitor and ‘interested person’ of the unbefriended dying person in the care home or hospital, has its own intrinsic value.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

14.1. IMCA referral numbers have consistently risen year-on-year since the start of IMCA in 2007, and although in some areas, such as serious medical treatment referrals there may be dramatic increases as a hospital trust reaches a tipping point in awareness of IMCA, there is still much room for improvement within health care. It is difficult to pinpoint the causes of weakness or strength in differing referral rates across regions, as the problem is multi-factoral but the following factors can affect rates:

1) Demographics of the local population may be a factor in the numbers of isolated or unbefriended individuals.

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2) The performance of the local MCA Coordinator or team charged with implementing the Act can influence overall MCA activity including IMCA referral rates.
3) The number of social workers or social work teams in a local authority can affect referral rates.
4) Having senior individuals within an organisation championing the Act and IMCA.
5) IMCAs who are proactive in seeking possible referrals and vigilant for any Deprivation of Liberty.
6) An IMCA service which is successful in building strong working relationships with referrers and statutory services.

14.2. Out of all of the above factors, the one which appears to have most impact, for worse or for better, is the quality of the leadership provided by a MCA lead or coordinator within an organisation or local authority. Even where there is one individual professional, for example a community matron, who informally champions the Act and IMCA, this can generate disproportionate numbers of referrals within an area, by their actions in identifying the need for IMCA involvement.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

15.1. It is by virtue of the experience of the work, which automatically provides a vast variety of complex issues, problems and experiences of working with different professionals and services, that an IMCA becomes skilled at their work. The mandatory MCA knowledge and formal IMCA training are basic starting points, often followed by a steep and prolonged learning curve for the trainee IMCA. Therefore, generally speaking, the longer the career of the IMCA, the more skilled the IMCA becomes. Having advanced skills in communication, both oral and written, combined with personal traits of initiative, persistence and a dedication to the Act and its evolving nature, are all ingredients for any effective IMCA.

15.2. IMCA started in 2007 just prior to the global recession, and as Local Authority funding became constrained just at the same time as IMCA use was accelerating, many IMCA services found that their commissioners were unable to increase IMCA resources at the rate of increasing referrals. Some services now still have the same numbers of IMCAs presently as they had in 2007, six years on. It is not uncommon for there to be only 2 to 3 full-time IMCAs serving between two to four local authorities. With insufficient numbers of IMCAs combined with the demands of the work, which includes a large proportion of the time travelling across large regions and writing high-quality mandatory IMCA reports, IMCA work can often be high-pressured and very demanding for the individual IMCA and the service.

15.3. As non-Statutory advocacy provision is being financially squeezed and services decreasing annually, the Statutory advocacy services such as IMCA are being put under ever increasing demand.

15.4. The IMCA role has altered significantly since its implementation in 2007, it is now a far more legal role yet there has not been any specific training on evolving roles such as ‘Litigation Friend’. IMCA’s are increasingly being asked to take on this role, yet IMCA training does not prepare an IMCA for the role and responsibility of being a Litigation Friend. Training on Court procedures is also needed.

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15.5. It can cause many dilemmas when being asked to take on the role of Litigation Friend due to the increasing demand on resources. How does an IMCA service decide who to represent when at full capacity and are unable to carry out the function of Litigation Friend? Leaving some individuals without necessary representation goes against the core principles of advocacy for the most vulnerable people in society.

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

16.1. The DoLS safeguards are presently inadequate for a number of reasons, which are widely agreed by the majority of MCA/DoLS practitioners. Firstly, the initiative taken by the IMCA, RPR or Supervisory Body to challenge an Authorisation via the Court of Protection can depend largely on external factors such the financial cost, the knowledge of best practice or up to date case law and the confidence of the professionals to undertake formal legal action. Secondly challenges can take a long time to conclude: in one real case, the proceedings have lasted a year to date (even though all parties have long agreed that the Relevant Person is should not be accommodated where they are); and thirdly, the complexity of the bureaucracy of Deprivation, mean that many Deprivations are undoubtedly unidentified or un-assessed and therefore no DoLS safeguards are in place.

16.2. The DoLS Safeguards require on-going awareness-raising, especially with private providers. IMCA services are finding big training gaps exist in many care homes where in some cases only the Manager has received training.

16.3. One real case example showed how the involvement of a 39A IMCA proved invaluable in ensuring the client’s voice was heard and right to family life upheld. An ‘urgent’ DoLS Authorisation required a 39A IMCA to participate in the qualifying assessments. A woman with mild learning disabilities had been placed in emergency respite following her partner being admitted to hospital. The couple had been living together as a couple for twenty years. The partner was the carer for the woman and they had no care package in place; only regular visits by the social worker. Concerns were raised about the ability of the man to continue being the main carer for his partner due to his ill health and the couple’s unsanitary living conditions. The woman was very upset and verbally explicit in her wish to return home. The man was equally clear in his wish for his partner to return home and confident in his ability to care for her. Various professionals felt the woman should remain in respite care until a Best Interest decision was made in relation to returning home or staying in respite care until her partner was well enough to look after her. The IMCA and Best Interest Assessor both felt the lady should return home as both the female and male wanted to stay together living at home as they had been doing and managing for the past 20 years. The partner agreed to receiving support at home until he was physically better to care for the female. The IMCA would have considered challenging a Authorised DoLS via the Court of Protection, but in the end it was not necessary. After much negotiation with the IMCA, the BIA decided to return her back home despite this conflicting with the views of other professionals.
17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

17.1. Urgent DoLS paperwork can often be sent so late, within the 7 working day deadline, that the 39A IMCA has very little time to do their necessary work.

Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

24.1. From the experience of IMCA services, mental health services rarely use IMCAs. One may presume that this is because the MHA (1983) is used instead excluding IMCA instruction; however a large proportion of mental health service users, are ‘informal’ inpatients or living in the community with cognitive impairments. Anecdotal experiences show that common preconceptions or assumptions exists amongst mental health professionals that the MHA and MCA are mutually exclusive or that the MHA always ‘trumps’ the MCA; however neither are correct but consequently the MCA and its safeguards and rights are underused and often poorly understood by psychiatrists, community mental health teams and its staff.

This evidence is given and signed by:

- Kevin Chan - Project Coordinator / IMCA for the Halton, Knowsley, Warrington and St Helens IMCA Service
- Sarah Goodfellow - Project Coordinator / IMCA for the Kirklees and Wakefield IMCA Service
- Heather Walinets - IMCA for the Kirklees and Wakefield IMCA Service
- Gemma Hill - Project Coordinator / IMCA for the Teeswide IMCA Service

On behalf of Together for Mental Wellbeing

28 August 2013
Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The MCA has unquestionably had a significant impact on the provision of health and social care. It has

a) clarified a process to establish capacity, and a framework for substitute decision making

b) made significant progress in empowering individuals and service user communities who would have previously experienced limited choice and control

c) given greater protection for incapable adults, and professionals

d) explicitly stated in law the rights of capacitous adults to make decisions perceived by others as “unwise”

However it seems that in many areas the MCA has yet to be either recognised or embedded in practice. There appears to be a pervasive culture in many settings that capacity assessments are “someone else’s business” and should be carried out by someone who may work in another field or profession simply because it is believed they are more able to do so (rather than for instance the clinician who would be assuming responsibility for undertaking the procedure.) In other areas there seems to be a culture of “Doctor knows best” or “we’ll just consent her.” Sometimes this is not explicitly challenged as consent forms can make very bland ambiguous references to capacity.

2. Which areas of the Act, if any, require amendment; and how?

In my view the area of the legislation which requires a substantial overhaul is the Deprivation of Liberty Safeguards and the related Eligibility Criteria (Schedules A1 and 1A.) There are a number of difficulties which this piece of Legislation creates.

a) In the mind of professionals DoLS are perceived as a direct legislative response to HL v UK the “Bournewood Case.” This is unfortunate as it has led to a fundamental misunderstanding of the position of the Safeguards in relation to hospital inpatients receiving treatment for mental disorder. There remains a belief among many Mental Health staff (including Consultant Psychiatrists) that DoLS is a “less restrictive” option than detention under the Mental Health Act 1983 (MHA.) While DoLS may be less stigmatising, it seems difficult to justify that the balance of restrictions and rights under the Safeguards compares favourably with the MHA.

The interface of DoLS with the MHA is complex and the attempt to clarify this in Schedule 1A only serves to add to the confusion. There appear to be a cohort of patients where there is some
dispute as to whether they are “within the scope” of the Mental Health Act. This often appears to be when the patient is in hospital as a direct consequence of their mental disorder (rather than any physical disorder) but are not in receipt of active pharmacological treatment. This may in turn be related to differing interpretations of “medical treatment” as referred to in S145 MHA. Some colleagues believe therefore that in the absence of pharmacological treatment the threshold for appropriate treatment is not met, and therefore the patient is not “within the scope” of the MHA, but is eligible for DoLS. This in turn can lead to conflict between Responsible Clinicians, Section 12 Approved Doctors, Approved Mental Health Professionals, and Best Interests Assessors, with the mentally incapacitated patient and their family caught in the middle.

b) The threshold for DoLS is largely governed by case law but this is highly inconsistent. Judge’s summaries explaining their rationale can be long and difficult to interpret and apply.

c) DoLS allows for limited rights of appeal compared to detention under the MHA. Any appeal against Authorisation of DoLS would need to be taken to the Court of Protection by the Relevant Person’s Representative (usually a family member) and any costs would potentially be chargeable to the Relevant Person. A patient detained under the MHA however has direct access to an Independent Mental Health Advocate and a Solicitor (funded through Legal Aid) at a Tribunal held within a prescribed time frame at the hospital.

d) DoLS gives authorisation in hospitals and registered care homes (which account for a diverse range of settings) It does not however address the needs of people in other types of accommodation for instance incapacitated people locked into their own home for their safety (and therefore arguably deprived of their liberty) or people in hostels or small group homes. Any authorisation for people who may be deprived of their liberty would have to go via the Court of Protection.

e) The complexity of this process leads to misunderstanding amongst professionals. How does this impact on the Relevant Person who is both incapacitated and deprived of their liberty, or their carers?

I would echo the sentiments of Professor Richard Jones and others who have called for the Deprivation of Liberty Safeguards to be discontinued. I would agree that an alternative could be sought through amendments to Guardianship (S7 MHA.) This would authorise the Guardian (usually the Local Authority) to require the Service User to reside in a specified place. The provision could I think be modified to enable a deprivation of liberty under the provision. Given the significant changes that could have on Approved Mental Health Professionals existing Best Interests Assessors would need to be “Approved” for the purposes of the amended Guardian Order (as opposed to being fully Approved Mental Health Professionals which is a much wider role in terms of assessments and applications under the MHA.)

3 At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

As a series of underpinning principles Section 1 of the Mental Capacity Act presents a logical step wise approach to the complex (and hitherto murky) area of decision making capacity. Its message of initially focussing on the domain of capacity before moving into incapacity and best interests mirrors
Richard Tucker (Rotherham, Doncaster, and South Humber Mental Health NHS Foundation Trust) – Written evidence

the process (and emphasises the need to put the “horse” of capacity and consent before the “cart” of substitute decision making and best interests.)

The principles also instil a clear message of individual autonomy and the requirement to follow a process of promoting and enabling any individual Service User to make decisions before professionals and carers are authorised to assume that decision making role on the Service User’s part.

I think that the principle of assumption of capacity sends a powerful message and explicitly changes the “default position” where traditionally many professionals would have tended to assume incapacity with Service User groups such as people with a Learning Disability or Dementia. As such it sets the scene to empower the capacitated individual to make a decision deemed by others to be “unwise.”

However I think this principle needs greater consideration. At face value it can be misconstrued to discourage a capacity assessment and potentially seems open to misuse or abuse- it enables professionals to carry out interventions with passively compliant service users on the pretext that they have capacity and are consenting. Conversely we often find that a refusal of intervention can lead to inaction on the part of the professional without recourse to a capacity assessment. Discussions with professionals suggest a deeply ingrained belief that a capacity assessment is a potential breach of Article 8 of the Human Rights Act- the right to respect for privacy and family life. My observations are that staff are reluctant to undertake capacity assessments (although it would have seemed to me appropriate) and cite the assumption of capacity as the underlying rationale. I believe this does not promote the rights of Service Users.

While the functional process of establishing whether an individual has the capacity to make a specific decision at the material time is sound greater guidance may need to be given to how this should be carried out.

It seems to me that often the threshold perceived by professionals for decision making capacity is too low. This can lead to interventions carried out without true consent or, conversely inadequate safeguards put in place to safeguard an individual deemed to have capacity making an unwise decision. The highly subjective nature of the “weighing up” phase makes this very difficult to assess without the influence of the assessor’s own value base. Anecdotally this appears to diminish the importance of this stage of the process to the extent that it can be overlooked and as long as the Service User expresses a preference then they are deemed to have used and weighed up even if there is no evidence to suggest they have.

The “black and white” nature of the MCA ultimately fails to reflect the reality and complexity of many individuals with fluctuating levels of cognition and understanding which may be related to medical and/or environmental factors.

Related to this is (in my view) differing understandings of the concept of the “material time.” Capacity assessments are often carried out in “clinical environments” (hospital wards, offices etc.) sometimes out of expediency but sometimes to give the Service User the optimum chance of being able to make the decision and thereby “passing the test.” Undoubtedly overcoming the barriers to effective decision making is central to the process (and underpinned by Principle 2.) However I do wonder whether the “material time” actually relates to the time (and place) where the decision

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Richard Tucker (Rotherham, Doncaster, and South Humber Mental Health NHS Foundation Trust) – Written evidence

needs to be made and by carrying out the assessment outside of that context dilutes in some way the accuracy/essence of the capacity assessment.

Implementation

6 Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

In my locality there has been a substantial amount of work carried out to promote and develop awareness of the MCA within health and social care. It does however feel that there is a lack of consistency in terms of knowledge and implementation. Both formal audit processes and anecdotal evidence indicated that some areas of health care provision (e.g. Older People’s Mental Health and Learning Disability) adopted the MCA more readily than others. We have addressed this locally in terms of our Mental Health services. Anecdotally some areas of Physical medicine are yet to fully embed either principles or processes.

Has the Act ushered in the expected, or any, change in the culture of care?
As identified earlier the underpinning principles of the MCA has sought to fundamentally establish a legislative expectation of an entirely different relationship and power dynamic between users and providers of services. While Social Care staff largely embraced the MCA, the change in professional cultures for Nursing and, to a greater extent, Medical Staff has led to more limited implementation of the Act. It seems to me that while in most areas of health and social care there have been significant changes in the culture of care there remains substantial resistance to this from some senior members of staff.

11 September 2013

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Submission to be found under Victoria Butler-Cole in Volume 1.
VPM – Written evidence

We are the parents of four Adult children. One of our sons has experienced two major episodes of Mental Health instability in the past twelve years.

The first episode was prior to the Mental Capacity Act. That was an extremely difficult experience for the whole family but we were able to support him through it with minimal MH Service involvement to a full recovery over time.

He suffered delusions in that episode but Services both listened to and heard what we had to say.

The next episode was subsequent to the MCA implementation and about nine years after the first. Our experience was totally different and our son was detained in three different hospitals under Section 2 and 3 of the Legislation for almost a year.

Our son was a Social Worker in MH Services, understood MCA and Human Rights, had a good script and convinced his Consultant that he had capacity on a number of occasions. That allowed him to take actions, based on his delusions that were not in his best interests.

Although Services accepted our input and past experience they totally ignored it and the outcome was as we predicted.

We were investigated by Safeguarding twice having been accused of stealing his money by him. The money was in his Bank Account and we could not access it so in reality funded him for many months.

His partner was also investigated after he made similar accusations against her. He was allowed to threaten her and hector his three children from the hospital wards.

He was also allowed to throw clothing and other possessions away. We were unable to make any progress with complaints about the Service since he would not allow it.

He has lost his family, the woman he loved and all of his possessions.

We are left to pick up the pieces.

The Act is flawed. It enables sick people to close out those who care about them and take actions which devastate their relationships.

Yours Sincerely

2 September 2013
I am the carer of a young person with autistic spectrum disorder and epilepsy, and as such, have found it necessary to make myself aware of the Mental Capacity Act, which has been beneficial in the sense that I have some idea how to deal with my young person’s best interests within the framework of the act and the procedures surrounding it. However my experience from listening to many other carers is that knowledge of the Act is by no means widespread even now, and that interpretation of the act is frequently about protecting the staff and care givers of various agencies from legal challenge under the act rather than protecting the best interests of the vulnerable person they are caring for.

Whilst young people do indeed chronologically become adults at 18, those with any form of learning disability developmentally do not, and operate at a cognitive, emotional and mental level far below that of an 18 year old.

I was not told of the existence of the MCA by any agency involved in my young person’s care, at, for example any transition meeting, but somehow became aware of it, and realised that in order to have a legal right to be involved in decisions relating to my young person beyond the age of 18, the young person themself would need to have either Power of Attorney or I would need Deputyship through the Court of Protection.

It subsequently became clear that if the young person had the capacity to understand the intent of the power of attorney, they were able to designate people to assist them with decisions relating to both health and welfare and finances.

By contrast, a young person with no capacity to enter into a power of attorney arrangement, can be supported through Deputyship by his or her parents for financial matters, but apparently the Court of Protection will not give Deputyship for Health and Welfare, which seems entirely anomalous, since these are by definition people with the least mental capacity and the highest level of welfare need, whose parents are thus prevented from assisting them in a legal capacity with decisions relating to their health and welfare.

Whilst there has been a slow but steady increase in awareness by more organisations and agencies that family carers are the ones who know their young person the best, this clearly does not extend to giving them the legal right to assist those more disabled youngsters with health and welfare decisions.

When reading the act, it became clear that the right to make an unwise decision was enshrined in law - in the ensuing years I have seen how this particular aspect of the act has been interpreted by care providers and other agencies in the widest sense, both social and medical, in a way that actually undermines the wellbeing of the vulnerable person, rather than enhancing it, as the following example illustrates.

I know of care providers, who in looking after a young person with Down's Syndrome, and a considerable eating disorder, allowed them to eat on one occasion 8 pieces of bread for breakfast - when this decision was challenged by the young person's mother as not being appropriate, given the difficulties with food, the mother was told that it was the young.
person's right to make that decision and they could do nothing to stop the young person from acting on that decision.

This is clearly a nonsensical interpretation of the act, defying common sense; and the logical conclusion of continuing with such an approach in that type of scenario would be damage to the health of that young person - something which is surely at odds with the whole concept of setting up an Act to protect the more vulnerable in society.

The sense one gets is that some care providers and others are more afraid of being prosecuted under the act for denying a person the right to make an unwise decision than in protecting the best interests of that person for whom they care by managing their needs in an appropriate fashion.

I know of parents who have been told that their young person 'has capacity' by representatives of various bodies who did not at the time know that this judgement cannot be a blanket judgement, and is related at all times to a given specific situation, and decision making process related to that situation.

This blanket approach does, with time, seem to be changing, presumably after more 'training' from employers; something, which, by the way, most family carers are not given personally - whilst Carers support groups do a very good job of trying to bring the issues to the notice of carers, many carers do not attend these groups, for various reasons, not least that full time caring is often an all consuming activity with very little respite.

It is my experience that even now many family carers have no knowledge of the act and what it says. Some carers have been sidelined from being included in the decision making process around their young person, by all kinds of agencies, despite best practice guidelines stating that family carers should always be included in the decision making process - but best practice guidelines are not the law, and if sticking to the letter of the law is going to have budgetary benefits for agencies or providers, best practice will go out of the window unless the carers are very knowledgeable about the processes involved and how they may act.

I and other carers are hearing more and more from care providers at every level that our young people are adults and that they, as care providers, have no right to challenge our young adults decisions or their actions, irrespective of whether those decisions and actions are damaging to the young person's wellbeing. In theory, therefore, if taken to its logical conclusion, if a vulnerable young person with very little impulse control, sees something they like in a shop across the road, and decides to step off the kerb into the path of an oncoming car, the care giver should respect their 'right to make an unwise decision' and not intervene - quite how this is protecting their best interests is incomprehensible and yet this is the approach taken by some agencies to slightly less extreme examples.

Whilst it would seem self evident that Interpretation of the Act needs at all times to be within the spirit of the law and not only about the letter of the law, and tempered with common sense as to what constitutes the best interests of the person concerned in any given situation, this is in many cases not the reality of how the Act is followed.

I welcome the review of the Act and its efficacacy by the House of Lords and will be interested to see the outcome of the review.

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**VoiceAbility, Asist and POhWER – Oral Evidence (QQ 106 – 125)**

Transcript to be found under Asist in Volume I.
1. Summary

We strongly endorse the principles of the Act and believe that its provisions are in general sound. Its implementation is however patchy and incomplete both within social care and health. The overwhelming focus now needs to be on continued implementation rather than amendment of the Act, however some changes to Regulations would help to achieve this. There is a need for greater national and local leadership and a high profile system wide approach to ensuring effective implementation.

We recommend the following.

1. The Ministry of Justice and Department of Health, together with key leadership organisations, prepare a major programme of awareness and competence building to take place in 2015, one decade on from the legislation.

2. The Department of Health review mechanisms to hold local authorities to account for their performance in relation to the MCA.

3. The CQC to be asked give greater priority to MCA implementation in their inspections of NHS and care provision.

4. The Department of Health encourage health providers to undertake and publish internal audits/spot checks to assess their own compliance with the legal duty to refer to the IMCA service where applicable in relation to SMT decisions.

5. NHS England is asked to review the most effective approaches to encourage and verify General Practitioners’ understanding of and adherence with the Act, which may include considering the relevance of the GP revalidation process and GP contracts to this.

6. The Department of Health provides clarification to local authorities of the purpose of the non-ring fenced grant made to them for MCA implementation.

7. The Ministry of Justice and Department of Health, together with the charities most active in the area, as to appropriate and effective steps to increase public awareness of the Act.

8. The Department of Health to encourage NHS providers and local authorities to ensure that training for social workers, clinicians and care staff focuses on enhancing capacity and supported decision-making.

9. The Department of Health to remind commissioners of value of the IMCA service in developing professional competence in the MCA and the helpfulness of this being included in services specifications.
10. The Care Bill be amended to create a duty to appoint an advocate to support and represent a person during assessment, care planning or review if the person would experience substantial difficulty in participating in these processes for reasons related to compromised capacity.

11. That regulations are amended:
   i) so that there is a duty rather than a power to refer to an IMCA when decisions are being made in relation to protective measures for an adult who lacks capacity and to instruct an IMCA in relation to a care review following a change of accommodation for which the IMCA service was instructed;
   ii) to create a power to refer to an IMCA when there are disputes between the relevant authority and people who are appropriate to consult;
   iii) to include Supported Living within the ambit of DOLS;
   iv) so that an IMCA is always instructed in relation to an application to deprive someone of their liberty and when a person is deprived of their liberty.

12. The Department of Health draws to the attention of commissioners the quality elements of IMCA services which should be included in service tenders, contracts and monitoring arrangements.

13. The Department of Health review the Code of Practice to provide a clearer definition of what constitutes a deprivation of liberty.

14. The Department of Health commission a communication campaign directed at care providers explaining what a deprivation of liberty is and encouraging applications where these cannot be avoided in an individual’s best interest.

15. The Department of Health advise commissioners to test the competence of providers in relation to DOLS when letting contracts.

16. For any review of access to the Court of Protection to consider the future role to be played by IMCAs as Litigation Friends and how the appropriate use of mediation can be encouraged.

17. For refreshed guidance to Commissioners on the IMCA service to include consideration of the role of IMCA as Litigation Friend.

The above condenses and summarises our recommendations and the numbering of them is different from that within the body of this submission.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
2. Introduction

2.1. The principles and provisions of the Mental Capacity Act go to the heart of how a civilised society ought to respond to some of its most vulnerable citizens. The Act provides rights and protections ultimately for every person. We strongly endorse the principles of the Act and believe that its provisions are, in general, sound. The degree to which the Act has been implemented is therefore of the utmost importance and so we therefore warmly welcome the Lords Committee’s inquiry. I hope that this submission and the recommendations within it are helpful to the review.

2.2. This should be read in conjunction with my oral evidence to the Committee and with VoiceAbility’s written responses to specific questions provided following that sitting, some but not all of which is incorporated into this submission.

3. VoiceAbility

3.1. VoiceAbility is an independent national advocacy charity (registered as VoiceAbility Advocacy, charity no.1076630) which works to enable people who face disadvantage or discrimination to exercise their rights to be heard, to be equal and included and to live free from abuse. We work especially with people who need the greatest support to realise these rights, including people with learning disabilities, autism, mental health needs, older people and people with physical and sensory impairments. We expect to work with approximately 20,000 people this year.

3.2. The organisations which came together to form VoiceAbility played a key role in the development and implementation of the Independent Mental Capacity Advocacy (IMCA) service, including designing much of the original training materials, running 3 of the 7 pilots for the service, and providing information and expert guidance on the Act under commission from the Department of Health. Together with a subsidiary organisation, Advocacy Experience, we now provide the service to approximately 2,400 people each year in 33 different local authorities. We therefore have experience of the delivery of the IMCA service, its benefits and limitations as well as insight into how the Mental Capacity Act has been implemented, the positive difference the Act has made in the lives of people affected by it and how this can be increased.

4. Overview and Context (questions 1-3)

4.1. The Mental Capacity Act has created a benchmark to enable humane and respectful responses to many of our most vulnerable citizens, which balances the protection of autonomy and rights with well-being more generally. As noted above, we endorse its principles and believe that its provisions are generally sound. Its implementation is however still very partial.

4.2. The overwhelming focus must now be on the implementation of the Act, rather than its amendment. We are aware however, of a number of areas relating to the IMCA service in which regulation ought to be amended to ensure the practice better reflects the principles of Act and to better protect people’s autonomy and well-being; these are included in this submission.

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5. Implementation (questions 1-9)

5.1. People using our services are most affected by and concerned about social care and health services and by their experience of receiving or providing informal care. Our comments focus in these domains.

5.2. Within social care implementation is patchy. Some local authorities have given priority to the implementation of the Act and taken measures to enhance their own competence and that of other agencies (e.g. training provision, active local implementation groups, inter-agency and provider forums, fully engaging the IMCA service in raising awareness of the Act and the need for referral to IMCA). Others have not. It is not uncommon for there to be considerable variance within authorities, for example between different geographic social work teams, here a lack of overall leadership is apparent. As Local Authorities increasingly focus on what is viewed to be basic provision (and do not include promoting MCA implementation in this), we believe that the measures associated with effective implementation are placed increasingly at risk.

5.3. There is at least as much variability between health services as between local authorities, but examples of effective implementation and understanding throughout a health provider are rarer. There is a strong need to increase understanding the Act in primary and secondary care and for clear auditable mechanisms to be put in place to achieve this and to monitor it. We are also concerned as to the effectiveness of mechanisms to spread understanding of the Act between different health services – both within the NHS and the independent health sector.

5.4. To date, despite the excellent work of some charities, there has been insufficient work to enable people who may become subject to the act and informal carers to understand it.

5.5. There is a need for greater national and local leadership and systemic approaches to promote the implementation of the Act. We recommend the following:

i) The Ministry of Justice and Department of Health together with key leadership organisations (e.g. ADASS, NHS England, Voluntary Organisations Disability Group, the Law Society) prepare a major programme of awareness and competence building to take place in 2015, one decade on from the legislation. This would include professional training programmes and public awareness initiatives. It would be aimed both at increasing professional understanding and adherence with the Act in the short and medium term and at promoting long term cultural change in public and professional understanding and attitude.

ii) The Department of Health review the adequacy of mechanisms to hold local authorities to account for their performance in relation to the MCA. There are very clear indications of the disparity in approach, for example the variance in IMCA referral and use of DOLS. Local democratic pressure alone is insufficient to ensure effective performance given the limited voice of people affected directly by the Act including carers. We believe that it would be extremely helpful for the Lords Committee to make recommendations to improve mechanisms to hold to...
account local authorities in relation to their performance in relation to MCA implementation.

iii) The CQC to be asked give greater priority to MCA implementation in their inspections of NHS and care provision, for example by:

- Spot checking/auditing care plans to assess whether serious medical treatment decisions and deprivations of liberty are identified and responded to correctly.
- Clarifying the level of training required by clinicians and care staff and taking a more exacting approach to evaluating the sufficiency of training provided. Our experience suggests that when the MCA and DOLS are included within training for care providers and clinicians, this is often covered briefly, superficially and/or is not considered mandatory.

iv) The Department of Health encourage NHS Trusts and independent hospitals providing NHS funded care to undertake and publish internal audits/spot checks to assess their own compliance with the legal duty to refer to the IMCA service where applicable in relation to SMT decisions.

v) NHS England be asked review the most effective approaches to encourage and verify General Practitioners’ understanding of and adherence with the Act, which may include considering the relevance of the GP revalidation process and GP contracts to this.

vi) The Government provide clarification to local authorities of the purpose of the non-ring fenced grant made to them for MCA implementation. We understand that historically this includes (albeit limited) resources to support training across sectors, but that practice varies considerably with some local authorities viewing it as a part of their responsibility to encourage or help fund the training of (for example) NHS professionals and many not doing so.

vii) For consideration to be given, together with the charities most active in the area, as to the most appropriate and effective steps to increase public awareness of the Act, and especially to enhance the understanding of people who are most likely to become subject to it and carers.

5. Enablement and protection (question 4)

5.1 The experience of people using our services shows the need for greater emphasis to be given to enablement. In particular there is a need for greater attention to enhancing capacity and to on supported rather than substitute decision-making.

viii) We recommend that NHS and Local Authorities are encouraged by the Department of Health to ensure that training for social workers, care staff and clinicians focuses on enhancing capacity and on supported decision-making. Training needs to encompass both major and day to day decisions as appropriate to the participants.

6. The Independent Mental Capacity Advocate service (questions 12 and 13)

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
6.1 Our experience is that the IMCA service has made a fundamental positive difference to the experience of people who have received it. This is borne out by research findings (416). It enables people who lack capacity to nevertheless be more fully involved in decisions, facilitates communication by the person enabling their voice to be heard and their wishes to be responded to, enables the person to have a greater understanding-sometimes to the degree to which they have capacity, uncovers new information and options which have a material effect on the decision-taken and lives of the individuals, advances and protects people’s rights. We have many examples where the involvement of the IMCA has enabled people to stay more fully in control of their lives and has enabled people views as to where and how to live to be respected. It has enabled people to receive life-saving treatment when this would otherwise have been inappropriately denied.

6.2 In addition the IMCA service has played a vitally important role in increasing professional and carers understanding of the Act and promoting adherence with its principles and provisions. It has played this role both informally and through commissioned training for professionals.

6.3 There are however several severe limitations on the effectiveness of the IMCA service. Firstly, there is unacceptably high variation in referrals between local authority areas and the low level of referrals in relation to serious medical treatment relative to likely levels of eligibility, both of which suggest that a service which is essential to ensuring the rights and well-being of vulnerable people is being denied and legal duties are not being met. These issues largely flow from the incomplete implementation of the Act in general.

6.4 In our experience the following factors tend to correlate with a higher number of eligible referrals being made relative to population.

- Investment by the local authority in dedicated Mental Capacity Act lead officers with sufficient authority to hold colleagues within the authority and partner agencies to account and sufficient resources to service intra and inter-agency work.
- A continued cycle of training provision for local authority, NHS and independent sector staff.
- Commissioning and contracting relationships with IMCA services which allow for the IMCA service to deliver training and to draw professional attention to their service and encourage eligible referrals. As local authority commissioners respond to increasingly exacting budgetary constraints a growing number of commissioners expect the IMCA service to simply work with people referred to it – rather than to play an active role in encouraging compliance with the legal duties and powers to refer.
- IMCA services which view it as an integral part of their work to be actively involved in relevant local fora (e.g. MCA implementation groups), to generate understanding.

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of the Act and their service and to encourage compliance with the duties and use of the powers to refer.

- An absence of ‘gatekeeping’ arrangements which have been created in some local authority areas between decision-makers who have a legal duty to refer and the IMCA service.

6.5 In addition to our general recommendations in relation to the implementation of the Act, we recommend the following.

ix) That the Department of Health remind commissioners of value that can be obtained from IMCA service in promoting understanding of the Act and encouraging compliance with the duty to referral and use of the powers to do so. The components of the IMCA service described in the SCIE guidance (417) is relevant in this regard.

6.6 The second major limitation on the effectiveness of the IMCA service is that the triggers for referral exclude too many people who need it and for whom there is no other provision. For example an individual who is profoundly unhappy about their residential care provision will only become eligible for IMCA if a professional decision-maker is aware of the person’s unhappiness and judges that a decision must be made about the person’s long term care (in addition to the person lacking the relevant capacity and being without friends or family to consult). Absent of this no change may be made. We therefore recommend the following.

x) That the Care Bill is amended to create a duty to appoint an advocate to support and represent a person during assessment, care planning or review if the person would experience substantial difficulty in participating in these processes for reasons related to compromised capacity.

6.7 Thirdly, we believe that the powers to refer to an IMCA, which exist in relation to protective measures and care reviews, are underused. It was estimated that there would be up to 12,500 instructions under these powers (418) whereas in 2011/12 there were only 2,565 (20%), despite there being 130,000 safeguarding cases (419) a substantial proportion of which will have involved people who lacked the relevant capacity.

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417 These components are providing IMCAs, IMCA information service, awareness-raising and training, supporting the local integration of the MCA into policy and practice. SCIE 2010: Good practice guidance for the commissioning and monitoring of Independent Mental Capacity Advocate services


419 Department of Health 2013: The Fifth Year of the Independent Mental Capacity Advocacy (IMCA) Service - 2011 /2012

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
6.8 The experience of people using our services is that commitments made at the point of decisions about changes of accommodation are not always followed through on and that reviews following moves—so important in ensuring effective transition and future support—do not always take place. During 2011/12 IMCAs were instructed in relation to one fifth as many care reviews as change of accommodation decisions. Given the IMCA’s prior working relationship with the person and understanding of the situation, their continuity of input at this time of change would provide a great deal of additional value for limited additional resource.
6.9 We therefore recommend the following.

xi) Regulations are amended so that the power to refer to an IMCA when decisions are being made in relation to protective (adult safeguarding) measures for an adult who lacks capacity is replaced by a duty. This would provide far stronger protection for the rights and well-being of people in extremely vulnerable situations and that it is necessary given the very partial uptake of the existing power.

xii) Regulations are amended so that there is a duty - rather than a power as presently- to refer to an IMCA to support and represent a person in relation to a care review following a change of accommodation when an IMCA was instructed in relation to the change of accommodation decision.

6.10 The fourth limitation which we would like to draw attention to are the occasions upon which the involvement of an IMCA would be extremely valuable, but a referral cannot be made as the person has friends or family who are appropriate to consult. This occurs for example when there are difficult to resolve conflicts between carers and decision-makers. There is anecdotal evidence that in these circumstances some decision-makers determine that such carers are ‘inappropriate to consult’. We recommend the following:

xiii) To create a power to refer to an IMCA when there are disputes between the relevant authority and people who are appropriate to consult. Alongside, but distinct from, greater use of mediation (see section 9), this may provide for better dispute resolution and decision-making. Such a power would require guidance, including on the desirability of both authority and consultees agreeing in advance that the referral would be beneficial.

7 IMCA and supported and substitute decision-making (question 15)

7.1 We believe that IMCAs in general have the skills required to perform their role professionally, sensitively and effectively. We recognise that there are however challenges for commissioners and for providers in ensuring the delivery of a demanding service within exacting financial limits. The mandatory training for IMCAs provides for a general level of understanding of the varying conditions of people using the IMCA service and of communication methods. There is a dependence on the IMCA service provider to supplement this with continued guidance, training, development and peer and management support to ensure IMCAs are sufficiently skilled and their practice of a high standard.

7.2 As described above we believe that there remains an overemphasis on protection at the cost of empowerment and on substitute rather than supported decision-making. Effective supervision of IMCAs is required to ensure that their work is in general highly professional, without over-absorbing these particular professional norms. Furthermore, considerable time is often needed for effective supported decision-making and this is under pressure as funding for IMCA is increasingly restricted.

7.3 The reliance on IMCA providers to ensure effective guidance, training and supervision, together with sufficient time to engage fully with the person and encourage supported
decision-making is entirely reasonable, but needs to be taken into account in contracting arrangements. The ability to deliver effective support to IMCAs and to allow them sufficient time to develop their skills and to do their job well is potentially compromised by contracts which fail to take account of the cost of this. As a result we are finding an increasing number of competitive tenders for which we decline to apply as we do not believe that the arrangements allow for the quality of service to clients that we believe to be required.

7.4 We recommend the following.

xiv) The Department of Health draws to the attention of commissioners the quality elements of IMCA services which should be included in service tenders, contracts and monitoring arrangements.

8 Deprivation of Liberty safeguards (questions 16 and 17)

8.1 The importance of a robust well implemented framework to safeguard the rights and well-being of people whose own best interests are served by having their liberty restricted or deprived cannot be overstated.

8.2 We believe that the safeguards do not provide adequate protection as they are not sufficiently implemented. The number of applications made under the deprivation of liberty safeguards remains very significantly lower than that predicted by the consultations before their implementation, and the Government’s impact assessment. Predictions such as these are an art more than a science and might not alone be compelling evidence of poor implementation. The variance across local authorities does however make very clear the failure of comprehensive implementation. The difference from the area in which the highest number of applications per head of population are made to that in which the lowest are made is over 100:1 (calculation based on a researchers use of government statistics and population data (420)).

8.3 There are justified criticisms of the complexity and comprehensibility of the DOLS procedure which need to be addressed. Alongside this, some change is required to the legislation or regulation, as indicated below. But altering the process or legislation alone are unlikely in our view to have sufficient positive effect. Changes must increase effective implementation, rather than simply amending what should be implemented. We have made recommendations to promote better implementation of the Act in general above; specifically in relation to DOLS we make the following recommendations.

xv) That the Code of Practice is reviewed to provide a clearer definition of what constitutes a deprivation of liberty safeguard. We believe that this is especially important following Cheshire West and Cheshire Council v P (which is subject to appeal in October 2013).

xvi) For the Department of Health to commission a communication campaign directed at care providers explaining what a deprivation of liberty is and encouraging

420 Statistics on the Mental Capacity Act 2005, the Deprivation of Liberty Safeguards and the Court of Protection http://thesmallplaces.blogspot.co.uk/2013/06/your-statistical-guide-to-mental.html

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
applications where these cannot be avoided in an individual’s best interests. Care providers tend to identify depriving someone of their liberty as automatically doing something wrong – this militates against applications being made even when they rightfully ought to be resulting at times in the deprivation being made, but without any safeguard. Clarification and communication occasioned by a review of the code would be helpful.

xvii) That regulations are amended to include Supported Living within the ambit of DOLS, given that frequently the effect of the deprivation on the person will be similar or identical to that were s/he to reside in a residential care home.

xviii) That regulations are amended to so that an IMCA is always instructed in relation to an application to deprive someone of their liberty and that this duty is not restricted to when there is no other person appropriate to consult. The gravity of this decision and its consequences demands that the person subject to it has sufficient protection of their rights and well-being; this must include ensuring that s/he is provided with independent knowledgeable representation and support. Whenever there are friends and family, the IMCA can work effectively in concert with them. This is consistent with the oral evidence which the Committee heard on the views and needs of carers which indicated that carers have not been sufficiently informed and supported as a part of the implementation of the MCA and would welcome increased advocacy involvement to support them and the people they care for. Currently IMCAs are appointed in a relatively small and declining minority of cases when DOLS applications are made (421).

8.4 As at other times, for people who are subject to a DOLS, family members and friends are very often the best informed people about a person’s interest. For the reasons described above they may in many cases be insufficiently aware of how and when to challenge the continuation of a DOLS. Conversely, there is anecdotal evidence of family members who act as the person’s representative being unfairly assessed by local authorities to be acting contrary the person’s best interests when the family member disagrees with the deprivation. The automatic involvement of an IMCA, alongside a friend or relative, both to support the person deprived of their liberty and their friend or relative, would enable the person to be represented effectively without excluding the friend or relative, whether or not such an assessment was correct. We recommend the following.

xix) That regulations are amended to ensure the appointment and continued input of a paid representative (currently under section 39D) to work alongside and support a friend or relative who acts as an unpaid representative to a person subject to a DOLS in all cases. Since 2009/10 the number of referrals under 39D has increased dramatically, and referral under that section is recommended by ADASS/SCIE at the start of all standard authorisations. However in 2011/12 the number of referrals to IMCA under section 39D was still under 15% of total number of authorisations made.

421 In 2011/12 there were 11,393 applications to use the Safeguards and 888 (7.8%) IMCA referrals under section 39A (to represent and support a person who is being assessed as to whether they are being, or need to be deprived of their liberty). The number of IMCA referrals under 39A has remained fairly steady from 2009/10 to 2011/12 despite an almost 60% increase in applications.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Voiceability – Written evidence

xx) That an entitlement to advocacy support in assessment and care planning in specific circumstances is created by amendment to the Care Bill (see recommendation xi above). This has particular relevance to DOLS as advocacy involvement increases the likelihood of there being awareness that a person’s liberty might be being deprived, makes it more probable that alternatives are explored- or when strictly required- a DOLS is correctly applied for and considered. It is clear that current approaches which largely rely on service providers identifying that a person’s liberty is being deprived do not work sufficiently.

xxi) That local authorities are advised by the Department of Health to test the competence of social care providers in relation to DOLS when letting contracts and to specify and monitor performance standards in relation to DOLS. This is likely to require improved training on DOLS for commissioners.

9 The Court of Protection and the Office of the Public Guardian (question 18)

9.1 We are concerned that the limited capacity of Official Solicitor has placed an additional obstacle in the way of justice for many people who may lack capacity. We recognise that IMCAs acting as Litigation Friends provides one potential partial solution to this and so has received considerable attention.

9.2 In some cases it may be appropriate that IMCAs act as Litigation Friends and we have examples of IMCAs working successfully in the context of the Court of Protection.

9.3 We recognise that it is a legitimate and at time necessary part of the advocacy role to ensure access to the Court.

9.4 We are however concerned that IMCAs need to be appropriately trained or otherwise informed and aware of their role and responsibilities in acting as Litigation Friends, that they or their organisations may need to check that they are appropriately indemnified and that contracts for the advocacy service need to allow for what can often be a highly resource intensive process.

9.5 We are also concerned that reliance on IMCA services alone to in effect substitute for a lack of capacity within the OS is insufficient to encourage greater access to justice by people who require it.

9.6 We understand that in the light of the barriers experienced by people in applying to the Court of Protection, there is considerable interest in alternative methods of dispute resolution. Whilst far from being applicable to every situation, we believe that greater use than currently should be made of mediation services.

9.7 We recommend the following.

xxii) That any review of access to the Court of Protection considers the future role to be played by IMCAs as Litigation Friends and considers how the appropriate use of mediation can be encouraged.
Voiceability – Written evidence

xxiii) That refreshed guidance to Commissioners on the IMCA service includes consideration of the role of IMCAs as Litigation Friend.

10 Further information

I hope that this submission and its recommendations are helpful to the Select Committee and would be happy to supply any further information which would assist the Committee in its inquiry.

1 September 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

In my opinion the MCA has made considerable progress in achieving its aims ("to protect and empower vulnerable adults"). This progress is however limited by the still wide-spread ignorance of the Act, mainly in the general public, but also to some extent with professionals. Where professionals are aware of the provisions in general they still lack confidence in applying the basic elements (assessment of capacity and best interests decision making). Many professionals are not clear about their responsibilities as decision makers and will for instance refer capacity assessments to supposed experts (usually psychiatrists). The lack of knowledge in the general public means that professionals are not challenged when failing to apply the MCA or family members have unrealistic expectations about their rights and authority to decide for relatives who lack capacity.

2. Which areas of the Act, if any, require amendment; and how?

The only area of the Act that needs amendment is the Deprivation of Liberty Safeguards. In my view they are wholly unfit for purpose for a number of keys reasons:

- the regulations are too complex and rigid and do not fit real life situations
- the standard forms are too wordy and repetitive
- there is an inherent conflict of interest for LSSAs as Supervisory Bodies and Commissioners of the care the results in deprivation of liberty
- the conditions are ineffective, because they are imposed on the MAs, whereas the care regime is dictated by the commissioner of care, in most cases the SB that imposes the conditions!

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

The core principles encapsulate the philosophy of the MCA in a nutshell and provide the key guidance to professionals and relatives on how people who may lack capacity should be treated. They are a very useful aspect of the MCA and adherence to those principles will go a long way to achieving the Act’s aims, even if people know little else about the Act.

Assessment of capacity and best interests is more problematic, because they are issue specific. Whilst I am favour of this, rather than a status based approach to capacity, it creates practical difficulties. Identification of the decision to be made, whether someone has capacity and, if not, what is in their best interests is a simplistic way of describing a complex process. Many decisions are made in the context of ongoing situations and often involve more than one person. People with capacity will often make decisions with others and decision makers on behalf of those who lack capacity often work in multi-disciplinary settings. Identifying a single decision maker, who holds the responsibility under the Act, is not always possible. Linked decisions may involve multiple decision makers. Other decisions have to be made.
repeatedly, sometimes many times a day. Going through the whole process of assessing capacity and best interests in such situations is not practicable and such decisions have to be built into a care plan.

Nevertheless I feel that the issue specific approach to capacity is the right one and these complexities are unavoidable. There are though implications for achieving a better understanding of the MCA and how training is delivered.

**Implementation**

3. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

As stated previously the 5 principles provide a useful shorthand for the overall Act and in my experience the principles are understood and applied in practice, albeit not always explicitly so. I cannot provide concrete evidence to support this view – capacity and best interests are not routinely stated in practice records.

As far as the balance between enablement and protection is concerned I believe protection is sometimes overvalued and people’s autonomy not given enough emphasis in best interests decisions. This is particularly the case when professionals lack training and confidence or for members of the public and families, who often adopt the view that ‘something should be done’.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

I think implementation has been reasonably successful, but more is still needed. I think in particular more should have been done to inform the general public about the new law. The information booklets provided by the DH are excellent, but supplies ran out very soon. As far as professionals in health and social care are concerned ongoing training is required. This is hampered by work pressures and other training demands.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

The Act is better known by professionals generally that the public and families. I think it is best understood in social care professions and less so in medical professions. Many professionals still apply their understanding of common law rather than a proper knowledge of the Act. I have little experience of the banking and legal sector.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

I don’t think it is well understood by those directly affected. Some aspects, such as power of attorney are partially understood by those using the powers. There seems to be little
understanding of the difference between financial and welfare powers of attorney. Many families believe they have authority to make decisions about their loved ones and fail to make a distinction between what they want and what is in their relative’s best interests.

8. Has the Act ushered in the expected, or any, change in the culture of care? Only partially. It is not well enough known.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender? Not to my knowledge.

**Decision making**

1. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

2. What evidence is there that advance decisions to refuse treatment are being made and followed?

1. Has the MCA fostered appropriate involvement of carers and families in decision-making?

1. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

1. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

1. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

**Deprivation of Liberty Safeguards**

1. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

No: there is an inherent conflict between the roles of the Supervisory Bodies: in most cases as well as authorising dol they are also the commissioners of the service that causes dol. The conditions in an authorisation are imposed on the Managing Authority, who has very little control over the care regime, which is commissioned and funded by the same body as issues the authorisation and conditions. The ultimate safeguard, court of protection, is too inaccessible.

2. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
No: The process is very bureaucratic and unwieldy. The forms are extremely repetitive, difficult to understand and overlong. The regulations are far too complex and inflexible. I encounter many situations where the regulations do not fit and the process has to be improvised outside the regulations in order to achieve sensible results. As a professional with 20 years experience of managing statutory processes, including community care and mental health act, I struggle to understand the process. It is almost impossible for relatives tasked with representing people, let alone those people subject to the process.

The only effective solution is to withdraw the regulations and redraft them in an integrated way with the Mental Health Act.

The Court of Protection and the Office of the Public Guardian

1. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

1. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

1. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

1. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

Regulation

1. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

2. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Other legislation

1. How well is the relationship with the mental health system and legislation understood in practice?

Devolved administrations and international context

1. Does the implementation of the Mental Capacity Act differ significantly in Wales?

1. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

1. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

30 August 2013
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Warrington and Halton Hospitals NHS Foundation Trust – Written evidence

Overview and context

The Trust Response is based on the document circulated for comments on behalf of the Commons Select Committee and has been completed by the Associate Director of Governance (Trust lead for Mental Capacity Act) and the Adult Safeguarding Matron (Trust Lead for DOLS). Both parties work collaboratively and are members of the Trust Safeguarding steering Group, reporting to the Trust Governance Committee via the Safeguarding Strategy group.

Implementation

At the time to implementation of the Act the Trust the importance to implement was left to a small cohort of staff. A Trust wide plan was not developed and hence the knowledge base to staff was fragmented.

Since November 2010 a number of changes were made due to new Executives and senior managerial new starters. Working with the Adult Safeguarding Matron the Associate Director of Governance undertook a thorough review of the Act which included a relaunch, education, training and audit.

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

Consent, Assessment of Capacity and DOLS now forms part of all clinical mandatory training programmes which is monitored as part of key performance indicators reporting to the Trust Strategic Workforce Sub Committee and onto the Trust Governance Committee.

Consent and Assessment of Capacity has been included in all Trust employed medical staff Appraisal and Revalidation procedures.

Two Grand Rounds (whole hospital audit days) were held in June and September 2012

The Trust has developed an Assessment form (see link attached).


This has been seen as a exemplar document by the CQC during a Unannounced visit. Completed assessment forms are audited for compliance and the outcomes reported to the Trust Safeguarding Committee.

As part of the Trust Clinical Contract with Commissioners all DOLS are reported and monitored.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

Evidence is limited before 2010 however it is the Safeguarding Matrons view that there were limited resources provided to embed the Act and educate the front line practitioners in its usage. As it was such a significant piece of legislation and not enough funding was placed behind it to ensure that the implication and education reached front line practitioners in a timely manner. Funding for regional coordinators was time limited and disbanded after approximately 12 months. Prior to 2010 many professional groups at the Trust e.g. Medical, Allied Professional, Nursing had never heard of MCA and its implications.

Since 2010 this has been a marked increase to knowledge. This has led to increase of assessments, DOLs and referral to IMCAs. The Trust has set up a Mental Capacity Act and DOLS information community for staff to access. The community houses all publications including patient/relative/carers information leaflets provided in different languages.

6. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

The Act is now well embedded into the Trust Safeguarding Agenda and educates staff on being alert to vulnerable groups and patients who have cognitive imbalance and may lack capacity. At the trust Health, Social Care and IMCA services work closely together to ensure best interest decisions are co-ordinated in a timely fashion.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

This is hard to quantify. From a Trust Governance and Safeguarding point of view its about education and more education, staff support, Governance Drop in sessions for advice and Audit in addition to close working relationships with the IMCA Services.

8. Has the Act ushered in the expected, or any, change in the culture of care?

Yes, but in addition to other NHS patient experience programmes of Privacy and Dignity, Care and Comfort rounds, Regional DNA/CPR Policy to ensure all key stakeholders working together. Staff are now more confident in understanding how to assess capacity on a decision specific, time specific assessment, rather than a overarching statement of ‘no capacity’

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

No evidence to date

Decision making

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

The Trust assessment criteria includes how the people involved in the assessment has helped the patient. The Trust uses a Communications Tool. See link attached.


This is in addition to photographs for Specialist areas, use of anatomical aids etc. The assessment process includes as may persons involved in the care of the patient and IMCA services for patients who do not have relatives and if they do are still classed as vulnerable

There remains little evidence at the trust to support the use of Lasting Power of attorney by patients as very few present with evidence that they have sort to put this in place with only a few family members identifying themselves as LPO. There are processes in place at the trust to record electronically that a patient has a POA if the Trust has been made aware.

11. What evidence is there that advance decisions to refuse treatment are being made and followed?
The Trust has an agreed Standard Operating procedure which was jointly agreed with Commissioners. See link attached.

http://www.warringtonandhaltonhospitals.nhs.uk/_store/documents/sopadvancedescions.doc

All requests come via the Governance Dept for checking and verification. Once all criteria is met an Alert is placed via Meditech which then prints off on all current and future patient admission screens and documentation.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?
Yes most certainly.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?
Yes we can only speak for our own Trust but knowledge of staff to refer to the IMCA in the first place is vitally important and links into education and training programmes

<table>
<thead>
<tr>
<th>IMCA Referral Type</th>
<th>Number of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Medical Treatment</td>
<td>12</td>
</tr>
<tr>
<td>Change of Residence</td>
<td>3</td>
</tr>
<tr>
<td>Adult Safeguarding</td>
<td>2</td>
</tr>
<tr>
<td>Inappropriate Referral</td>
<td>3</td>
</tr>
</tbody>
</table>

For 12/13 there was 7 more referral from 11/12 and this increase in trend has continued to be seen into 2013/14

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals? - Not able to comment

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity? – Not able to comment

Deprivation of Liberty Safeguards
16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

The Trust has seen a year on year increase in the request for Urgent and standard DoLs. On-going education has allowed for staff to develop there understanding of when to apply a DoLS and for timely review. This has taken a number of years to embed into front line practice

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

The process for application and reporting remain bureaucratic and confusing for front line staff. The key area causing confusion is that in most cases at the acute trust a Urgent and Standard needs to be completed at the same time each having duplicate information. Most staff believe that a slim line process could be easily implemented.

The Court of Protection and the Office of the Public Guardian
18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

There has been limited contact with the CoP and PG from the trust

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

Staff have required more support and education in this field from the Safeguarding team and governance department which has often led to more questions and advice being sort.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

None that I am aware of

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

No comment

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Yes there should be additional powers

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?
   Personally One Regulatory body should be in place

Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

Devolved administrations and international context

25. Does the implementation of the Mental Capacity Act differ significantly in Wales?
   Unable to comment

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?
   Unable to comment

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?
   Unable to comment

19 August 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Adrian Watts – Written evidence

I write as a Practitioner of the Mental Capacity Act with 5 years’ experience and as a Best Interests Assessor for the last 3 years.

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

The Mental Capacity Act legislation, as I understand it, is designed to put the person in the centre of the decision making process. In my 5 years working directly with the Act I have seen some positive work in this area, especially from the front line. I have also had to challenge assessments completed where Mental Capacity is not assumed, because it does not fit with the assessors views, or the consequences of the person having mental capacity is considered ‘too risky’.

I believe that the Mental Capacity Act 2005 has made a positive impact, but there is still much work to do.

2. Which areas of the Act, if any, require amendment; and how?

The main concern I have with the Mental Capacity Act is around the confusions in practice due to the language used.

When I first started in the role, Mental Capacity was muddled with Mental Health (mainly because the word Mental is used) and I was asked for Mental Health experts to undertake what was termed Mental Health Capacity Act.

Since the Deprivation of Liberty Safeguards has come into law, there has been confusion as to whether a Best Interests Decision is the same as a Best Interests Assessment.

Advance Decisions to refuse specific medical treatment are used interchangeably with Advance Directives/Advance Statements as can be seen by any trawl of websites on the subject.

IMHA (Independent Mental Health Act Advocate) is confused with IMCA (Independent Mental Capacity Act Advocate).

Lasting Power of Attorney is confused with Enduring Power of Attorney.

The other area I would like to see developed is the role of Independent Mental Capacity Act Advocates, who I feel have a valuable role when supporting decision making. I feel at the moment that their role is limited.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

My personal view is that the Principles of the Mental Capacity are positive. Strengthening the link between them and the Mental Health Act Principles (bearing in mind what I have
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

said in point 2 about confusion between the two Acts) I think would benefit the Mental Capacity Act.

In practice the issues are a). Best Interests decision making sometimes can be limited to one option, b). There is confusion between less restrictive principle in the Mental Capacity Act and least restrictive principle in the Mental Health Act and c). assessing Mental Capacity is a tricky business, and some more focussed guidance on assessing would I believe improve the assessment process.

Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

As discussed above I have been involved with the Mental Capacity Act for 5 years directly, and on a monthly basis I have been auditing Mental Capacity assessments using a tool that corresponds to the Assessment Paperwork I have developed.

In my experience I have seen pockets of good practice (care home managers advocating for the people they work for –often against medical practitioners).

I have also seen some poor practice (discussing issues with family rather than speaking to the person the decision affects) , recording a lack of mental capacity (or worse assuming a lack of mental capacity) without evidencing how that conclusion was reached . And having a Best Interests Decision where the only option is for the person to go into a care home/have the particular treatment.

There is a knowledge gap in the transition from children’s services to adult services. As the Principles of the Mental Capacity Act apply to anyone aged 16 and above, this gap can leave vulnerable people without the safeguards of the Act. In practice, this has led to Adult Services having to take cases to Court that really needed to be resolved before the person reached the age of 18.

Again in my experience Mental Capacity Act has been seen as an add-on to the Safeguarding of Vulnerable Adults process, rather than an integral part of it, this has in my view weakened the positive elements of the Mental Capacity Act in practice.

5. How effective was the Government's implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

I understand that the implementation of the Mental Capacity Act was left to the Local Authorities to implement. This meant that the implementation was only as good as the Local Authority tasked with its implementation.

My experience was that the implementation was not effective. As a practitioner I found out about the Mental Capacity Act by mandatory training I was put on the week after the Act was in place.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
6. **Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?**

My biggest concern group in implementation of the Mental Capacity Act are General Practitioners and Hospital Medical consultants. Most of the issues I have to deal with relate to these two groups. Other groups (Social Workers/Care Managers/Care Workers seem to have varying degrees of understanding, but grasp the basic Principles.

In my experience where Mental Capacity Act work is linked with Safeguarding of Vulnerable Adults the role ends up being marginalised and seen as an optional extra rather than a fundamental

7. **Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?**

I see the Mental Capacity Act as positive in giving a framework for decision making. In saying that however, raising awareness of the Mental Capacity in the wider public arena still needs much work. Where Mental Capacity is linked to Safeguarding it is Safeguarding that has wider public circulation, but a small shift in emphasis (Mental Capacity being considered as a fundamental, not an add-on to the Safeguarding process) could make it reach more people.

Given what I have said previously in relation to professionals understanding of the Mental Capacity Act, I have personally had to intervene to explain the Act to families where such an assessment is needed. Some of the tensions relate, in my view, could be avoided by professionals understanding that they are promoting the voice of the relevant person and not appeasing families or doing an assessment to the relevant person (it is about the approach taken).

I have not had any experience of information being kept from families/the relevant person, but if the professional is not confident on the Act, I can see how this can happen.

I was pleased that the BBC reported on 18th August 2013 an article discussing the Mental Capacity of a vulnerable person. This is one of the few occasions I have heard it mentioned on mainstream media (www.bbc.co.uk/news/uk-england-sussex-23746244). The more the positive impact of the Mental Capacity Act is reinforced, the more beneficial its principles will be.

The protections are in my view inherent in the Mental Capacity Act. The issues come with practice. If the professional assessing follows the Principles of the Mental Capacity Act 2005 and the Best Interests Decision Making process in particular (as defined by the Mental Capacity Act 2005 Code of Practice and current case law) then the relevant person/family/relative will be protected.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Where Power of Attorney is used, the relevant person will be protected should the Power of Attorney be registered with the Office of Public Guardian. If this document is not registered then there is not any protection for the relevant person. In my professional dealings, it is my experience that families/carers are not always aware of needing to register the document, and sometimes it seems that Solicitors/Legal advisors are not always aware of this also. I have been involved in cases, however, where using an unregistered Power of Attorney document has been considered to be deliberate.

Power of attorney documents have a statement that holders of the document have to act within the principles of the Mental Capacity Act 2005. I think that the Principles of the Mental Capacity Act 2005 are positive, and I see no reason why these cannot be extended to family/carers who don’t hold a power of attorney.

What I think would help

a. Putting a greater emphasis on recording of the relevant person’s choices before they lose the mental capacity. Whether this is professionals families or carers.
b. Having scrutiny built into the decision making process to ensure compliance with the Mental Capacity Act Principles.
c. Having a mediation support to manage disagreement before the issue has to reach the Court of Protection (so something like a Local Authority/Health Authority mediation or tribunal type where the relevant person can challenge.
d. Expanding the excellent work of IMCA’s to ensure that there is always an independent advocate working on behalf of the relevant person (like in the Assisted Decision-Making (Capacity) Bill in Ireland).

8. Has the Act ushered in the expected, or any, change in the culture of care?

The Act has in my view made a positive contribution to person centred decision making. Where I have had experience of it working the outcomes have been really positive.

The up side of it being linked with Safeguarding Vulnerable Adults work is that this legislation has a greater drive within the Health and Social Care system. The down side of being linked with Safeguarding of Vulnerable Adults legislation is that it can get lost.

9. Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?

Not that I am aware of.

Decision making

10. Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The Mental Capacity Act's first principle that the relevant person is the best person to make decisions that directly affects them. I think that there is still much work to do in ensuring this is upheld. It is easier to ignore this sometimes, especially when the decision in question is 'risky'.

**Where the relevant person is unable to make informed decisions**

Expanding the positive role of advocacy on behalf of the person who is directly affected would help (even where there is family involved). Although the Act talks about ensuring the wishes of the relevant person are recorded, in my experience this does not happen very much (except in the recording of Advance Decision to refuse specific medical treatment). Making more of supporting people to record their wishes before they lose mental capacity would in my view benefit the voice of the relevant person.

Again in my experience, families think that they can make decisions for the relevant person, sometimes in collusion with medical professionals. I think that strengthening the responsibility of professionals to listen to the voice of the relevant person, and then the relevant person/family when a Best Interests Decision is required.

In some cases I have been involved in, I have had experience of unregistered Power of Attorney document being used to make decisions on behalf of the relevant person. This sometimes happens as Care Homes/Hospitals are not always aware of what to look out for.

Where a proxy decision maker is required, reinforcing (or making to have a Power of Attorney registered with the Office of Public Guardian would strengthen the voice of the relevant person and the Mental Capacity Act. Also, perhaps an amendment could be to use the wilful neglect element of the Mental Capacity Act to legally challenge the misuse of Power of Attorney documents which I think would benefit the relevant person.

Regarding Best Interests decisions, I have seen improvements in how this has been done, however there are still in my experience, occasions when there is either only one option discussed, or the process has been agreed by family and the professionals beforehand, and the paperwork is seen as a formality rather than a necessity.

11. **What evidence is there that advance decisions to refuse treatment are being made and followed?**

I know that there are Advance Decisions to refuse specific treatment as I have been involved in Court cases in relation to them. These decisions are still rare in my experience. Health Practitioners are aware of this area and the people I have talked to are extremely nervous.

There is confusion about Advance Decisions/Advance Directive/Advance Care Planning, and Health Practitioners I have discussed the issue with are unsure what to do/not to do, even with their knowledge of the Mental Capacity Act Code of Practice (Chapter 9). It is not always clear whether this is to do with a change of culture, or genuine uncertainty?
Adrian Watts – Written evidence

The main example I have come across is a Health Professional considering the use of the Mental Health Act to override a valid and applicable Advance Decision in order to provide the person with the treatment they have refused.

12. Has the MCA fostered appropriate involvement of carers and families in decision-making?

In my view the Mental Capacity Act has offered a framework for decision making.

The concerns I come across are
  a. Families and Carers discussing issues that affect the relevant person with professionals in the absence of the relevant person.

13. Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?

In my view yes it has. The main difficulty professionals have with the IMCA service is when to apply for an IMCA as opposed to a generic advocate.

The main issues I have had relate to when to involve IMCA in Safeguarding cases, there does not seem to be consistency in this across the country.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

I think that IMCA could and should be used more often, and I would advocate for an extension of their role because I have experienced the positive impact of their input.

Some of the regional variations could be to do with
  a. Professionals understanding the IMCA role (and the MCA in general)
  b. Professionals experience of IMCA service (some professionals have complained to me that the IMCA involvement has unduly delayed the decision making process)
  c. Inconsistent criteria across the country.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

In my experience IMCA’s are skilled practitioners, and offer a positive contribution to the decision making process.

In my own area the IMCA role and the Generic Advocacy role are run by the same organization. I also understand that in other areas the IMCA and IMHA roles are run as one organization also.

In my own area, the IMCA role is very responsive; however I am of the opinion that the service in other areas is under-resourced.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Deprivation of Liberty Safeguards

1. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

As a Practitioner the Deprivation of Liberty Safeguards is an interesting area to work in and has links with so many different issues (case law/safeguarding/mental health etc). Again in my opinion, positive working knowledge of the Mental Capacity Act is essential in grasping a good understanding of the Deprivation of Liberty Safeguards.

As a practitioner it is very tricky working your way through the often contradictory case law and legislation, and trying to apply it to practice. A practitioner effectively needs to have a good working knowledge of the Legal world to get by.

In addition, I have worked out an effective way to communicate the Deprivation of Liberty Safeguards to family/friends and the relevant person, however this often increases the anxiety rather than calming it. I think that the limited public awareness around Mental Capacity Act contributes to this anxiety.

In practice I have seen some positive outcomes from the use of the legislation (changes to the care packages/placement/ people being supported to return home). Nationally, I also think that the Deprivation of Liberty Safeguards were a useful vehicle/framework for the legal challenge in LB Hillingdon v Steven Neary (2011) EWHC 1377 (COP) even when the process was not effectively followed.

However there has been, since the beginning, an inconsistency in the implementation and numbers of assessments has varied considerably from place to place. To answer the question, I think that there are positive elements to the Legislation, however I do not think it is entirely adequate as it stands.

Some suggestions I have to help

a. The Deprivation of Liberty Safeguards Code of Practice needs updating with more realistic scenarios
b. There needs to be more of a link between The Deprivation of Liberty Safeguards Code of Practice and the Mental Capacity Act Code of Practice with cross referencing (or better still just one code of practice incorporating the Deprivation of Liberty Safeguards).

c. I think that the name should be amended from Deprivation of Liberty Safeguards (which has negative implications, as stated by care homes when challenged as to why they had not requested an authorisation) to something more positive like (suggestions) Protective care Safeguards or Advanced Care Safeguards.

d. There needs to be a National standard set, by which Authorities can check and judge their performance.

e. Returning to the Regional models of support practice for areas, and maintaining the Knowledge Hub for up to date information would benefit individual practitioners.

2. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Adrian Watts – Written evidence

The processes are only as good as the arrangements the Local Authority/CCG’s have. It is also subject to having someone in post to ensure it is driven, and maintained on the agenda of the organisation.

The trouble is there is no National standard, comparisons are only really between Authorities via the statistics they return, and these in my view are not adequate markers.

The Authorisation process requires good and positive scrutiny. A suggestion to ensure the scrutiny is adequate is to add an external element to the sign off process. An external person who has the authority to challenge the decision (this could be an additional role for IMCA?) if they are unhappy.

Regarding the Review of Authorisations, my experience is that Care Homes/Hospitals leave the Authorisation to expire rather than end the process at the moment the situation has changed.

The Review process in particular is confusing as in Care Planning a review takes place for someone who has a care package. My understanding is that this is a standard process and looks at the entire care arrangements.

A review under DoLs is specific to an area of change (for example someone no longer meets the Mental Capacity Act criteria and therefore the DoLS Authorisation requires a review). A suggestion would be to make the review process a standard process (as per the discussion in the previous paragraph) so that the entire DOLs authorisation is looked at.

I have not in my time ever witnessed a challenge to a DOLs. In my experience, families are keen for a placement to continue, even when a person is objecting.

Also there needs to be an internal process for challenge/mediation which does not involve Court of Protection. If there is an IMCA involved in the process from start to finish then the issue of challenge/scrutiny may be better represented. This would only work if there is a standard process for the IMCA role.

Having a trigger in the internal challenge/mediation process to take cases to the Court of Protection (perhaps there needs to be a legal representative on the challenge/mediation panel) would ensure that cases that need to go to Court will continue to do so.

The Court of Protection and the Office of the Public Guardian

1. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

Public perception may be tainted by some of the media presentation of the courts as ‘secretive’, however I have had a good working relationship with Court of Protection and the Office of Public Guardian.

Where the Court of Protection and Office of Public Guardian have been involved, I have been pleased with their consultation with me and their input.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The difficulty in this area is having the sufficient legal knowledge to know when a case can be resolved through mediation/internal panel and when the case needs to go to the Court of Protection.

2. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

I think that the important element of the Lasting Power of Attorney is the element of registering with the Office of Public Guardian. Although the document informs holders that they need to comply with the Mental Capacity Act 2005 I do not think that this is understood. Increasing public awareness of responsibilities under the Mental Capacity Act will be essential in ensuring that people are compliant.

There still needs to be an emphasis on the relevant person making informed decisions for themselves (until such time as the relevant person is no longer able to). I am not sure this is always understood and more work is required in this.

3. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

Should a person be subject to Deprivation of Liberty Safeguards, then providing that the Authority authorising the DoLS has appointed a relevant persons representative who can effectively advocate for the person (and/or objects to the placement) then there is access to legal aid. The issues come when the Authority does not appoint the representative who knowingly objects (as in the Neary case mentioned earlier)

Should the person not be appointed Relevant Person’s representative, then the cost of going to Court can be prohibitive.

I also feel that this expense can be managed better should there be a mediation or panel held by the Authority to ensure that appropriate cases go to court, and those that can be sorted out locally do so.

Regarding registration of Power of Attorney documents, I am of the view that registration is fundamental to protect someone who potentially can be a vulnerable person. In my experience I am unsure where solicitors draw up the power if attorney, whether this information is imparted, or sometimes whether the holder deliberately does not register the document. This area needs strengthening.

4. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

As far as I understand it the current legal aid scheme is still available. It would be very difficult to argue that there is a swift and easy access to court to challenge, if legal aid has been removed.

Regulation

1. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
No, in my view there is not enough teeth in the external scrutiny of actions to enforce change, and, as far as possible, standardise practice. This may be one of the reasons the Mental Capacity Act and DOLs processes do not have the same drive as say the Safeguarding process.

I think that having additional power would require CQC to have a more in depth understanding of the DOLs process (perhaps recruitment of Best Interests Assessor qualified people to inspect) and also a National framework from which to balance the actions of individual authorities would be needed.

Understanding of the MCA/DOLs process generally within the Local Authority/CCG apart from practitioner level will be limited. Any changes that are needed will need to consider application and understanding beyond the Practitioner level.

2. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

As far as I understand things, the Health and Social Care professions regulators are involved in the process where poor practice in relation to the Mental Capacity Act process is evidenced (for example nursing staff struck off the register for poor practice).

The external scrutiny would be of individuals rather than an overarching process. The College of Social Work have already produced a Capabilities set for Individual Assessors which should be being practiced by all involved in this field, and the scrutiny may need to consider how effectively this is implemented in the individual authorities and their framework for checking this is the case, rather than individual Best Interests Assessor practice (unless there is sufficient cause for concern in that practice).

Other legislation

1. How well is the relationship with the mental health system and legislation understood in practice?

There is confusion in this matter, and some of the most complex cases I have had to deal with have been on the fringe of Mental Health Act/Deprivation of Liberty Safeguards. Some people may well not be eligible for Deprivation of Liberty Safeguards, but Mental Health professionals are reluctant to use sectioning under the Mental Health Act, and the relevant could end up becoming stuck between these two pieces of legislation.

There is more work to do here.

Devolved administrations and international context

1. Does the implementation of the Mental Capacity Act differ significantly in Wales?

The differences I understand to be minimal.
1. **What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?**

**Irish Bill**

The idea of Assisted Decision Making agreement for the relevant person seems to be in place of the independent advocacy service (the bill doesn’t state it, but I would presume that the person would need to have mental capacity at the time of choosing them).

An assistant can give a stronger voice to the person around specific decisions, especially when it challenges the views of family/friends. This has an advantage over the Mental Capacity Act as it stands, because it gives greater responsibility to the person who the relevant person chooses (rather than an independent Advocate). This also has its disadvantages such as

a. What checks and balances will be in place to prevent the relevant person being manipulated into giving over authority to another person
b. Who determines whether the relevant person has the Mental Capacity to make the decision as to appoint an assisted decision maker
c. What authority would this person have over say professional views?
d. Would the relevant person still maintain decision making autonomy? And how would this be checked?
e. What safeguards would be put in place to avoid the mis-use of the power for Assisted Decision Makers be managed?

**Scottish Incapacity Bill**

I am not so keen on the idea of focussing on incapacity rather than on capacity.

I am also interested in how the Incapacity Act seems to try and define what situation constitutes a Deprivation of Liberty, which would be extremely useful for practitioners in England and Wales, where it is left up to professional discretion.

Both the Irish and Scottish Bill seem to use Guardianship (or equivalent) to cover the Deprivation of Liberty Safeguards, however as far as I am aware, Guardianship cannot effectively cover what was termed the ‘Bournewood gap’

1. **Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?**

One of the questions asked relating to the CRPD is whether ‘substituted decisions’ on disability related grounds is permissible? And whether is meant by a substituted judgement?.

Those issues dealt with under the Mental Capacity Act 2005 include

- Major personal welfare decisions, like refusal of and consent to medical treatment (including life saving treatment, end-of-life decisions and also non-therapeutic sterilisation), where a person should live, what community care services they should receive (including service refusal), contact with (potentially abusive)
friends, partners or family members – these disputes do not necessarily need a deputy or attorney.

- **Financial authority** – like whether to activate a [Lasting Power of Attorney](#) for property and affairs, whether a [court appointed deputy](#) should manage a person’s financial and property affairs, whether an [appointee](#) should manage their welfare benefits.

- **Day to day personal welfare and financial decisions**, like what a person purchases when out shopping, what a person wears, what they eat, taking medication, etc. These do not necessarily need a deputy or attorney.

28 August 2013
SUMMARY
The 14 local Authorities in the West Midlands submit the following views. The consensus is that in the main MCA has achieved its aims in part. Successful implementation has varied dependent on the priority it has been given. The key element in successful implementation has been the continued provision of the MCA grant and where local authorities have managed to maintain a specialist role, implementation has been successful.

A specific power for the purpose of conveying a person following a best interest’s decision to remove someone to a care home or hospital may make this area clearer for practitioners.

The principles underpinning the Act are clear and if followed, ensure compliant practice. They provide a value base on which training and development can be based.

All Local Authorities completed a best practice tool in 2007; this was a highly effective in assessing readiness for initial implementation. Follow up to this could easily be developed nationally. Local audits have taken place. Links with Safeguarding Boards are essential for ongoing monitoring of implementation.

The initial provision of Regional and National Leads gave a coherent message and direction was given. It has been assessed by the group that this support was withdrawn too soon into implementation. This has allowed for there to be no central direction on interpretation of case law.

A further concern has been that grant funding has continued but this has not been ring fenced. Given the current budgetary constraints in the Local Authority this can in some cases dilute the funds being used for MCA.

Professionals working in health and social care are aware of the Act and it has formed an integral part of the assessment process proportionate to the amount of training delivered

One of the difficulties in practice is identification of decision maker. For example when the decision maker is family or informal carers they may not have the knowledge or expertise of the application of the Act needed to make compliant decisions. Such disputes are then more likely to be placed before the Court now to ensure the rights of the carer are equally heard.

The Act has brought about a move away from paternalism towards empowerment and rights based provision in the person’s best interests. Capacity is no longer seen as the remit of “experts”.

People are being better supported to make decisions but generic staff need specialist training. Service users who are self-funding need support with assessing capacity and making best interests decisions. The MCA, if correctly applied, strikes the perfect balance between families’ rights and responsibilities. The involvement of an IMCA ensures voice for service users. Their role has developed into a highly specialised resource.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Serious Medical Treatment referrals are low and this may relate to the difficulty engaging hospital Consultants with training.

The DoLS are rights based and capacity-focussed response to an identified gap in the UK Law. They are effective in subjecting cases of suspected deprivation to scrutiny and assessment. People are going home from care homes that may otherwise have been forgotten. However the time limit for Urgent authorisations is too short and does not always allow for a comprehensive review of a case as the time limits are so short. A way of resolving this issue would be to allow for one application with a longer (perhaps 14-day) response time. The process could be simplified.

The overlap between MHA and MCA in general is misunderstood. Joint training is needed between BIA’s, AMHP’s and DoLS MHA’s to ensure learning takes place from each perspective.

DoLS authorises a deprivation of liberty on the basis of best interests. This is not incompatible with the United Nations Convention on the Rights of Persons with Disability.

Evidence for

HOUSE OF LORDS

Select Committee on the Mental Capacity Act 2005

West Midlands Regional DoLS Leads Group

Overview and context

4. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

- The framework has produced a change in thinking that is now centred on the needs of the individual and their individual circumstances.
- The framework has increased worker confidence when dealing with other professionals.
- It confirms good practice – therefore enabling worker to go through the process with increased confidence.
- Helps with supporting risky decision making and has meant that this is seen in a more positive light.
- More formal and focused Assessment.
- There is a clearer structure for Best Interest Assessments this helps to clarify the process.
- Hospital and Health staff have adopted the principles of MCA to a lesser degree, as the medical condition/diagnosis seems to take precedence over mental capacity act concerns.
- MCA needs to be more embedded into Health Professional Training.
- The large complex MCA decisions are generally thought to be well made but the small every day decisions – which are often the most important to the Client can be less clear.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Successful implementation has varied dependent on the priority it has been given in the organisation.
Every aspect of the core business of health and care professionals is impacted by the Act.
Local Authorities and other bodies have had to accept that they cannot make decisions for people where they have capacity, even if this involves them in risky decisions. This core culture change will continue to take time to embed.
The changes in documentation, assessment content, policies and procedures needed to ensure that people are empowered to make decisions, take time to put in place.
The key element in successful implementation has been the continued provision of the MCA grant and where local authorities have managed to maintain a specialist role, implementation has been successful. However, with grant funding no longer ring fenced which could give rise to concern about the future specialist roles for MCA.
Training across the health and care workforce, the independent sector and families and carers has been instrumental in disseminating the messages of the MCA.
Having a dedicated MCA lead helps successful implementation and ensures consistency. Case law needs to be shared and the effects must be incorporated into practice.
The West Midlands Regional DoLS Leads Group has carried out extensive work to review the original DoH DoLS Forms. This was primarily to ensure the voice of the relevant person was clearly heard and represented in the process. Best Interests Assessors were often consulting, as required by s4 of the Act, but were not recording the views of P or of relatives and others. This has been addressed by adding specific sections to the Forms.

5. Which areas of the Act, if any, require amendment, and how?

- Amendments to the substantive Act may be required in terms of Conveyance. There is still confusion as to where the MCA and the DoLS diverge. A specific power to convey following a best interests decision to remove someone to a care home or hospital may make this process clearer for practitioners and provide a more robust instruction to the ambulance service, for example.
- Issues of particular difficulty are removal from home and restraint necessary to provide essential care.
- Greater clarity could be provided in the Code of Practice addressing the more complex areas which social care and health professionals encounter, rather than the very simplistic examples which are given.
- The West Midlands Regional DoLS Leads Group (WMRDLG) is developing a regional conveyance policy under the MCA. It is also developing a regional document on restraint, restriction and removal from home. This is to ensure regional application of the MCA principles with consistency and to give a clear lead and direction across the region in relation to definitions and application in practice.

6. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

- The principles underpinning the Act are clear and if followed, ensure compliant practice.
• They provide a value base on which training and development can be based. The definition of capacity is clear although the diagnostic test is open to interpretation. There is no indication of the need for any degree of impairment as this is tested by the functional approach which comes next. There is sometimes a tension with the assessment of mental disorder and the diagnostic test for general capacity decisions.

• The concept of best interests is still developing. Its progression from being almost an entirely medical concept, to a holistic concept encompassing well-being and emotional and psychological health, is an extremely positive effect of the MCA.

• The Court of Protection are leading the way in directing professionals away from the “protection imperative” and towards rights based responses which incorporate positive risk taking. This is a highly successful outcome of the Act. This is particularly powerful in the work of BIA’s who are becoming a highly skilled set of professionals. Their ability to step outside generic practice and focus on best interests is producing excellent work and challenging risk adverse practice.

• The WMRDLG have developed a new Form 10 for BIA’s which assists with best interest’s decision making for DoLS. This form is based on a best practice document also developed by the group and shared with all BIA’s in the region. The group also developed guidelines for practitioners and DoLS Authorisers to support more robust and consistent decision making and they are just about to begin an audit of practice with a specifically designed audit tool.

Implementation

7. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

• All Local Authorities initially completed a best practice tool developed by the DH in 2007; this was a highly effective tool in assessing readiness for initial implementation. Follow up to this could easily be developed nationally.

• Local audits have taken place and the West Midlands plan a regional DoLS Audit tool.

• Some Local Implementation Groups still meet and where they do this provides a valuable resource. Where these groups link to Safeguarding Boards this provides ongoing monitoring and scrutiny.

• Joint working is key to successful implementation and the delivery of a coherent and consistent message.
  • Recognition of unwise decisions is accepted but family carers find this issue difficult.

• There has been discussions in some areas about dealing with the balance of enablement and protection via the use of multi agency professionals meeting. This enables agencies to ensure that risk is managed collectively and reviewed regularly. I.e. in the case of self neglect/fluctuating capacity.

8. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
West Midlands Regional DoLS Leads Group – Written evidence

- The initial implementation plan was effective. By providing Regional and National Leads to support the work a coherent message and direction was established. This support was withdrawn too soon into implementation.
- Grant funding has continued but is not ring fenced and is not transparent therefore easily transferred to other areas of spending. There is no central direction on interpretation of case law as there was in the beginning and no centralised circulation method or methodology for dissemination of information.
- The West Midlands Regional DoLS Leads group has risen from the ashes to become a highly functioning group providing leadership and direction across the region in improving practice, developing tools and raising standards.
- The work with families is still ongoing and an area of much needed investment. Publications, films, support and advice are still needed to ensure that families are aware of the rights of the person they care for. The implications of the Act for 16 and 17 year olds is a specialist area in its own right and the parents of young people need targeted material to support them, and the young people need specific programmes to inform them of their rights under the Act.

9. Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?

- Professionals working in health and social care are aware of the Act and it has formed an integral part of the assessment process. This can be dependent on the amount of training delivered and whether this training is organic and grows in response to new issues.
- From the experience of the group: training provision for the harder to reach groups such as the medical Consultants working in hospitals. This group does not have an easily identifiable corporate identity and it has been hard to persuade them of the relevance of MCA for everyone, not just for those working in Mental Health.
- Some of the West Midlands Regional Group found that decision making in hospitals often seems to be age discriminatory and very risk averse with decisions made by statements rather than by assessment as directed under the Act.
- Legislation generally is not as ingrained in Adults Services as it is in Children's Services.
- The need for reinforcement and the 5 core principles to be widely accessible to staff when in that decision making process. - i.e. Posters on walls as reminders.
- MCA does not seem to have reached as far as Schools yet.
- Police appear to work on the initial assumption that a person has capacity.
- Health's initial main focus tends to be diagnosis first.

10. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between struck between protection of the carer and protection of the individual lacking capacity?

- One of the difficulties in application of the Act is identification of decision maker. There are times when this is family or informal carers but they do not usually have

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.

1769
the knowledge or expertise of the application of the Act needed to make compliant decisions. Practitioners need to be alert to this and willing to support people.

- There are many self-funding service users who require help and support due to issues of mental capacity and therefore need allocation to a social worker. The role of IMCA only supports those who do not have family or friends when often it is the family and friends who need support to understand and apply the principles of the Act.
- Disputes are more likely to be placed before the Court now to ensure the rights of the carer are equally heard.
- MCA is not as widely known or understood by carers/family.
  - Carers often struggle with the decisions made in accordance with the Act and think them unwise. Least restrictive decisions are sometimes viewed as being wrong by the carer. Sometimes parents/family sees the decision made as a threat to the person’s well being. This can cause conflict with family/carer – unsafe sexual relationships are an example of this.
  - Media – no support for MCA and this is reinforced in society as a whole.

11. **Has the Act ushered in the expected, or any, change in the culture of care?**

- The Act has brought about changes in the culture of care. A move away from paternalism towards empowerment and rights based provision in the person’s best interests. The Act ensures Human Rights issues are appropriately considered in the assessment and care management process.

- Staff working at all levels expect to consider capacity in their day to day work. It is no longer seen as the remit of “experts” or of mental health professionals. However it is essential that the principles are correctly embedded and supported by rigorous training programmes as it is easy for direct care providers, for example, to pick up the language of best interests without acquiring the understanding of its full meaning.

- The balance is always between rights and risks, and the MCA helps to ensure this is correctly applied.

12. **Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?**

- The only data which is mandatory relates to the DoLS and this does not suggest that the provisions are experienced any differently by any particular group.

**Decision making**

7. **Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general**
authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?

- People are being supported to make decisions more than previously but this is an area which can be developed further. Generic staff will not have had training in communication. The Act has made this a priority and specialist training is needed - communicating with the person with dementia, communicating with severely autistic people, for example, are specialist areas.
- Service users who are self-funding still need support with assessing capacity and making best interests decisions. Even if family members hold an LPA, they are rarely aware of the requirements of the Act and need the support and guidance of social workers. This has resulted in increased workloads for social workers.
- The need to apply to the Court of Protection for resolution in areas of dispute or complexity has provided welcome scrutiny for local authority decision making. Although the process is lengthy and time consuming, the decisions are helpful and often influence the policy development for others. Sadly, the cases which attract publicity from the Court of Protection are often those where Local Authorities have failed in their duties under the Act, or failed to correctly apply the principles. There are numerous other examples of good decision making where applications have been made to the Court in a timely manner and the Act has been correctly applied to empower the service user.

8. Has the MCA fostered appropriate involvement of carers and families in decision-making?

- The MCA, if correctly applied, strikes the perfect balance between families’ rights and responsibilities, and clarifies who is the decision maker and when this is or is not the family member. The IMCA role would be beneficial if it also related to situations of dispute rather than simply where there are no family or friends to consult with.

- Best interests meetings ensure that families and carers are fully involved in the process of decision making. Even where families offer a dissenting or oppositional view their views are recorded and considered by the decision maker. It can often be the case that the vehicle of a best interests meeting is the means by which family understand the implications of the MCA for the first time.

- Family consultation is at the heart of the DoLS process often during a very difficult time for them.

- The role of the BIA as a conduit to other professionals is becoming extremely valuable. The family member is able to give their views and opinions on best interests and to see these views recorded thoroughly in the final report.

- The role of the BIA in clearly explaining to family members the meaning of DoLS cannot be underestimated. People can be very frightened by the language and need to understand this as something to protect their loved one rather than something punitive.
Family members are often selected as the Relevant Persons Representative under DoLS and can have additional support with this role from an IMCA. It is rare for family not to be selected if they wish to take on this role.

9. **Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?**

   - The involvement of an IMCA is generally very valuable in ensuring a voice for service users. Their role has developed into a highly specialised resource. There is perhaps a need for more enforcement in terms of the Report they produce to Decision makers.
   - Most Local Authorities have good liaison with their IMCA providers.

10. **Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?**

   - In general there is a still a way to go in terms of IMCA referrals. Serious Medical Treatment referrals are low and it would seem that this may directly relate to the difficulty engaging hospital Consultants with training programmes.
   - Some Authorities in the West Midlands have above average amount of referrals to IMCAs when taking into account other similar size local authorities. Possibly this is because it is a local resources and not a national one.
   - DoLS referrals are made directly from the DoLS team and are likely to be accurate.
   - Regional variations probably depend on the existence of a clear expert or MCA lead, the amount of training provision and the existence of local Implementation groups for scrutiny as well as demographic circumstances.
   - IMCAs themselves are a specialist source of non-instructed advocacy and useful in situations outside the generally commissioned service.

**Deprivation of Liberty Safeguards**

3. **Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?**

   - The DoLS Safeguards attract a lot of criticism nationally. Often from those in the Mental Health field who may not actually administer them or apply them. There is minimal if any research into the impact of the safeguards on people subject to them.
   - The safeguards are a new, rights based, capacity-focussed response to an identified gap in the UK Law. The DoLS are effective in subjecting cases of suspected deprivation to scrutiny and assessment. The DoLS are challenging.
   - The ongoing development of definition and interpretation of meaning is challenging but people are protected now who have never been protected before, such as those with a learning disability who do not fit the definition within the MHA. The process ensures this protection is provided to them and is scrutinised fully.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The dissemination of information and meaning requires ongoing communication and training for Managing Authorities, and centralised support and leadership was withdrawn too soon. Managing Authorities lack confidence in identifying restrictions and supervisory bodies need to respond to this.

The concept of BIAs as a distinctly different role to AMHPs is extremely valuable. A new type of professional is emerging skilled in putting the person first, challenging assumptions, challenging risk averse practice and clearly identifying the least restrictive option. People are going home from care homes that may otherwise have been forgotten.

As an independent professional, the BIA is able to challenge over-protective practice within Local Authorities. MCA principles are adhered to in establishing the building blocks to support placements and challenge inadequate risk assessments.

Clinical decision making which often is made on the basis of age alone can be challenged and changes are made which promote the persons autonomy.

Part of the process also ensures scrutiny of care planning within care homes and many changes have occurred for the person resulting in improvements to their care even though they may be deprived of liberty, as a result of the involvement of a BIA.

The WMRDLG have carried out extensive work to provide leadership and direction in relation to DoLS practice across the region. The groups’ focus is on benchmarking aimed at raising quality and consistency of practice.

The opponents of DoLS appear to focus on the interaction with the Mental Health Act and the ways in which Guardianship could have been used instead. It must be remembered that this option was explored initially and rejected by the Government. The DoLS focus is on the person, their wishes and feelings and their perception of the situation and it encompasses the whole of the MCA principles. The assessment is complex but holistic and consultation is a key element.

Hospital DoLS ensure safe delivery of treatment for people usually during particularly difficult circumstances. DoLS in care homes are usually a longer term safeguard.

There are undoubtedly bureaucratic changes which would improve the smooth running of DoLS, some are mentioned in the response to the next question. There are some circumstances which have not been envisaged, such as suspension of an authorisation for any reason other than failing eligibility – for example the person could be admitted to an acute hospital from a care home and there is no facility to suspend the authorisation; the person could go on holiday and there is no facility to suspend the authorisation.

Repeat requests for authorisations require less detail to be given and some reviews are very specific and do not have associated Forms. The WMRDLG has adopted Forms to address this regionally. One is a repeat request form and another is a hospital discharge review.
4. **Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?**

- The process is without a doubt convoluted but it is also effective.

- The time limit for Urgent authorisations is too short and can be a barrier to providing a detailed overview of a case. The Government envisaged that Urgent authorisations would be for “sudden unforeseen circumstances” however, in practice, a majority of first time applications are Urgent. This is because a deprivation is much easier to identify if the person is in situ rather than assessing a hypothetical care plan and a hypothetical set of restrictions.

- The above could be addressed via creating one application with a longer, perhaps 14-day, response time. The Managing Authority could simply state the date from which it is required.

- Although the process is administratively difficult from the Supervisory Body perspective, it is straightforward from a Managing Authority perspective (although they dislike the complexity of the forms). They are simply required to identify when restrictions exceed those allowed by the MCA and then request a DoLS authorisation.

- The training needs result from the requirement that they identify, as far as possible, when a restriction has exceeded what is allowed under the MCA. This requires training for all staff in the MCA itself, in the DoLS and, particularly, the ever changing concept of deprivation of liberty.

- Reviews are easily accessible.

- The process of application to the Court of Protection is a huge jump from a basic decision to a High Court scrutiny. People who are supported by Paid Representatives are likely to be aware of their rights to challenge decisions. People with family members as representatives may not always be advised of their right to challenge decisions. This is because there is an inherent tension in the role. Often there is a tension between the views of the family member and those of relevant person. The relevant person may desire to leave a care home whilst the family member may wish them to remain there.

- It would perhaps be better if all people deprived of their liberty had a paid representative ensuring parity of information and access to appeal.

- It would be more timely if local tribunals heard a first tier level of appeal with the right of further challenge to the Court of Appeal.

**Other legislation**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
2. How well is the relationship with the mental health system and legislation understood in practice?

- This is an area which grows in complexity as the Act is implemented in practice. The overlap between MHA and MCA in general is misunderstood, and the overlap with DoLS is still developing.

- There are situations where people are assessed as ineligible for DoLS (within the scope of the MHA and objecting to treatment) and subsequently assessed as ineligible for the MHA. This is becoming known as a “mini Bournewood gap”. Supervisory bodies are advised to develop protocols to address this. The WMRDLG has developed a protocol for the region and this has been shared with the national ADASS mental health lead.

- To support the protocol the WMRDLG has also reviewed the Mental Health and Eligibility forms used by DoLS Mental Health assessors, s12 doctors were involved in this review and the new form is currently being piloted. There is within this form a requirement that a MHA assessment is requested in order to ensure the best protection for people.

- There is an identified dedicated s12 lead in the West Midlands to work alongside the DoLS Leads and regional training is organised jointly for BIA’s and MHA’s. This involves an element of practice and has contributed to better working relationships and improved quality of reports.

- Joint training is needed between BIA’s, AMHP’s and DoLS MHA’s to ensure learning takes place from each perspective.
  
  - Some BIA’s find decision making difficult that if they do not specialise in Mental Health.
  
  - There are issues regarding resources – often when someone presents with challenging behaviour – where they can be accommodated and what can be put into place for their support is led by what resources are available.

Devolved administrations and international context

4. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

- There have been issues raised questioning whether DoLS are incompatible with Article 14, liberty and security of the person, as it states ‘the existence of a disability shall in no case justify a deprivation of liberty.’ The question is does DoLS authorise deprivation of liberty on the basis of disability i.e. mental disorder?

- DoLS authorises a deprivation of liberty on the basis of best interests. The person needs to lack capacity for this decision due to an impairment or disturbance in the functioning of mind or brain. They also need to have a mental disorder.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
• It can be argued that the requirement to have a mental disorder is an unnecessary requirement and the safeguards would have the same effect if they were operated purely on the MCA definition of impairment or disturbance in the functioning of mind or brain. This is of course qualified within the MCA as not to be made simply by reference to age, disability, behaviour and appearance and so on.

Complied by Lorraine Currie, Chair of the West Midlands Regional DoLS Leads Group on behalf of the following Local Authorities -
Birmingham
Coventry
Dudley
Herefordshire
Sandwell
Shropshire
Solihull
Staffordshire
Stoke
Telford and Wrekin
Walsall
Wolverhampton
Worcestershire

2 September 2013
West Sussex County Council – Written evidence

Author: Helen Feazey, Deprivation of Liberty Safeguards Team Manager WSCC

Content Approved by Amanda Rogers, Director of Adults Services WSCC

Staff from WSCC Adults Services, Mental Health Services and Learning Disability Services, along with health colleagues, were consulted to produce this submission.

Overview and Context

1) There were very positive views of the Act from everyone consulted. However all agreed that there was still a long way to go to achieve the Act’s aims.

2) S44 on Wilful Neglect sets the bar too high for successful prosecution. West Sussex County Council acted to close Orchid View, a Southern Cross care home, but despite the seriousness of the allegations of neglect and abuse, no care home staff have been prosecuted. There is further evidence of this problem from Winterbourne and mid Staffs. We would like to see implementation of a less serious offence, more likely to result in prosecution.

The Deprivation of Liberty Safeguards, whilst being absolutely necessary, have been drawn up in an overly bureaucratic way, making it difficult for those affected to understand.

3) We are happy with the MCA’s principles, and definitions of capacity and best interests. They are clear and well written.

Implementation

4) We are not aware of significant research about how the principles of the MCA are being implemented. Staff are doing their best to implement the principles of the MCA in the context of understanding of the principles of the MCA being patchy across the wider system. Understanding in recently qualified professional staff is noticeably better. The balance between enablement and protection is becoming more generally understood by staff through experience of Court of Protection rulings. There is poor understanding of this balance amongst frontline workers who have poor overall knowledge of the MCA. Amongst frontline staff this is most notable in domestic and residential care staff, and in some senior medical staff.

5) The Department of Health implementation plan made huge efforts to get relevant staff to know about the MCA. However the Department of Health overestimated the pre knowledge of staff who needed to be trained in the MCA.

Within WSCC the initial implementation programme for staff seemed to have been successful, with relatively high rates of IMCA referrals and Dols applications. However WSCC is now seeing reducing referrals for IMCAs and reduced Dols applications from the care sector. It is not felt that this is due to reduced need. Plans for remedial action are being considered. These local difficulties probably mirror the national picture.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
6) The government implementation programme for families was less successful. There has been success in publicising LPAs. However, families caring for people who lack capacity often know little about the Act. This is probably not so important for day to day care, but can be crucial for families and the person lacking capacity in more complex situations.

7) WSCC acknowledges that some of our own staff do not have the level of knowledge required. This problem is more serious in health settings, with community health colleagues often asking social care staff to carry out capacity assessments for them, and senior doctors and GPs sometimes appearing to know little about the Act. However two local hospital trusts have produced very noticeable recent improvements in the knowledge of their nursing and therapeutic staff.

Knowledge within the independent care sector is often poor. It is rarely understood that all staff providing care needed some understanding of the Act.

WSCC staff have had difficult experiences with banks on behalf of WSCC customers who had LPAs, Deputies etc. All banks generally performed badly on MCA issues.

We are concerned about poor knowledge amongst ambulance staff and police. This is particularly the case where restraint may be needed to convey someone to hospital for physical treatment, or to a care home for care. Ambulance and police may refuse to do this, leaving the person at risk, rather than looking at the person’s capacity and making a best interests decision as to whether to carry out the action requested. National guidance to Ambulance and Police may be helpful.

7) The Act is understood by some directly affected by the Act and by some non-professional carers. However, many carers have little understanding of the Act. Carers without Health and Welfare powers often believe that they can substitute decision make for those they care for, particularly for young adults with learning disabilities. This limits the cared for’s rights to make daily choices and to take risks. Many people’s lives are stifled by kindness. We would welcome a national awareness campaign to address this.

Similarly, health and care staff sometimes believe that they have the right to make decisions for the person without properly consulting carers. However where the Act is understood and used we feel that it strikes the right balance between protecting the person and carers. Decisions from the Court of Protection emphasising the Article 8 rights of carers have been particularly helpful.

The widespread use of the term Next of Kin in health and social care settings can be unhelpful. Staff may believe Next of Kin have decision making powers they do not have, or may wrongly exclude people not named as Next of Kin who are of great importance to the person concerned.

8) WSCC staff consulted felt that a change of culture was creeping in, rather than being ushered in!

9) We are unaware of research or data in this area, other than in Dols, where there appeared so far to be no disparity in its application, unlike the MHA. However we In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
suspect that people aware of the advantages of LPAs are probably largely white and middleclass, leaving more disadvantaged groups facing greater difficulties when people they care for lose capacity.

**Decision Making**

10) There are slow improvements in people being supported to make their own decisions since the introduction of the MCA. The task of helping people to make their own decisions needs to be balanced with protecting people who do not have capacity. WSCC has a policy on self neglect, as this is a particularly difficult area for social care staff. The quality of decision making generally improves as one moves up the hierarchy of formality of decision makers. Those who make most day to day decisions, such as families and care assistants often know little or nothing of the MCA. There was also anecdotal evidence that many Attorneys had a poor understanding of their role, and little knowledge of the principles of the MCA. Attorneys may require more support and supervision.

11) There is little evidence of advance decisions outside of DNAR decisions being made. Where they are made, they are sometimes not known about, and not properly displayed in medical notes. DNAR decisions made where the person lacks capacity are sometimes still arrived at without consulting others. There appears to be little knowledge of the powers of LPAs Health and Welfare in health settings.

12) The MCA has noticeably improved the involvement of carers and families in decision making. In health and social care settings there was an understanding that best interests meetings were environments for reaching major decisions about care and accommodation and these needed to involve family and carers.

13) IMCAs have been effective as an additional safeguard for clients. IMCA’s often bring challenge, which is welcomed.

14) Referrals to IMCAs are almost certainly not yet at the level that they should be, and that this was down to patchy understanding of the MCA in general.

15) IMCAs are adequately skilled for their task. However they may not be adequately resourced for the level of referrals that there should be.

**Deprivation of Liberty Safeguards**

16) The safeguards provided by the independent assessments from Best Interests Assessors and Mental Health Assessors, and the scrutiny of senior managers, are adequate for the authorising of deprivation of liberty. The difficulty in challenging Authorisations is a weakness in the Safeguards.

17) The processes for Authorisation and Review can be bureaucratic, and difficult for others to understand. However it should not be easy to deprive someone of their liberty. The real difficulty is in challenging authorisations. The lack of a tribunal system means that challenges are expensive, difficult and involve delays. The Court of Protection as the initial means to challenge authorisations is not accessible or timely. The Court and the Official Solicitor appear to be overburdened by this work. For
example the Official Solicitor became so overstretched last year that they could only take on Dols appeals and serious medical treatment cases.

The Court of Protection and the Office of the Public Guardian

18) CoP and the OPG are not sufficiently well understood or accessible. They sometimes do not operate effectively. There was a perception that the OPG failed to act in a timely manner against Attorneys and Deputies suspected by social care staff of financial abuse.

Staff generally had positive experiences when involved in hearings at the CoP. There was praise for judges who in pursuit of the right outcome for the person, had been very searching in their questioning of the local authority. There were concerns about long delays in the CoP and the lack of resources of the Official Solicitor. There were complaints about some CoP judges allowing excessive use of expert witnesses in the CoP, resulting in inordinate delay and expense.

19) LPAs were viewed by staff as a positive step and an improvement on EPAs. LPAs for property and affairs are becoming much more widespread. Anecdotally, LPAs often appear to have poor understanding of their duties and responsibilities. We are concerned about the lack of supervision of Attorneys considering their wide powers.

LPA's Health and Welfare are only just starting to exercise their powers. It is difficult to make comments about the impact at present. Their powers appear to be poorly understood by health and social care staff.

Social workers reported difficulty in the "real world" with differentiating the powers of different types of LPAs. E.g. LPAs property and affairs who refuse to pay for certain types of care, or LPAs Health and Welfare who insist on certain types of care which there are no funds to pay for. This can be very challenging for social care staff.

20) There is concern about the cost to register LPAs, as this can be off putting to carers who are financially disadvantaged due to their caring role. The costs of applying for deputyship are problematic. There is insufficient guidance to help deputyship applicants reduce costs and understand how to access funds quickly to pay for care.

21) Legal Aid will be curtailed for CoP applicants who are not directly challenging their deprivation of liberty. Most CoP cases are not directly challenging deprivation of liberty, but requesting determination of someone's best interests. This is likely to adversely affect the rights of the most vulnerable and their carers.

Regulation

22) The CQC do not inspect Local Authorities regarding their operation of the Deprivation of Liberty Safeguards, nor are they requires to inspect the cases of people subject to Dols when they inspect a hospital or care home. It is difficult to understand why people subject to the Mental Health Act have these safeguards and those subject to Dols do not.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
There is experience of CQC inspectors apparently having poor understanding of the act, and appearing to give poor advice to care home staff. We are also aware of a large NHS trust that was registered by the CQC, despite none of their consent forms being compliant with the MCA in any way. Do the DH not provide hospitals with standard forms for consent?

23) We are interested in the idea of health and social care professional regulators making specific reference to a need to understand the provisions of the MCA and act in accordance with them. This may impress upon professionals their need to understand and uphold the Act and would be particularly helpful with regard to doctors, who often work outside other management structures, and who look overwhelmingly to their professional bodies for direction.

Other Legislation

24) The relationship between the Mental Health Act and the Mental Capacity Act is poorly understood. The schedule covering this is extremely difficult to understand. WSCC believe that people with dementia and learning difficulties are still subject to defacto detention in mental health units without legal oversight. Clinicians believe that s5 and s6 of the MCA allow them to do this. Whilst the use of the MHA was a vehicle for abuse at Winterbourne, it does not follow that a failure to use the MHA when necessary is an improvement. WSCC also had concerns about inpatient mental health staff understanding how to use the MCA to protect their patient’s physical health.

Devolved administrations and international context
WSCC does not wish to offer evidence on these matters.

30 August 2013
John White (Mental Health and DoLS Manager, South Gloucestershire Council) – Written evidence

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

Undoubtedly, there has been a shift in practice in both care homes and hospitals since the introduction of the DoS, with evidence that a wide range of vulnerable people have had their rights protected in circumstances where this would not have been likely in the absence of the DoLS legislation.

However, compliance with the (Mental Capacity Act) MCA and DoLS is variable, with some care settings showing an advanced understanding of the legal requirements and others showing very limited understanding.

Bespoke practice based training within a particular care setting seems to be more effective in creating the required improvements in knowledge, skills and understanding (leading to improvements in policy, practice and procedure) than traditional legally based presentations.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

There is a large amount of debate about the eligibility for DoLS authorisation in psychiatric hospital settings. One major view is that anyone in psychiatric hospital who is not detained under the Mental Health Act 1983, who lacks mental capacity to consent to the hospital admission should be under a DoLS authorisation. An alternative view, held by myself, is that unless the person is objecting to being a hospital patient, or to all or part of the treatment, they are unlikely to be deprived of their liberty. If they are objecting, they will be ineligible for DoLS authorisation and the Mental Health Act should be used.

There is no mechanism for the eligibility assessor to record that the Mental Health Act would be a more appropriate legal vehicle to authorise detention in a care home setting.

Whilst reviews of DoLS authorisations have been requested and carried out accordingly, they have rarely brought about an end to the authorisation.

The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

Applications to the Court of Protection do not provide an easy or timely route of challenge for either the relevant person or their representative.

The quality of advice from the Office of the Public Guardian is extremely variable, with different advisors giving different answers to the same question.

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
John White (Mental Health and DoLS Manager, South Gloucestershire Council) – Written evidence

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

There is a large amount of confusion among the general public about the new powers, with little understanding of the different decision making powers offered by Property and Affairs as opposed to Health and Welfare LPAs.

Health and Social care staff are not making adequate checks into the detail of the decision making powers and in some circumstances, whether or not the LPA has been registered.

There can be a confusing crossover of responsibilities when a Property and Affairs attorney has concerns about the quality of health or social care that is being purchased from the donee’s finances. How far they should have access or decision making ability in relation to health or social care records and practice requires clarification.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

I understand that this has been a source of reluctance or barrier to registering an LPA for a number of people.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

No experience or strong view in relation to this, although it is clearly another factor that will dissuade representatives challenging DoLs authorisation.

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

There is little evidence that the CQC are using the powers that they already have as part of their inspection regime. I have found little evidence that they have been checking DoLs paperwork, picking up on incidents of possible DoL, monitoring the use of restraint or checking other DoLs matters e.g. a record of visits by the representative.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

I think it would make more sense to make the CQC inspection of the MCA and DoLS regimes more robust.

Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
John White (Mental Health and DoLS Manager, South Gloucestershire Council) – Written evidence

As detailed in 17 above, there is considerable discussion and variance in practice regarding the MHA, MCA / DOLS interface. Managers and practitioners involved in the DoLS process who are also Approved Mental Health Professionals seem to have a better grasp of this complex interface.

It could be argued that in order for a DoLS best interests assessor (BIA) to have “knowledge and skills relevant to the particular circumstances of the case” (DoLs regulations), assessments in mental health settings should be carried out by a BIA who is also an AMHP.

John White
Mental Health and DoLs Manager
South Gloucestershire Council*

*This is an individual professional response and does not necessarily represent the view of South Gloucestershire Council.

29 August 2013

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?

We as an IMCA service share the view that the MCA is achieving its aims in so far as it enables and empowers people and also protects those who are lacking in mental capacity. When used appropriately, the MCA achieves its objectives however, there are instances when the IMCA safeguard is ignored and there appears to be little redress for when professionals do not adhere to the MCA. An example is when an IMCA came across an ex client in hospital with a DNAR notice in place and no referral to the service had been made and no consultation taken place and this patient was ‘unbefriended.’

2. Which areas of the Act, if any, require amendment; and how?

DOLS area is very confusing, and could be simplified with a definition. We feel that the regulations should be extended to cover those vulnerable people who are in supported accommodation or deprived within their own home. We do not believe that applications are made in every case to the Court of Protection. Also we feel that the Code Of Practice requires udating to include the recent changes in case law.

3. At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?

We agree that the principles and definitions of capacity are appropriate, however the problem lies with how these are applied. In our experience when capacity is assessed it is sometimes not decision specific. An example is when professionals declare that a person lacks capacity and does not report in what area or to what particular decision. Also our experience shows very little evidence of capacity assessments, it is documented that the person lacks capacity but very often there is no evidence of the actual capacity assessment.

Implementation

4. To what extent have the five principles of the MCA been implemented in frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

It is part of the IMCA role to ensure that the principles of the MCA are implemented. We have found as a service that there is a lot of good practice in this area however there are areas where improvement should be made. The evidence available would be the minutes of the Best Interests meeting. Also the template used by the Local Authority which steers through the best interests process and provides evidence of the principles being applied.

There are many instances where protection and safety of the individual will override their rights and autonomy. In 2009 we had an example of a lady with dementia being refused to return to live with her son following respite as it was felt that she would be safer in the care

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
home. This was challenged by the IMCA and four years later mother and son remain at home, where mum wanted to stay and son wanted to care for her.

5. **How effective was the Government's implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?**

We feel this was not effective enough with families. Although the Dept of Health issued booklets, we have found that families have no knowledge of the MCA even six years after the Act was passed. It has led to a sustainable change is so far as professionals are concerned however more needs to be done for families and carers who also have little or no understanding of the Act.

6. **Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?**

Our service takes the view that the Act is understood by front line social workers, however in the area of health, referrals to the IMCA service remain worryingly low. We feel we are making some inroads as we have met with the safeguarding lead for the local health trust and are piloting two particular wards to promote the service and the MCA. This will be reviewed in three months time. We feel that the Act is not widely known or understood amongst health professionals and feel that mandatory training may address this problem. Many of our referrals for SMT have come from associated health workers such as the LD nurses, care homes, social workers highlighting a failure to refer by the decision maker, in many cases not delegated by the Doctor/Consultant.

7. **Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?**

We agree that the right balance has been struck between protection of the carer and protection of the individual, having consulted sections 5 and 6 of the Act we believe this is appropriately balanced.

In our opinion the Act is not widely known and understood, we as IMCA’s explain the Act and constantly offer guidance but we do find a huge lack of awareness that could be addressed. We participate heavily in any training provided and offer training to organisations such as carers groups, we do this as an added value for money.

8. **Has the Act ushered in the expected, or any, change in the culture of care?**

It has improved awareness that decisions cannot be made unilaterally, we do feel that there are more safeguards available now for extremely vulnerable people, and there is more of a focus on people participating in decisions about them. We would agree that there is a shift in
culture in practice, cynically it could be said that in some cases professionals are protecting themselves.

9. **Is there any evidence that the provisions of the MCA affect some groups disproportionately? If so, what data exists to compare representation across different socio-economic groups, Black and Minority Ethnic groups, and gender?**

It is our experience that the principles are implemented regardless of the ethnicity and socio-economic background, we have accessed translators, signers, and visual aids. However in this geographical area, we have a low proportion of people of different ethnicities.

Toby Williamson from Mental Health Alliance reports that 50% of people from BME groups in old age psychiatry did not have an interpreter present when having capacity assessed despite having language difficulties. (Shah at al 2009)

**Decision making**

10. **Are those directly affected by the Act being enabled and supported to make decisions for themselves to a greater or lesser extent than they would have been in the past? Does the means by which the decision is made – ‘general authority’, Lasting Power of Attorney, deputyship, Court of Protection – affect the quality of decision making?**

Those directly affected by the Act are enabled and supported to make decisions for themselves to a greater extent than they would have been in the past. There is a focus now upon participation due to the MCA, also in terms of wishes and feelings, which the IMCA service represents as well as the least restrictive option. Those who are deemed to lack capacity must still be encouraged to participate and express their views. The means by which the decision is made improves the quality in our view as it is now more open to scrutiny and challenge.

11. **What evidence is there that advance decisions to refuse treatment are being made and followed?**

Unfortunately, we have very little experience in this area, as it is rare to come across a client who has made an advance decision.

12. **Has the MCA fostered appropriate involvement of carers and families in decision-making?**

Consultation with others is part of the process, however sometimes if family disagree with the proposed decision they have been deemed inappropriate to consult. The IMCA service is able to determine if this is the case and will challenge if appropriate. The CQC have highlighted in their report 2011/12 that there are instances where relatives and friends have been excluded from decision making or asked to consent on behalf of the person in a way that is not lawful.

13. **Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?**

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
As identified in the 5th IMCA Annual report there has been a 9% increase in referrals to the IMCA service. We agree that the IMCA service is successful in providing a voice and an additional safeguard for those who have no-one to speak on their behalf. Examples we can offer are:

Very recently, a move was proposed by the Local Authority for a gentleman with learning difficulties to leave his home of seven years and share with three other gentlemen. Although there was some excitement initially, the IMCA was able to determine by meeting this gentleman at his own home, his proposed new home and the day centre that he did not wish to leave his own home. The IMCA did a lot of work in representing this gentleman and the Local Authority eventually agreed it was in his best interests to remain.

The IMCA’s have represented clients whose cases have gone before the COP, one was a nephew abusing his power under a financial deputyship, another a lady who remained in residential care as her son was neglecting her care at home, there are many cases where the IMCA is not an additional safeguard but the ONLY safeguard for this client who can sometimes be powerless against the decision-maker.

14 Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

Our referral rate is high and has exceeded expectations we would explain this by our working in partnership, good relations and links with professionals and the Dols co-ordinator in this area. Referral rates may also be linked to the tendering process that Local Authorities are now obliged to have. Large organisations tender for IMCA services and undercut local providers by reduced the amount of provision. It is our experience that trying to make referrals to other IMCA services are sometimes difficult and this can be related to the number of staff involved. We participate in training events and promote our service which could account for the high rate of referrals we receive.

1. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

Our service has suffered a reduction of 10% this year which has directly impacted on the service. The cuts to LA funding have directly impacted upon the 3rd sector providers that offer IMCA services although MCA funding is ring fenced. We could not meet the demand if we did not take a team approach as in all our Advocates are trained to offer IMCA, IMCA (Dol) and RPR. The organisations commitment to offer training and supervision means we have to use scarce resources more wisely. The Department of Health requirement that IMCA’s have the Independent Advocacy Qualification has put a strain on resources. Many conferences and training events are offered in London therefore burdening us with the extra cost of travel, unfortunately this has meant us being unable to attend for example The Capacity, Liberty and Choice conference in July. We have asked for the same quality training and conferences in the North of England but to no avail.

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
The safeguards now provide a framework for determining whether people are deprived of their liberty; however, according to the CQC report 2011/12 the implications of the safeguards in practice are not easy to understand. In previous reports, CQC has noted concerns about the complexity of the systems surrounding the safeguards. Nonetheless at least now there are safeguards and there is the provision of redress and challenging deprivations. Our experience is that clients and their families do find the safeguards difficult to grasp.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?

Authorisation takes place swiftly; however challenging decisions, particularly with regard to access to the Court of Protection can be a very lengthy process. One case we have worked, took at least 12 months and another is taking over a year with the imposition of 4 periods of DoLS.

The Court of Protection and the Office of the Public Guardian

18. Are the Court of Protection and the Office of the Public Guardian sufficiently understood and accessible to all? Are they operating effectively and successfully?

Issues relating to the Court of Protection are not widely understood in our experience and accessing the Court is particularly slow. We have an ongoing case of a client who is awaiting Deputyship to be granted to the LA so that his funds can be released to improve his home ready for his return. This is taking a considerable amount of time and is approaching 9 months whereby he is on delayed discharge at the rehabilitation unit where he currently resides.

19. What has been the impact of the introduction of Lasting Powers of Attorney (LPA), especially with regard to decision making on matters of personal care and welfare?

Big impact as it allows people to plan for the future and this wasn’t previously an opportunity prior to the MCA. Many people could be put off by the process and lack of accessibility and not be in a position to afford this. A lot of people don’t seem to appreciate the relevance of LPAs when health providers still recognise next of kin and marital status.

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

The cost may be prohibitive for some, particularly if involving a solicitor. One person we know of has applied for both LPAs for themselves and their partner and two years on, only has three out of the four, resulting in high costs. In the economic climate we feel people will view this as an unnecessary expense.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to legal aid have?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
We are of the understanding that legal aid may be available for welfare, however it is unclear as to whether it is available for financial. Claimants of non-means tested benefits still may qualify for legal aid; however for others there needs to be clarifications.

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

The CQC has done a great deal, however in terms of their role, they have no enforcement powers to ensure that the MCA legislation is adhered to, they can only make recommendations. If there is an authority that would have those powers, we are assured that certain areas of health care would come quickly in line with the MCA.

23. Should other regulatory bodies, such as health and social care professional regulators, be acting in this area?

Yes – the more regulatory bodies that are in existence and are involved, the better outcomes for those affected by the MCA.

Other legislation

24. How well is the relationship with the mental health system and legislation understood in practice?

On several occasions we have encountered situations whereby people have been treated for a mental health issue and mental health professionals have wanted to use the MCA rather than the MHA; these include Responsible Clinicians and CPNs. For example, a CPN wanted to apply for a DoLS in order to administer antipsychotic medication to an individual who had got to the stage of not eating or drinking. Another individual was detained on a mental health ward by a responsible clinician under MCA/DoLS, as opposed the MHA. Once again, the situation would improve with mandatory training, as this area can be very confusing.

Devolved administrations and international context

25. Does the implementation of the Mental Capacity Act differ significantly in Wales?

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

It is our understanding that a statutory definition of what constitutes a DoL has been proposed by the Scottish Law Commission. If considered, this would clarify the complicated process that exists at present in England.
27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

1 August 2013

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In my written and oral evidence to the Joint Committee on the Draft Mental Incapacity Bill I argued that the proposed Bill was human rights compatible and an improvement on the existing common law development of the law on incapacity. I still believe that this is the case, although as with all legislation it is essential that legislative intentions are translated into practice. A particularly valuable provision in the Mental Capacity Act 2005 (MCA 2005) is the list of statutory principles in section 1; these not only assist practitioners and others in decision making, they also provide a means by which decisions can be questioned or challenged.

2. It is important is that the provisions of the MCA 2005 are disseminated widely across health, social care, criminal justice, housing, the third sector and others. It is sometimes assumed that capacity is purely a matter for health and social care. It is not. Other statutory agencies have responsibilities under the MCA 2005. The third sector and private sector (including care homes, lawyers, and advisers) should also be aware of its provisions. There is also a need to provide guidance to informal carers on the broad working of the MCA 2005 as it is they that often make daily decisions for a person lacking capacity. Addressing, questions 6 and 7 of your briefing, my experience is that knowledge of the MCA 2005 does vary across sectors and within sectors. Not everybody needs to be fully trained in the finer details of the MCA 2005. However, it is essential that all practitioners, at whatever level or sector, do at least understand the basic principles and working the MCA 2005. Similarly for informal carers.

3. In my evidence I will concentrate on a specific application of the MCA 2005, namely safeguarding and protection. It addresses in particular question 13, but also indirectly covers some of the other issues raised in your briefing. My opinions are based on a review undertaken by Aberystwyth University of the Welsh Government’s Access to Justice Pilot Project for Victims of Elder Abuse. The review involved an analysis of case records and interviewing practitioners from health, social care, criminal justice and third sector. Although the project was not primarily about older people lacking capacity, capacity arose as an issue from the data analysis and interviews. A number of concerns were identified.

4. Is the possibility of incapacity always considered under safeguarding and protection procedures? The presumption of capacity is an underpinning principle in the legislation. It is a basic human right. However, this should not result in an unwillingness to address potential incapacity in all but the most obvious of cases. An analysis of the case management records in the review of the Access to Justice Pilot study review shows that in the majority of cases whether the person had capacity or not was not recorded. In some of the records there was a lack of clarity about the basis of the

http://wales.gov.uk/docs/caecd/research/121220accessotojusticeen.pdf

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assessment of the victim’s capacity. It would be useful if guidance and procedures, without undermining the presumption, required the question of capacity to be addressed in relation to anybody coming within the procedure. In most cases, this matter could be quickly and easily resolved – the person has capacity. In others a fuller assessment may be triggered.

5. **The time and context sensitive nature of the capacity test:** Capacity is a dynamic and pervasive feature of adult protection. Initial assessments of capacity will invariably be undertaken by social care or health at the time of entry into the procedure. However, that should not necessarily seal the issue of capacity for the duration of any investigation. Capacity may fluctuate. People may have capacity for some decisions in the process and not others. The time and place of any discussions with the victim may affect their ability to be involved; being interviewed at 9.00 am in a formal setting may be less conducive to the ability to decide than at 3.00 pm in the person’s own home. This might be particularly important when discussing civil or criminal justice seeking options. The important point is that it may be necessary to review capacity rather than rely on what becomes an initial once and for all assessment. The fact that the victim has or does not have capacity at one stage of the process does not mean that it is the case for the entirety of the process.

6. **Responsibility for assessing:** As an investigation progresses other agencies become involved, in particular the police and the Crown Prosecution Service. They should be aware of their obligations under the MCA 2005. For example, the CPS should address the issue of capacity in relation to the decisions required of the victim that fall within their statutory remit; similarly, for the police. They should be confident that the victim has the necessary capacity to be involved in their processes. Of course, this works both ways. An earlier finding of incapacity may be inapplicable or inappropriate at a later stage of the process, and vice versa.

7. **Involving a person lacking capacity in decision making:**

   a. Both the Welsh and the English guidance on adult protection procedures emphasise that consent is the key driver in adult protection. The recent reviews of *In Safe Hands* and *No Secrets* emphasised the importance of participation by and representation of people who lacked capacity. The best interest checklist in s.4 MCA 2005 requires decision makers to ‘permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done and decision affecting him.’ Section 4(6) requires consideration of past and present wishes and feelings, beliefs and values and other factors he or she may have considered important. The courts have emphasised the importance of this right. The person’s point of view should inform best interest decisions. This applies with equal force to decisions in safeguarding and protection procedures, including justice seeking options as it does to health, social care and financial matters. The role of the IMCA is particularly important in this regard. Although an IMCA must be instructed in deprivation of liberty cases, not all safeguarding and protection

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423 *In Safe Hands and No Secrets* (see para 7.17 and para 6.20 respectively).

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cases necessarily involve such an authorisation. In those that do not, there is discretion to appoint an IMCA. The role of the IMCA in safeguarding and protection, as elsewhere, is important in empowering the victim as options are considered. These may include the use of special measures in any criminal proceedings.

b. Our review of the Welsh Government’s Access to Justice Pilot found that IMCAs were sparingly used in safeguarding and protection. Of the ten victims identified as lacking capacity, only two actually had the services of an IMCA (one was referred, but did not appear on the IMCA records). Of the remaining seven cases, the files indicate that they met the IMCA criteria, but one was not appointed. This raises the question whether the IMCA service is fully integrated into the safeguarding and protection procedure. It should be.

c. Although the review of the Access to Justice Pilot involved a relatively small cohort (total 130 people), it raises questions about the use of IMCAs in safeguarding and protection. Two of the possible reasons for underuse of IMCAs identified during interviews are:

i. A feeling by agencies that the involvement of an IMCA should be delayed until the investigation is complete; and

ii. IMCAs may compromise the investigative process.

These resonate with findings in other studies that practitioners from the statutory agencies can be ambivalent about the involvement of IMCAs. There may be a reluctance to recognise that, for example, in a health care setting a non-medic could make a contribution. It may also be the case that practitioners feel that they are good enough advocates for people who lack capacity.

d. Delays in involving, or a failure to involve IMCAs may breach the statutory principles and the best interest checklist in the MCA2005. In addition, they may violate the article 6 European Convention on Human Rights right to access justice and the article 13 right to an effective remedy. Prosecutions are rare, and the use of civil justice options even rarer. Justice seeking options may be closed off without considering the views of the person who lacks capacity who is the one most directly affected. Of course, that is not to argue that justice seeking options (civil or criminal) are always the right outcome, but they should be considered and an IMCA can assist in that. Failure to do so ignores their human rights.

8. The MCA 2005 has improved the law on capacity. The existence of a clear statutory framework has provided a framework for improving decision making and record keeping, and for placing the person at the centre of the process. Although much has been achieved and practice has improved, there is still some distance to go in


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ensuring that the MCA 2005 is embedded in all agencies, organisations and individuals involved in working with people who may lack capacity. One particular example of this is in the safeguarding and protection procedures where a welfare approach may, with the best of intentions, override the rights of the person under the MCA 2005 and the European Convention on Human Rights.

2 September 2013
1. **(Question 1)** Our research about best interests decisions, carried out in 2010-11, covered professional practices across health, social care and property and affairs, and collected examples of cases involving different client groups. We highlighted some positive examples of professional practice, in health and social care particularly. The methodology (self-selected participation from 385 staff in NHS trusts, social care departments and legal practices in four areas of England) does not allow us to judge how widespread these practices might be; instead, we can reliably say that there are now pockets of professional expertise in the MCA, and that we can recognise them as exemplars of good practice – e.g. practices for involving and listening to the person lacking capacity; multiple attempts to re-assess capacity; involvement of significant others and information-giving practices. These are important, as they allowed us to analyse ‘what works in what circumstances’, and to provide some detailed guidance and examples to practitioners and to policy makers.

We had plenty of evidence about the beneficial effects of the MCA, and the welcome it had received from professionals in different sectors. For instance, people in our research told us:

‘Whereas before (decision making) might have been a bit fuzzy, and we may not have documented everything the person was telling us in relation to these kind of decisions, now we make sure that we do. So I think it has helped enormously.’ *(Occupational Therapist)*

‘It’s actually forced us to stick to a particular format, given us the framework to use. Obviously it’s not perfect, but it’s better than what was there before.’ *(Consultant gerontologist)*

‘It makes you more confident in making the decision as well, really, because you can justify why. And you justify why by referring back to the Act as well. So it’s confidence building.’ *(Corporate Financial appointee)*

‘I think it’s one of the best bits of legislation that has ever been written actually. It’s user-friendly, it’s common sense.’ *(Specialist nurse)*

‘I think it’s made a huge difference. It’s provided a clear structure. And it has a good balance between opposing situations. So that you get less neglect, but you also get the person’s voice heard, but you also get the system’s voice heard where there’s a difference of opinion. I think it is good. I’ve certainly found that I think that services are much more contained and less impulsive as a result of the Act.’ *(Learning Disability Psychologist)*

2. **(Qs 3 and 4)** The five principles of the MCA were well known to most practitioners taking part in our research.
Dr Val Williams, Toby Williamson, Dr Geraldine Boyle, Dr Paul Swift, Dr Marcus Jepson and Dr Pauline Heslop (School for Policy Studies, University of Bristol) – Written evidence

- In general, the ‘best interests’ principle was well understood, but the necessity to carry out an assessment of capacity prior to a best interests decision was arguably the most difficult aspect that practitioners found in the Act. In 10% of 385 cases, it appeared that a decision had been made for someone, even though they were assessed as having capacity. The basis of an assessment of capacity was sometimes unclear, and on occasions illegal, with participants in interviews particularly mentioning ‘lack of insight’ (into one’s own condition) as a basis for lacking capacity.

Our second recommendation was:

The Mental Capacity Act Code of Practice should be supplemented to enhance and clarify the distinction between “lack of insight” into one’s own care needs, and lack of decision making capacity.

- Practitioners taking part in interviews reflected long and hard about the difficulties of actually assessing capacity, and the lack of guidance or knowledge about how these ‘conversations’ about decisions should be conducted.

An important recommendation for future research was that:

Assessment of capacity emerged from this research as the most difficult and sensitive area for practitioners, and it could therefore be followed usefully by more research about the practices involved in assessing capacity.

- The ‘unwise decisions’ principle often caused difficulties in practice, with practitioners wishing to protect people from themselves. This would sometimes tip people into ‘going down the best interests route’; for example, we heard of cases where people with a moderate learning disability were engaging in sexual activities that were unwise; people with mental health needs were spending money unwisely; older people making unwise decisions about their own care needs. In all these cases, an assessment of capacity was influenced by the unwise or risky nature of the person’s own choices.

Our first recommendation was:

The Mental Capacity Act Code of Practice should be supplemented to enhance and clarify the distinction between unwise decisions and a lack of decision making capacity.

- The balance between enablement and protection was well understood by most of the people who took part in the various stages of our research. However, it was said that frontline staff in care homes had difficulties in balancing out the ‘choice’ principle with the ‘best interests’ principle. Sometimes, they were said to swing too far towards the necessity of affording choice. However, practices in care homes also need more detailed research.

3. (Q 6) There were notable differences between different professional sectors, in understanding and implementation of the MCA. Our research showed that this was not

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simply a matter of contrasting 'health care' with 'social care' for instance, but that a differentiation of professional roles within these sectors was important. In health care, the gaps in implementation were broadly attributable to senior medical consultants; the majority of those who had good understanding and implementation were professions allied to medicine (therapists, specialist nurses) rather than the clinicians themselves. However, we did find some exemplary practice examples which involved clinicians, working in partnership with other professionals, involving those close to the person lacking capacity, and taking ultimate responsibility for making a considered decision about a person’s holistic ‘best interests’ (rather than just their medical interests).

4. (Q 7). We had little evidence directly from family carers in this research, although plenty of evidence about the issues regarding their involvement. 69% (264) of the respondents to our survey reported that people close to the person were in fact consulted about the person’s best interests. In at least 20 cases out of 48 in our telephone interviews, a person close to the individual lacking capacity was brought in at the outset, to assist with communication and support. We were also told of many cases in which the views of a family member were absolutely key to the best interests decision and the outcome. These included serious medical treatment, including life-saving treatment such as artificial feeding; a suitable accommodation placement for someone with learning disabilities; the need to protect people from financial problems. One nurse spoke for many, in saying:

‘I don’t think I would like to make decisions regarding patients’ treatment purely on what I felt was appropriate or not appropriate, really. I think it has to be that everyone that’s involved with that particular individual, that all their opinions are taken into consideration really.’

However, we found that difficulties arose when family or friends were suspected of infringing the rights of a person lacking capacity, and where the best interests decision was triggered by that suspicion. In one case, for instance, a woman’s daughter was suspected of having profited unduly from her mother’s share of the finances. As they shared the mortgage on a house, the appointees for her mother decided that it would be in the older woman’s best interests to sell the house back to the Building Society, and release the cash for the woman’s use. In such cases, instead of involving and listening to family members, decision makers were essentially finding ways to exclude them from the lives of the person lacking capacity.

There were also several cases that fell in between the two extremes of a) involving a family member; b) excluding a family member from a decision. These were instances where a family was not entirely ‘on board’ with a decision, and so had to be persuaded and talked to.

Despite these cases reported in our research, we were not successful in including evidence directly from family members themselves. We made recommendations therefore for future research:

Given that the current research revealed the complexity of real-life decision making from the point of view of decision makers, it is important that further research is carried out to understand better the different perspectives of those involved in best interests decisions, including people lacking capacity themselves and their family carers.

…it would be useful to examine everyday decision making, and also the practices involved in resolving disagreements and disputes that arise from capacity assessments.
5. (Q. 8) While not wishing to make claims for the widespread nature of change, the site visits we made during this research study provided strong evidence of reflective practice, and awareness of the difference made in the culture of care. Broadly, this was seen as swinging the pendulum towards a ‘listening’ culture, in which the MCA gave people the right to challenge poor practice. One of our participants summed this up by saying:

‘You’ve got more strength behind questioning why nobody’s listening to the lady in the bed’.

6. (Q. 11) Although there were very few examples in our research (385 cases) of advance decision making, we followed up one case in which the notion of advance decisions was very poorly understood by the medical practitioner, who allowed an older person with a terminal illness to make a positive statement about resuscitation, rather than an advance decision to refuse any particular treatment. This caused potentially grave difficulties within her terminal care, which were only resolved when the decision was reversed by the intervention of someone who had a lasting power of attorney for her.

7. (Q. 12) In the cases described in our research, we were able to distinguish different process models for making best interests decisions and involving families, carers and others (e.g. care home staff) in the process. While in general all practitioners seemed to favour consensus decision making, these ‘joint’ processes could sometimes lead to muddle. In particular, it seemed important to separate out the roles of a) leading a best interests process; b) being the decision maker; c) chairing best interests meetings. Models of good practice did not always involve meetings, and the important aspects of decision making often took place via more informal discussions outside the formal meeting. We noted that often one ‘major’ best interests decision often led to a raft of sub-decisions. Several of our recommendations related to this set of findings:

Terminology in the Code of Practice about roles in best interests decisions should be revised, to include the different positions taken by a best interests decision maker, a best interests leader and a chair person.

Successful best interests practices should be listed within current guidance, including the MCA Code of Practice. These should include reference to the practice of separating out different ‘layers’ of decision making in best interests decisions, where a main decision leads to several sub-decisions.

Training providers and local MCA leads need to develop more case examples about assessment of capacity and best interests decision making for the MCA Code of Practice, which reflect the complex, real-life situations and dilemmas in the current report, especially ‘consensus’ or joint decision-making approaches, and demonstrate how to avoid the common errors in assessment of capacity and best interests decision making.

8 (Q. 13). The role of IMCAs was very important in the cases where they were deployed in our research. In the online survey, whilst just 7 IMCAs completed the survey themselves, they were involved in 22 of the 93 (24%) personal welfare or social care cases, and in 47 of the 184 (26%) health care decisions. In subsequent stages of our research, we heard of cases where IMCAs had challenged assessments of capacity, or the processes involved with the best interests decision, effectively standing up for the rights of the person for whom the decision was being made.

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The involvement of an IMCA was sometimes associated with disagreement or conflict in the best interests case; there were disagreements in 19% (9 of the 47) healthcare cases where there was IMCA involvement, and in 31% (7 of the 22) personal welfare/social care cases. While this is not an official part of the IMCA role, it seemed that IMCAs were sometimes deployed in order to resolve disputes that had arisen in determining someone’s best interests.

We recommended that:

Guidance for practitioners about the role of IMCAs needs to be reviewed and revised, with examples based upon real life situations where IMCAs have been involved.

References425

29 August 2013

425 Main report:


Journal papers:


In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Please find below Wired response to the House of Lords select committee on the Mental Capacity Act 2013. Wired currently provides an IMCA service to Wirral and North Wales. We also have a trading arm that is City and Guilds approved to provide IMCA/IMHA/DoLS training and The National Advocacy Qualification. Wired has provided an Independent Advocacy service for more than 20 years. We have provided the IMCA service in Wirral since 2007 and in Wales since 2009.

Overview and context

1. To what extent has the Mental Capacity Act 2005 (MCA) achieved its aims?
   a. To the extent that people without capacity now have more control over their lives. The Act says that any decision must be explained in a way that can be understood and anyone who works with people without capacity have a duty to ensure that information is accessible. For instance Wired as the IMCA provider for Wirral and North Wales make sure that when we are with people without capacity we will use pictures, photographs, plain language, language of their choice etc.
   b. The Court of protection has stated through case law that the choices of the person must take priority unless that choice put them in serious danger. This means that local authorities and health that are very 'risk averse' now have to seriously consider the person’s choices. If they do not opt for the person’s choice they must say why.
   c. The use of IMCA’s has meant that there tends to be more creative solutions and a move away from traditional ideas.
   d. The widespread use of ‘best interest’ as a 'concrete' concept and not a subjective opinion. Wired ensures that the best interest checklist is exactly that. A list that must be followed to ensure that any decision made has checks and balances and if challenged can say how and why that decision was made.

2. Which areas of the Act, if any, require amendment; and how?
   a. As the IMCA provider for Wirral and North Wales (6 counties) we feel that the biggest area for review should be the deprivation of liberty safeguards (DoLS). It is overly bureaucratic; the danger being that the interests of the person gets lost in the long and drawn out process. DoLS does not cover the supported living setting, where of course many people with learning disabilities live. So there is a whole tranche of people who are not safeguarded.
   b. Staff do not seem as aware of the DoLS section of the Mental Capacity Act as other parts of it. They often are illegally depriving someone of their liberty.
   c. Residential and Nursing establishments knowledge of DoLS is very patchy.
   d. With relation to IMCA involvement, the MCA Code of Practice, Chapter 10.71 states that “where a person has no family or friends to represent them, but does have an
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However there is no clear guidance in the MCA CoP in respect of the situation when the attorney or deputy is also a friend or family member.

e. In this instance, should an IMCA be involved, bearing in mind that there is no requirement for IMCA where there is family or friends willing and able to consult.

f. 10.71 continues with the statement that the Government is seeking to amend the Act at the earliest opportunity to ensure that an IMCA should always be appointed to represent the persons views when they lack capacity relating to serious medical treatment or long term accommodation moves.

g. To-date, (August 2013) no reference to an amendment to the Act can be located in relation to the 10.71 ref. in the CoP.

h. As practicing IMCA’s throughout North Wales, we felt that an IMCA referral for care reviews when someone lacks capacity should be a compulsory requirement.

i. In practice, when we are involved in a change of accommodation decision, suggestions are made as to the content of the person’s care plan derived from findings and discussions the IMCA has conducted during the process. Once the move has taken place, there is no way an IMCA can ensure the findings that may be important to the person, are being implemented and remain evident in the care plan. Part of an IMCA’s role is to act as a safeguard for the person lacking capacity during a best interest’s decision process. However, once the move of accommodation has been made there is no requirement for statutory bodies to refer other than a discretionary one. It is therefore difficult to ensure that recommendations made by an IMCA in the IMCA report for that person are actually being carried out once the move has taken place.

2. **At the core of the MCA are its principles and definitions of capacity and best interests. Are these appropriate?**

a. The MCA principles are appropriate if used correctly and in conjunction with each other. However, with experience as an IMCA provider, there is yet to be a case where the person for whom the decision is to be made has been given the opportunity to make that decision prior to a capacity assessment. This in itself goes against the 1st and 2nd principles in the MCA. Decision makers should be establishing a person lacks capacity for a particular decision at a particular time by supporting them to make said decision in the first instance.

b. The ability to make a particular decision at a particular time continues to be grossly overlooked when it comes to an individual’s ‘capacity’ being in question by decision makers. This is a practice issue rather than an issue within the legislation.

c. The MCA does not define best interest because of the broad range of decisions and actions that are covered under the MCA. Best interest within principle 5 of the MCA is often not followed through to the ‘checklist’ stage of working out what is in
somebody’s best interest as individual decision makers adhere to this principle as if it is a definition based on their own understanding of ‘best interest’. Doing something for somebody in their “best interest” has been widely over used prior to the MCA, and based on individuals own judgement of what is in somebody’s best interest. It may have been more appropriate to define a different term for best interest within the MCA that individuals may have associated with the act itself. Not many people used the term ‘capacity’ prior to the MCA and it is now mainly associated with the act.

d. While the definitions and principles of capacity and best interest are appropriate within the MCA, the question should be explored as to whether they are being used and implemented within the decision making process appropriately. IMCA services responses would likely be negative in this respect. This raises the question as to the real and actual safeguard the MCA is providing for people to make their own decisions for those who do not have an IMCA or knowledgeable professional.

4. To what extent have the five principles of the MCA been implemented in Frontline practice? What evidence is available to assess this? Is there a satisfactory balance between enablement and protection?

Assumption of Capacity:

a. In some instances, hospital staff, i.e. nurses, state they have not received sufficient training and therefore don’t feel confident in assessing and recording capacity, and they are ‘afraid to incorrectly complete a legal document and the implications it could bring’.

b. Other professionals appear to ‘set the bar too high’ in capacity assessments leading to inconsistent standards in relation to assessment.

c. Fluctuating capacity is also an issue, as there is not always the time/opportunity to re-visit and make a capacity assessment when a person is thought to be at their best.

d. IMCAs in N. Wales have regularly asked for second opinions on capacity which has resulted in the person being assessed as having capacity, and the person’s wishes have then been implemented.

e. Least restrictive option: Some decision makers err too much towards making risk factors the main determinant in coming to a best interest’s decision. There does not seem to be any awareness of the excellent DOH paper: “Nothing ventured Nothing Gained” – Maybe it needs a re-launch!

f. Best Interests – this is highlighted and adhered to when an IMCA is involved. Feedback from professionals across the 6 counties of North Wales in which we work is on the whole very positive.

5. How effective was the Government’s implementation plan? What measures were taken to ensure that professionals and families of those who lack capacity know about and act in accordance with the provisions of the MCA? Has it led to sustainable change?

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**Family and friends**

a. Wired’s experience over the last six years has been that families have very little, if any, understanding of the Mental Capacity Act or where to access such information. Some are not apparently aware of its existence until told in a hospital, care home, or crisis situation.

b. If there are any family involved and the IMCA service Wired ensures that they have information about the MCA. We can guide families through the act and make sure that they know that they have to act in the person’s best interest.

c. One option would be to extend the IMCA role to all persons who lack capacity even if they have family or friends. In our experience, families do not have the knowledge to ask for any other option than what is offered by the Multi-disciplinary team.

d. One example occurred where we were requested to become involved was when the referrer wrote that ‘the family lacked insight into the extent of their relative’s needs. With IMCA input, social services agreed to the family’s wishes to take their relative home and care for them with additional support and training with respect to manual handling.

e. Over the course of the last 5 years only a small handful of cases we have seen involved a Power of Attorney for Welfare whereas on reflection around 1/3 have had Power of Attorney for finance. A reason for this might be that an IMCA is not required where there is POA for welfare; therefore our low figures reflect this. However the relatively high number of LPAs for finance gives rise to the question as to why taking out a LPA for Welfare was not actively pursued at the same time.

f. An issue (see Q 2 response also) is that in relation to the Finance POA issue, the Code of Practice is not clear on the involvement for IMCA when it is a family or friend that has POA for finances, and the decision is change of accommodation. Some authorities still request the involvement of IMCA due to any possible conflict of interest, whilst others say that there is family and or friends and therefore the requirement to refer to IMCA is not met.

6. **Is the Act widely known and understood by professionals required to implement it? How does this differ across different sectors, such as health, social care, banking and others?**

Wired’s experience is that generally social care staff (social workers) are more aware of the Act than health workers. Wired offers awareness raising to staff. We also provide training on the MCA/IMCA/DoLS and how to carry out Capacity Assessments.

a. **GP’s Wirral:** Wired recently carried out a leaflet drop to all GP surgeries in Wirral. As a result there has been an increase in GP referrals. GP’s are also more likely to contact us for information and guidance about the Act.

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b. **GPs North Wales:** In the last 12 months only 2 referrals to the North Wales IMCA service have come from GPs. We have commenced GP practice training now and this has been well received.

c. One GP has recently expressed concern to us that there are 2 DNAR forms in operation in Wales – one for Hospitals and one for Community and this does not facilitate transfer of important information relating to DNAR decisions made in hospital by medical staff when a patient is discharged.

d. **Banks:** If a bank customer/account holder lacks capacity in relation to their finances and no appointee/LPA has been appointed, the bank will not release money or financial information to a professional body or appointee without prior consent of the client. Banks appear to have a low level of awareness regarding capacity and finance issues and making best interests decisions when someone loses their capacity.

e. **Dentists Wirral:** The Wirral dentist service has a specialist dental surgeon who carries out treatment on people with learning disabilities and dementia. This has meant that they are fully aware of the Mental Capacity Act and the IMCA service.

f. **Dentists North Wales:** A recent IMCA case involving dental treatment highlighted the almost nil referral rate from the dental profession across North Wales, this includes specialist dental surgeries (for people with learning disability & challenging behaviour brought about for example through fear of going to hospital or dental interventions.)

g. In one instance the dentist concerned was not aware that they could make the referral to the service. The practice in this instance was an NHS practise.

7. Is the Act widely known and understood by those who are directly affected by it and by their non-professional carers? To what extent does the Act provide protection and reassurance for informal carers? Has the right balance between protection of the carer and protection of the individual lacking capacity?

8. **Has the Act ushered in the expected, or any, change in the culture of care?**

   a. Professionals in majority of issues are more now more likely to take and consider risk as a first solution to a change of accommodation or medical treatment as oppose to the response of past years where only a residential or care home is the available option. Throughout the 6 counties of North Wales, it is apparent that not all professionals realise that the MCA promotes taking acceptable risk and considering the higher risk option along with others.

13. **Has the role of the Independent Mental Capacity Advocate (IMCA) succeeded in providing a voice for clients and an additional safeguard against abuse and exploitation for those who have no-one to speak on their behalf?**

   a. Safeguarding Adult referrals for adults who lack capacity should become a **statutory** requirement, and always involve an IMCA.

   b. Professor John Williams Dept. of Law University of Aberystwyth has carried out research on Safeguarding Referrals for older people in Swansea. We understand he

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recommends that referral to IMCA (possibly) in all instances where a person lacks capacity and is subject to a safeguarding referral being considered.

c. Case Example – We had an IMCA referral received for a change of accommodation decision. Person involved had a diagnosis of dementia with aggressive behaviour. P lived in mainly in his bedroom which was located on an unstaffed locked corridor. P was being assaulted by other residents, and causing assaults to other residents. Staff had also been victims of assault due to P’s behaviour. Other professionals had been involved but no specific actions had been taken to safeguard the P, the other residents or staff. The IMCA visited, and requested a Safeguarding investigation be initiated. The investigation eventually resulted in the person being moved to a safer environment. This is an example of an IMCA being pro-active and trying to ensure that a vulnerable person’s best interests are upheld.

14. Has the level of referrals to IMCAs met expectations? What are the reasons for the regional variations in the number of referrals?

North Wales IMCA

a. In Wales there is no annual report on the activity of the IMCA service. In contrast to the system in place across England (produced by DoH). This could be carried out by Health Inspectorate Wales who already produce an annual report for DoLS. Consequently there is no ‘big picture’ for IMCA activity across Wales and areas of strength and weakness cannot be identified. Wales IMCA representatives meet 3 times /year in Newtown but there is no national ‘steer’ from The Welsh Assembly.

Wirral IMCA

b. Wired monitors referrals and contacts areas where there could be improvements.

15. Are IMCAs adequately resourced and skilled to assist in supported or substituted decision making for people lacking capacity?

a. Wired would argue that the IMCA services are inadequately resourced. IMCA cases are measured as being on average 8 hours long (a figure set by the government). However this is not realistic as most IMCA cases by their very nature of being with very vulnerable people, are complex. All IMCA’s must have undertaken the DOH/City and Guilds training. Wired ensures that all IMCA’s are up to date with any training that is available. Wired has a trading arm ‘Inclusive Access’ that carries out IMCA/MCA/DoLS training?

Deprivation of Liberty Safeguards

16. Are the safeguards in the Deprivation of Liberty Safeguards (DoLS) adequate?

North Wales IMCA

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a. There is no clear definition what constitutes a DoLS and we are therefore guided by case law, and by discussions with Best Interests Assessors with whom we meet as part of a N. Wales BiA group.

b. The administration of the considerable bureaucracy which applying for a DOLs authorisation involves, and the knowledge of the DOLS process varies from one local authority to another. In contrast this process is well co-ordinated by the BCU Health Board for hospital patients subject to DoLS. There must be some potential gain in considering the formation of a single Health /Social services Supervisory Body for N. Wales with funding for BIA (Best Interests assessor) training, recruitment of BIA's and administration of all DoLS applications.

c. In one North Wales County it took almost 2 months to get a mental health assessor to carry out a mental health assessment and an assessment of capacity for a client subject to a Standard DoLS authorisation.

Wirral IMCA

d. The Wirral IMCA service is part of the MCA/MHA group which looks at how DoLS functions in Wirral. The gap for both Wirral and North Wales is of course that DoLS only covers residential/nursing and hospitals. There are a huge number of people living in a supported living setting with no safeguards.

17. Are the processes for authorisation, review and challenge of DoLS sufficiently clear, accessible and timely?
See above

20. What concerns, if any, are there regarding the costs associated with registering an LPA, or with making an application to the Court of Protection?

a. In the last 6 years only 2 referrals have been made to the North Wales IMCA service where there is an LPA for welfare. This could be due to the fact that IMCA’s are not required to represent someone who has an attorney for welfare. However, in a recent case in North Wales an IMCA was instructed to represent a client in hospital. After reading the hospital records it was discovered by the IMCA that there was an LPA for welfare. Discussions were held with the decision maker and referrer and the IMCA withdrew from the case.

21. Is legal aid available and sufficient? What impact will the recent and proposed reforms to have?

a. Wired is working towards ensuring that if the person required some legal representation then an IMCA could act as the person’s litigation friend.

Regulation

22. Is the role of the Care Quality Commission in inspecting on the MCA standards adequate and appropriate? Is there a case for additional powers?

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
a. There is a case for closer working relationships between the CSSIW (Care and Social Services Inspectorate Wales) and the IMCA service, and consideration could be given to involving an IMCA in inspections particularly where people who may lack capacity are living, such as EMI care homes.

Wales IMCA service

b. We have been involved on a case specifically around the closure of a number of care homes. There was extensive IMCA involvement and in all of the cases the transfers have been in the person’s best interests. Upon reviewing the care in the new homes, measurable improvements in terms of quality of life issues, like access to more activities, and the community, can be demonstrated.

c. An IMCA can access residential and nursing homes on a more regular basis than is available to an inspector and can highlight areas for improvement for individuals. This links back to the point made earlier that referrals to IMCA for Care Reviews for people who lack capacity and are un-befriended should be mandatory.

24. How well is the relationship with the mental health system and legislation understood in practice?

a. As an IMCA / DoLS service, Wired see practical difficulties in the crossover area between the MCA and the MHA. Part of the practical difficulties are caused locally by the award of the IMHA contract and the IMCA contract to separate agencies, although as IMCA contract holder, we also provide training on the IHMA role, part of which is training on the crossover area. Closer collaboration or jointly commissioned contracts for the IMCA, IMHA and training roles would better facilitate joint working and practical understanding.

b. In MCA / DoLS, the broad codes of practice, that are becoming dated with the development of case law, do not now fit all the circumstances in an ever more complex area. This context is perhaps to be expected, as the development of the MCA and DoLS came out of the lacuna identified in the Bournewood case; the MCA is an attempt to fill a gap with the MHA, which it does with varying degrees of success.

c. In the relationship between MHA and the MCA / DoLS, it is generally held that the MCA has primacy and the potency of the MHA and the MCA is generally well understood by practitioners seeking to achieve their own defined outcome.

d. In GJ v The Foundation Trust (2009) the relationship between Mental Health Act and Mental Capacity Act was examined. The judgment makes the important point that “it is not lawful for the medical practitioners referred to in [the Mental Health Act], decision makers under the Mental Capacity Act, treating doctors, social workers or anyone else to proceed on the basis that they can pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship with

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WIRED – Written evidence

P) that they consider render one regime preferable to the other.” This appears to be what happens in some cases, when a predetermined outcome has been identified.

e. The IMHA role, as with the IMCA role, provides a crucial counterbalance, although the practical impact of the roles is blunted by the general inertia from patchy understanding of the acts and poorly understood and bureaucratic processes.

Devolved administrations and international context

25. Does the implementation of the Mental Capacity Act differ significantly in Wales?

a. The implementation of the service does not vary. However the one difference is that there is no annual IMCA report as there is in England. The lead agency for commissioning the IMCA service in Wales is the Health board, whereas across the border in England it is the Local Authority. There is an IMCA network in Wales that meets 3-4 times a year attended by IMCA representatives from the IMCA provide for North, South, Mid and West Wales. See also response to Question 14 above.

26. What lessons, if any, can be learnt from the approaches taken to mental capacity legislation in Scotland and Northern Ireland, or in other jurisdictions?

27. Is the MCA compliant with the United Nations Convention on the Rights of Persons with a Disability (CRPD)? Are there lessons that can be learnt from the CRPD for the successful implementation of the MCA?

In the response below Wired have drawn on extracts from the UN’s own document “The convention in brief.”

a. The convention on the rights of persons with disabilities “endeavours to elaborate in detail the rights of persons with disabilities and set out a code of implementation”. Countries that join in the Convention engage themselves to develop and carry out policies, laws and administrative measures for securing the rights recognized in the Convention and abolish laws, regulations, customs and practices that constitute discrimination (Article 4).

b. The question whether the MCA is compliant with the convention is a difficult one as many of the articles in the convention go far beyond the scope of the MCA / DoLS, which came from lacuna in UK law rather than an aspirational policy development. The convention encourages countries to combat stereotypes and prejudices and promote awareness of the capabilities of persons with disabilities (Article 8). This confers a positive duty towards disability, rather than the MCA which seeks to “avoid discrimination”.

c. The convention asks countries to guarantee that persons with disabilities enjoy their inherent right to life on an equal basis with others (Article 10), the MCA code of practice instructs practitioners not to be motivated in any way by a desire to bring about someone’s death, a more sombre instruction, with no role included for enjoyment.

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d. The convention notes that all persons are equal before the law and the convention prohibits discrimination on the basis of disability and guarantee equal legal protection (Article 5). In the MCA, only those that meet the criteria can have access to a professional IMCA and there is little support available for family members who advocate on a person’s behalf within the MCA. Similarly, people assessed as lacking capacity under the MCA do not have access to justice on an equal basis with others (Article 13); very often access to the official solicitor is difficult.

e. The convention seeks to ensure that people have an equal right to own and inherit property, to control financial affairs and to have equal access to bank loans, credit and mortgages (Article 12). The MCA allows for attorneys and deputies to manage money on individuals’ behalf although the practical application of the roles can be difficult.

f. As noted in other areas of this submission, people with disabilities do not always enjoy the right to liberty and security and are sometimes deprived of their liberty unlawfully or arbitrarily (Article 14). Whilst there are generally good provisions to protect the physical and mental integrity of people (Article 17) in the MCA, mechanisms can be very challenging to individuals who already have mental capacity issues. The MCA is in the heart of guaranteeing freedom from torture and from cruel, inhuman or degrading treatment or punishment.

g. Article 16 instructs that the laws and administrative measures must guarantee freedom from exploitation, violence and abuse; the MCA legislation was a direct response to the problems in the Bournewood case. Although the MCA is not perfect, it is an attempt to fill that gap.

h. People with disabilities are not to be subjected to arbitrary or illegal interference with their privacy, family, home, correspondence or communication. The privacy of their personal, health and rehabilitation information is to be protected like that of others (Article 22). The MCA provides for information to be disclosed if it is in someone’s best interest, but a common problem is the sharing of information between professionals outside of the best interest checklist and best interest is often confused with professional opinion. Best interests is a clearly defined (albeit non exhaustive) checklist within the legislation, it is not a moveable concept.

i. Article 9 promotes accessibility; even the broad concepts of MCA / DoLS are completely alien and misunderstood by many, including some trained professionals. For a disabled person that lacks capacity in one or more areas of their lives, application of Article 9 to MCA / DoLS may be completely impossible even though a country should promote access to information by providing information intended for the general public in accessible formats and technologies, by facilitating the use of Braille, sign language and other forms of communication and by encouraging the media and Internet providers to make on-line information available in accessible formats (Article 21). Although capacity is decision and time specific, a lack of capacity is often stated in the most general and incorrect terms and too little attention is given to developing capacity or regaining capacity.
j. Article 19 states that persons with disabilities must be able to live independently, to be included in the community, to choose where and with whom to live and to have access to in-home, residential and community support services.

k. Although the MCA instructs that the person’s wishes / views and feelings take a prominent position in decisions about them, all too often those wishes are overlooked in practice. Too few IMCA referrals are generated for care reviews, as they are not an area that requires a mandatory referral to an IMCA service.

l. The MCA does balance some situations for vulnerable adults, DoLS supports the article 28 right to an adequate standard of living and social protection, and this includes public housing, services and assistance for disability-related needs.

m. People with disabilities also have the right under the convention to the highest attainable standard of health without discrimination on the basis of disability. People should receive the same range, quality and standard of free or affordable health services as provided to other persons and to receive those health services needed because of their disabilities. Serious medical treatment is specifically covered in the MCA, but routine checks are covered by reference to the best interest checklist for those that lack capacity for a specific decision.

2 September 2013

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1. Overview and Context

1.1 In its entirety the Act seems fit for purpose. However, the general feeling amongst practitioners is that the Code of Practice could be developed in certain areas. These points are discussed in more detail later.

1.2 The principles of capacity and best interests are appropriate; although there is a lack of guidance around what exactly constitutes functional capacity and the difference between functional capacity and executive capacity.

1.3 The Act formalises the decision making process and encourages practitioners to think more carefully about making decisions on somebody else’s behalf.

1.4 There is a general feeling that the Act has brought about a positive change in culture, particularly in Social Care and Learning Disability and Mental Health Nursing.

1.5 The Act encourages practitioners to record the decision making process more accurately and in more detail.

1.6 Qualified Social Workers feel that training on the Act and on DoLS pre and post qualification is too brief.

2. Implementation

2.1 There is a general opinion that the balance between enablement and protection is promoted by the Act’s implementation, but that in practice it can be difficult to achieve this balance in many situations, especially when there is a significant risk posed to a vulnerable adult.

2.2 There is often a lack of clarity about who the 'decision maker' is, or whether there are multiple decision makers and how this works in practice. The Code of Practice can be misleading.

2.3 There is a general feeling amongst professionals that those who lack capacity are better supported to make decisions for themselves than before.

2.4 Families of people who lack capacity are not as aware of the Act as they might be. This may be because many professionals do not feel properly informed about the Act themselves.

2.4.1 When the Act is explained to families of people who lack capacity, many family members still feel they have an inherent right to make decisions on someone else’s behalf; this appears to be particularly evident in families of a person with a degree of learning disability.

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Worcestershire County Council and Worcestershire Health and Care Trust integrated Learning Disability Teams – Written evidence

2.4.2 Engaging families and ‘significant others’ in the best interests process can be difficult when they do not fully understand their roles.

2.4.3 An official leaflet explaining the Act, aimed at families and informal carers of people who lack capacity, would be useful.

2.4.4 There is sometimes a lack of willingness for families to accept the implications of the Act.

2.4.5 Many families do not understand the benefits of their relative having their capacity assessing i.e. they perhaps do not understand their relative's right to make their own decision as a basic human right.

2.5 Specialist practitioners (i.e. those working specifically with people with a learning disability) feel that if mainstream services (e.g. public health, acute services) were better informed about the Act then this would disseminate down to the general public more effectively.

2.5.1 Often capacity is considered the same as vulnerability by primary care professionals in particular.

2.6 There is a tendency with practitioners and professionals to only discuss the Act with families when a conflict arises.

2.7 Some professionals do not appreciate that they are considered the decision maker in the best interests process e.g. Consultant suggesting medical treatment, or Dentist suggesting extraction via surgery.

2.7.1 There is a general lack of understanding of responsibility for completion of capacity assessments, amongst care providers/ ‘Managing Authorities’/ care agencies etc.

2.7.2 Police medical experts often do not have the skills to assess capacity, or to facilitate a capacity assessment by aiding an individual’s communication; this can cause difficulty when decisions are to be made about pressing charges and/or detention, or when ensuring the right kind of support is provided for an individual lacking capacity.

2.7.3 Often in these situations referrals are made to a specialist service i.e. the Community Learning Disability team, to assess a person’s capacity. This is often in conflict with the Code of Practice that suggests if there is a professional who knows that person well, they are best placed to assess capacity.

3. Decision making

3.1 There is a lack of clarity around determining what the specific decision is that needs to be made; it is felt that different wordings for the same decision could lead to different results of a capacity test.

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Worcestershire County Council and Worcestershire Health and Care Trust integrated Learning Disability Teams – Written evidence

3.2 More guidance is needed about section 44 of the Act, ‘wilful neglect’. It states here that it is an offence to wilfully neglect someone who lacks capacity, but it does not state which decision this refers to.

3.3 More guidance is required on how much information is 'relevant' and 'reasonable' in relation to a decision e.g. signing a tenancy agreement - is the person expected to understand every word or just the basic principles of having to pay rent and to keep a tenancy clean and tidy etc.?

3.4 Assessing capacity in relation to risk can be highly difficult in practice when considering a capacity assessment needs to be undertaken at the time a decision needs to be made e.g. a person with an Autistic Spectrum Condition may be able speak clearly about the risks of making a particular decision but it is not until they act in a risky way that there is evidence they have not fully understood the implications of the decision they have made. Practitioners would like clearer guidance for use with people with a specific diagnosis.

3.5 The role of the IMCA is mostly effective and accessible.

3.6 The use of IMCAs can safeguard against abuse in some situations.

3.6.1 This is particularly poignant where families are in conflict with professionals about what is in their relative's best interest.

3.7 There is a risk of a culture developing amongst Social and Health Care professionals of not acting when somebody is assessed as having capacity but could still be at risk or need support.

3.8 Some solicitors are not familiar with the Act in practice and will pose as Deputies for people lacking capacity with no legal authority to do so.

3.8.1 Solicitors who are not familiar with Act in practice have a tendency to give incorrect advice to families of people who lack capacity.

4. Deprivation of Liberty Safeguards

4.1 Professionals have a knowledge of the existence of the safeguards but are not always able to demonstrate a sound understanding in practice e.g. reference to 'DoLS issues' for two very different situations or risks.

4.2 There is a lack of understanding of the safeguards and how to implement them on the part of Managing Authorities.

4.2.1 This is particularly evident with regard to understanding what a reasonable restriction under the Act is and what might constitute a deprivation of liberty.

4.2.2 Managing Authorities are generally over cautious and will seek advice from Social Care and Health Care professionals when they are unsure.

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Worcestershire County Council and Worcestershire Health and Care Trust integrated Learning Disability Teams – Written evidence

4.3 Practitioners feel that they have sufficient knowledge to understand the safeguards enough to consider somebody's rights when undertaking a review of their care services.

4.3.1 The same is true when seeking a new care placement for a person who lacks capacity.

4.4 The role of the DoLS representative is not clear amongst involved professionals.

4.4.1 Therefore, insufficient information is given to the representatives themselves and they often do not understand the importance of their role, or their rights to challenge decisions on behalf of the personal lacking capacity.

4.5 The DoLS Code of Practice makes reference to using 'more than persuasion or restraint'; this is too vague and could lead to authorities not acting or using undue force.

5. The Court of Protection and the Office of the Public Guardian

5.1 Professionals feel the Court process is too long, expensive and intimidating for all involved.

5.1.1 A local board such as the tribunal process for the Mental Health Act would be a (llore accessible process.

5.2 The Court is used appropriately and often enough, most commonly to ensure people stay living at home with families where there may be risks to manage in the home, but ensuring the vulnerable adult receives appropriate services.

5.3 It is common that Court appointed Deputies for people with learning disabilities have a limited understanding of their role and this can lead to an abuse of their decision making responsibility.

5.3.1 Clearer guidance is needed for professionals who do not agree with an application to the Court for an individual to become Deputy i.e. when there may be safeguarding concerns.

5.3.2 Time scales and logistics of co-ordinating legal support are particular barriers to a challenge being effective.

5.4 There is no parity of cost to the individual for a Deputyship e.g. Solicitor's charges; for family members and local authority there is no charge.

5.5 It is concerning that it appears a Doctor's assessment of capacity is often favoured by the Court over a different professional who has better knowledge of the individual being assessed.

6. Other legislation

In order to protect individuals the Committee has chosen in some cases to remove identifying information from the submissions.
Worcestershire County Council and Worcestershire Health and Care Trust integrated Learning Disability Teams – Written evidence

6.1 Professionals' understanding and effective implantation of Mental Health legislation and its interaction with the Mental Capacity Act varies greatly depending on their individual training and specialist practice area.

7. Other observations

7.1 In relation to people who have a learning disability, assumptions are still made by many people involved in their care about their cognition and ability to make decisions; it is often assumed by key professionals that because they have a learning disability, they inherently cannot make their own decisions.

23 August 2013
Dr Roger Worthington – Written evidence

Overview and context

1. Broadly speaking I think the Act has achieved its aims. Prior to its introduction there was a major deficit in terms of the protections available to people who lacked capacity in England and Wales, and given the uncertainties as the bill went through Parliament and the compromises made along the way, this can be seen as a positive result. The decision to draw up all new legislation and not to try and model the Act on Scotland or any other jurisdiction made the challenge even greater, and overall the Act has worked surprisingly well.

2. No particular comment

3. The fundamental principles are a crucial part of the Act. They are entirely appropriate and need to be retained.

Implementation

General comment: implementation has been good, given the educational hurdle that had to be overcome by many professionals in order for the Act to be effective. The length and complexity of the Code of Practice posed an additional hurdle but the series of booklets commissioned by DH would have helped.

Decision-making

Concerns remain about 16 and 17-year olds. This cohort does not have the right level of protection and decision-making support; in my view, this policy area needs to be reviewed. Young adults fall outside the scope of the Act, yet for the purposes of consent there is a presumption that they are to be treated as adults, which implies a policy contradiction and leaves an awkward gap. The solution could require making amendments to the Act (e.g., with regard to young adults refusing medical care).

DoLS

I worry that outside of psychiatry, DoLS are not well understood; i.e., only mental health specialists know how they work implying a wider education deficit. (It is regrettable that the government chose to wait for Bournewood and did not enact these additional safeguards at the time of drafting).

Court of Protection and Public Guardianship

426 RW was responsible for doing scoping work prior to the introduction of GMC guidance for doctors treating patients below the age of 18.


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Dr Roger Worthington – Written evidence

Trained professionals no doubt understand how things work; however, the general public probably has little idea about what the terms mean or what happens when they are employed.

Regulation

22. No. 23. Yes.

Comment: the CQC has too many roles to be able to fulfil this extra task effectively. Oversight should be left to other professional bodies, as implied by Q. 23.

Other Legislation

The relationship between the MHA and MCA is complex and the cause of some considerable confusion. The position adopted by DH to allow the courts to work out the detail was no doubt expedient at the time on account of successive failures to reform the MHA; however, now would be a good time to reconsider how the Acts work together, including the how they are used by the Police.

Devolved administrations

No particular comment.

Dr Roger Worthington 428
23 July 2013

428 Independent expert on healthcare ethics and policy and consultant advisor on workforce development, Ministry of Health, New Zealand.

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