



# HOUSE OF LORDS

Unrevised transcript of evidence taken before

## **The Select Committee on the Mental Capacity Act 2005**

Inquiry on

### **THE MENTAL CAPACITY ACT 2005**

*Evidence Session No. 4*

*Heard in Public*

*Questions 74 - 105*

TUESDAY 16 JULY 2013

10.45 am

Witnesses: Vanda Ridley, Beverley Dawkins OBE and Hannah Barnett

George McNamara, Peter McCabe and Paul Farmer

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### Members present

Baroness Browning (Acting Chairman)  
Lord Alderdice  
Baroness Andrews  
Baroness Barker  
Baroness Hollins  
Baroness McIntosh of Hudnall  
Lord Patel of Bradford  
Baroness Shephard of Northwold  
Lord Swinfen  
Lord Turnberg

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### Witnesses

**Vanda Ridley**, Communications Manager, Down's Syndrome Association, **Beverley Dawkins OBE**, National Officer for Profound and Multiple Learning Disabilities, Mencap, and **Hannah Barnett**, Head of Operations, National Autistic Society

**Q74 The Chairman:** Good morning and welcome. My name is Baroness Browning and I am standing in for Lord Hardie, who is the Chairman of our Committee but unfortunately is unable to be here this morning. We are very grateful to you for giving up your time to come and give evidence to our Committee. I remind you that this is a webcast session and there will be a transcription that will be made available to you for correction in the usual manner, so that will follow on from today's session. I should also, from the Chair, declare an interest as I am a Vice-President of the National Autistic Society, which is giving evidence to us this morning. I will try to be scrupulously fair with the information. Thank you very much.

I start with a question to all three of our witnesses today. When the Mental Capacity Act was passed it was widely viewed as progressive and welcome legislation. From your perspective, has the Act lived up to its expectations, and are there benefits or problems that were not foreseen at the time that the legislation was passed? Could I begin with Vanda Ridley, please, from the Down's Syndrome Association?

**Vanda Ridley:** Yes. We think that the Mental Capacity Act has a very common-sense approach if implemented correctly. One of our concerns, I think, is around the ability of local authorities, for example, to assess correctly the capacity of people with Down's syndrome, in that it is both time- and resource-dependent. Certainly at the moment there are limitations, because of shrinking adult care budgets, for that to be able to be done adequately.

**The Chairman:** Thank you very much. Beverley Dawkins from Mencap.

**Beverley Dawkins:** Yes, we would also agree that it was a very positive and welcome piece of legislation. I think before the Act people with a learning disability were pretty routinely excluded from many decisions that affected their lives, and decisions were plainly not always made in their best interests. We think that the Mental Capacity Act introduced a very good framework for people to have much more confidence in supporting decision-making for people with a learning disability, both with and without capacity. Again, we would echo the same concerns that implementation is probably where our biggest concern is, and probably in some specific areas such as in the definition of serious medical treatments, as set out by the confidential inquiry witnesses, where maybe some clarity is required.

**The Chairman:** Thank you. Hannah Barnett from the National Autistic Society.

**Hannah Barnett:** We were a key member of the Making Decisions Alliance decision-making body when the legislation came about, and we wanted to ensure that people had a voice; that people who struggled with communication were able to communicate their decisions better. We found in many cases that this has been the case, but again, I agree with the other two that often implementation has been quite difficult, and it does appear to be reliant on different local authorities and different people in the equation to ensure that some of the stuff is implemented appropriately.

**Q75 The Chairman:** Thank you very much. Could I just pick up on the point that was made by Vanda Ridley about local authorities and assessments? Is that at the point at which an assessment is being made to assess capacity or is it when there is an assessment for other decisions to be made when they fail to identify capacity in the first place?

**Vanda Ridley:** I think it is the assessment of capacity.

**The Chairman:** That should come first before any other decisions are made.

**Vanda Ridley:** Yes.

**The Chairman:** Would it be going too far to say that, in general, local authorities, which of course make a wide range of assessments about accommodation in particular—where people live and who they live with and all of that—make those decisions without thinking first, capacity?

**Vanda Ridley:** Definitely. Yes, I mean we have a number of cases that have come to us where decisions have been made without any recourse to the individual that it involves. We have a local authority who we have challenged on two occasions where they have not involved the person or their family in a decision about a change of residence, and this is despite the knowledge, as far as we are aware, that they knew that there was capacity.

**The Chairman:** Would it be going too far to say that because of the nature that presents itself with a disability like Down's syndrome, because it is visible if you like, that they automatically tend to defer to no capacity at all when in fact there could well be a level of capacity?

**Vanda Ridley:** I think so, yes, and there is also, I would say, confusion around the idea that it is each decision that should be assessed, not this blanket policy. It is sort of cultural in a sense that people still have issues with the word "assessment" and "mental", which perhaps affects their ability to interpret the Act accordingly or appropriately.

**The Chairman:** Thank you very much.

**Q76 Baroness Andrews:** Good morning. Clearly that was about cultural change, what you have been talking about with the difficulties of implementation, but you also raised a question about the definition of serious medical treatment. I wonder whether there is scope for the Act itself to be improved in terms of any of these definitions, or indeed any of the problems of the implementation that you have identified already around the individual decision-making. Is there anything the law can do to improve implementation, shall we say? I would like to ask a supplementary about the code of practice but we can come on to that.

**Beverley Dawkins:** I think I made the point about serious medical treatments and it is one that the confidential inquiry witnesses and recommendations have made clear. But I am sure there could be greater clarity so that there is a much clearer definition, possibly on the face of a Bill but certainly in the code. It seems to be that that confusion results in less referral or very slow referral to IMCA, so obviously it places people in very vulnerable situations. We would certainly welcome clarity of definition. But again, when considering all of the code and the good practice and the training that has gone behind this Act, it seems to us that some practical scenarios and simple examples are required to make sure that people really understand the particular circumstances where this might apply. I think some of this is very, very practical, simple-steps information.

**Baroness Andrews:** If we were thinking about recommending a change in the code, would you be more concerned to see the code reflecting good current practice—because of course it was written some time ago—alongside further clarity of definitions? Is that the most useful thing you could envisage?

**Vanda Ridley:** Can I just raise a particular concern I think is alongside that? Following being asked to present here today, I had quite a long look at local authorities' own guidance to practitioners and from a layman's point of view I feel that that is adding greater complexity to the guidance of individuals who are on the ground, at the coalface or whatever, and

perhaps confuses where they feel their obligations are. The Act and the code of practice are quite straightforward in terms of the steps that should be taken. Looking at some of this guidance it seems to make it much more complicated and formal. Perhaps that is just the way that local authorities operate anyway. They are large institutions; they have to have by their very nature a structure and a formality. But I think that is a problem for people who are looking after someone in a care situation.

**Baroness Andrews:** Do I understand, then, that each local authority has the discretion of producing its own guidance and that is what they do? Have most local authorities produced their own guidance?

**Vanda Ridley:** I have just taken a sample because I just came across one and was quite surprised, so then took a sample of about eight or nine and they all had their own guidance to practitioners, and NHS authorities also have their guidance.

**Q77 Baroness McIntosh of Hudnall:** I am sorry, but could we just be really clear about what we are talking about here? There is a code of practice that goes with the Act that is designed to explain how to implement the Act for people whose job it is to do that, yes?

**Vanda Ridley:** Yes.

**Baroness McIntosh of Hudnall:** Are you telling us that local authorities then devise a different code of practice to do the same job that is specific to them?

**Vanda Ridley:** They have guidance, yes. They have guidance for practitioners in regard to the Mental Capacity Act.

**Baroness McIntosh of Hudnall:** What would be, in your view, the reason why they would not use the code of practice that exists and goes with the Act?

**Vanda Ridley:** I do not know. I honestly do not know.

**The Chairman:** That is very interesting and very helpful. Thank you very much indeed.

**Vanda Ridley:** It is incorporated within it, but they have their own guidance.

**Baroness Andrews:** Is it generic, or is it directed towards specific professionals? For example, is it directed at social workers or directed at health workers, or is it our version of a code, as it were?

**Vanda Ridley:** The ones that I have looked at are specifically guidance to practitioners, so that is from a senior social worker down to a support worker in a care home.

**Lord Swinfen:** I am just wondering if you are able to let us have copies of the local authorities' codes of practices.

**Vanda Ridley:** I have looked at Cambridge, Walsall and Gloucestershire; those are three that come to mind. I have looked at others but, yes, I can—

**Lord Swinfen:** If we could have copies of them, it would be very useful, or if they are on a website somewhere, we could look at them.

**Vanda Ridley:** They are available on the authorities' website.

**Lord Swinfen:** If you could point us in that direction, we would be grateful, because we can then have a look at them ourselves.

**Vanda Ridley:** Yes, certainly.

**Lord Swinfen:** Thank you.

**Baroness Shephard of Northwold:** Are the codes of practice different for different groups of practitioners, or are they the same?

**Vanda Ridley:** I cannot answer, sorry.

**Baroness Shephard of Northwold:** Of course, I would not expect you to be able to, but I just wondered if you had happened to notice. One is just looking at duplication, replication, confusion and layers of and all the rest of it. As far as you know this is our code of practice for the Mental Capacity Act, and as far as you know it goes at least to the professions you have mentioned.

**Vanda Ridley:** Yes.

**Baroness Shephard of Northwold:** Okay, thanks.

**Q78 Baroness Hollins:** I was just picking up on one of the recommendations of the confidential inquiry into premature mortality for people with learning disabilities, and one of the recommendations was that Mental Capacity Act training and regular updates should be mandatory for staff involved in the delivery of health or social care. The Department of Health responded by saying, "Service providers have the primary responsibility for ensuring that existing staff have the required knowledge and awareness of the Mental Capacity Act". I suppose I am just wondering whether the guidance that you have seen was of that kind of nature, which was updates for staff locally, or whether it was a kind of alternative guidance.

**Vanda Ridley:** What I looked at I felt over-formalised the process of assessing capacity and set up lots of different layers that people should be looking at. I think because of that, certainly from my point of view, it created confusion, and by that token I think it would do that to people who were trying to implement it on a daily basis.

**The Chairman:** I am going to bring in Baroness McIntosh, but I am just floundering a bit here with a senior moment, not being able to recall a certain statute. I may be being very unfair to you, but when the Autism Act was passed and the autism strategy, as part of that, was subject to a form of statutory guidance that meant that if it was not implemented as per the autism strategy, the Minister at the centre retained the power to haul in a local authority that was not implementing that strategy. I cannot remember which section that is under, but it is pretty powerful stuff. I know I am being very unfair, but I think from what we have heard we need to check which statute applies to this guidance because clearly there are different levels of implementation. I am getting bids all around the room.

**Baroness McIntosh of Hudnall:** There is one other aspect of what Ms Ridley has told us that I would certainly be interested to know. When you were looking at these various guidances, did they also vary significantly one from another? Because obviously one of the

issues that has come before us already is the variation in local application of the Act and, if it were the case, for example, that different local authorities are producing guidance that is significantly different, each from the other, then that would go some way towards explaining why there were local variations. When you looked at them, were they broadly the same?

**Vanda Ridley:** I would say broadly the same, but what concerned us as an organisation was that the emphasis seemed to be upon the decision-making being very much in the role of the social worker. We did not feel that there was enough balance and support for the initial supported decision-maker.

**Baroness McIntosh of Hudnall:** Was that the case with all the guidance you looked at?

**Vanda Ridley:** Those that we looked at, yes. Obviously we did not take a complete—

**The Chairman:** Thank you. I am just going to allow Baroness Shephard to ask the final point on this. I am sure it is something we are going to want to come back to because it has been a very helpful contribution. Then we will move on because I know Baroness Barker has a question.

**Baroness Shephard of Northwold:** I just wondered whether the panel had any experience of the operation of the Mental Health Act—probably not, but if you had, whether there was a different practice with what was required with a code of conduct between the two. But if you have no experience, that is fine. It will be a question, I know, that the Committee will want to look at later on. We raised it in our very first meeting, in fact. If you do not have the experience, it is fine.

**Vanda Ridley:** No.

**Baroness Shephard of Northwold:** Thank you.

**Q79 Baroness Barker:** Thank you very much for that previous answer; it probably plays into my question. Previous witnesses have pointed up to us the difference in understanding of the Act among different professions. People have said to us that frontline social workers

tend to have quite a high awareness of the Act, albeit perhaps under a form of guidance that we might not like, and in primary care, for example, it is not very good at all. Does that tie in with the experiences of the people you work with? Specifically, I would like to ask you what sort of training you think different professions would need in order to deal with issues to do with assessment and fluctuation of capacity in decision-making.

**The Chairman:** Could I ask Beverley Dawkins to kick off with an answer to this, please?

**Beverley Dawkins:** Yes. Based on our “Death by Indifference” campaign, working to health inequalities, obviously our perspective is very much that medical professionals are the people that we feel ourselves, I guess, most challenged by in some of the cases that we handle at Mencap. I think going before Parliament today there is an ombudsman report into the case of a young man with severe learning disabilities and a decision made by his GP in terms of epilepsy medication. I can give this to the Committee, but 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.

That is just a very current example, but we have many examples through our case work where certainly doctors do not seem to either follow the steps properly or in doing so are not fully involving family members in a way that they should.

**Hannah Barnett:** Perhaps I can add to that a very similar response, especially around the healthcare professionals who seem to be unwilling to carry out routine checks as people are getting older—for instance, mammograms, smear tests, those kinds of things that, at a certain age, they are going to need. They seem unwilling to do the tests or to seek a decision-making mental capacity assessment on someone to see where that sits and how we

can go about achieving that, as opposed to just knocking us back at the GP door, so to speak. We do struggle with that across the UK; it is not location-specific.

Then adding to that, one of the things that we often have experienced is that a parent or family member is told that the young person they care for, or whatever it is, lacks capacity full stop. It is not based on individual decision-making, so where somebody might have capacity to make a decision around healthcare needs or where they live but not the other one. Once we have gone through it once, it seems that nobody wants to go down that route again because a decision has been made quite early on, certainly when someone is quite young, for example. We have had experiences of both.

**Q80 The Chairman:** Could I just put something to you from the Chair? People on the autistic spectrum, very often some of them will present, on a good day, as though they have full capacity on everything, but one of the things about the Act is, and we discussed this when the Act went through, was that people should be allowed to make bad decisions, like we all do. But when you have somebody, say on the autistic spectrum, for whom perhaps with a new experience they are automatically going to say no to because it is outwith their concept of what that involves, using the example you gave of somebody who might be presented as needing their first mammogram, how do you balance what the Act says about being able to say no automatically, which is what I think an awful lot of autistic people would say, and needing in their best interests to persuade them that this is needed? It is not an easy question, and I know it is not going to be an easy answer.

**Hannah Barnett:** No. Basically one of the issues that we experience with our client group is that people struggle with the consequence of events. It is the very here and now: do you want apple juice or orange juice? You can make a decision. But when it comes to the impact of the decision to have either of those, they cannot process it and see it through. So this is where we struggle. We had an example recently where somebody made it very clear they

did not want to live in a certain home that they had lived in for 40 years. The family were very much, “He should stay there, as he has been there for 40 years”, and he was very clear, articulating that he did not want to do that and should he live there any longer he was going to cause quite serious harm and damage to other people. This went on to-ing and fro-ing, and, from a provider point of view, obviously the risk to us was very high that he was going to harm somebody. But what he could not say was what he wanted to do. We knew he did not want this situation, but he did not know what the alternative situations were. A lot of the work we had to do was put in the form of, “If you do not live here, this is an alternative”, but then the family were coming back in and saying, “Those alternatives should not exist because he does not know what he is saying”. That was a case where we did call in an independent advocate and it was a very successful case. It was getting quite tense between us, as you can imagine, with us speaking up on his behalf and the family speaking up on his behalf. It is crucial that professionals have training in autism and the understanding that you have to go back and check that decision but also give different situations and alternatives as opposed to, “Do you want to live here or here”, which might still not be enough information.

**Baroness Barker:** Did I understand by your answer to Baroness Andrews that you thought that there was a real need for practical simple examples? Do you have a range of examples of good practice by different professions, such as medical and social work, that could be drawn upon to be included in an updated code of practice?

**Hannah Barnett:** We have probably got a handful I could access.

**Baroness Barker:** Okay, thanks.

**Q81 Lord Swinfen:** Are families, carers and individuals who may lack capacity aware of and able to access their rights under the Act, including through the role of independent mental capacity advocates and the Court of Protection?

**The Chairman:** Who would like to start? Beverley Dawkins, can I ask you?

**Beverley Dawkins:** We would say no, generally families are often not aware of their rights and, as they become increasingly concerned about decisions that are being made, find it difficult to know how to challenge decisions. We have had quite a number of examples indeed where we have had to intervene in situations like that. 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. We would suggest that if the Act was being properly followed, that would not be particularly necessary. I think families find themselves, in a variety of ways, very much on the back foot here, even when things like best-interests meetings are called and they are invited. They tell us that, “Well, everybody else had the papers days before, we did not have the papers. We got to the meeting, and it almost felt like the decision had been made”.

We had one family report to us that by the time they got to the best-interests decision meeting they got, “Four consultants think this medical decision is the right one and, no, we do not agree with you”, and not really telling them about what they could do if they strongly disagreed. I think families feel very disempowered in this process and remain quite confused about their involvement in the decision-making concerning an adult son or daughter.

**Lord Swinfen:** Do you do any training of the families or the person with the lack of capacity?

**Beverley Dawkins:** Yes, we would. We have produced a number of resources to empower families to know their rights. We have a resource—

**Lord Swinfen:** What do you mean by resources?

**Beverley Dawkins:** Fact sheets, template letters. We have a CD with lots of resources designed particularly for parents, with films to enable them to understand what their rights are. We have also developed a resource that is called “Involve me”, which is very much

about how you can involve people, with even the most severe and profound disabilities, as much as they possibly can in decision-making. So, yes, we try to share as much information as possible. In partnership with a firm of solicitors, we produced the template letters that we give to families that say, “These are the words to use to say, ‘You need to involve me in this decision because—and these are my rights, and this is the law’”. That proves to be quite an effective—

**Lord Swinfen:** So far I get the impression that everything they are given is on paper. Do you sit down and discuss it with them so that they have a real chance to ask questions and to be given examples?

**Beverley Dawkins:** As much as we are able to. When people contact us through our helpline or we speak to them directly, yes, we are able to do that. We have had one or two very serious situations where somebody is challenging a current decision in a hospital where we have directly intervened to assist the family and advise the hospital that they are stepping out of line and what they should do in response to that situation. But these are only the circumstances we come to hear about because people have thought to call us. They may have discovered our resources on the website or asked for them through our helpline. I am sure we are not reaching anything like the number of families that it would be ideal to reach.

**The Chairman:** We heard evidence from officials at the Department of Health that they often refer to some of the materials produced by the charitable sector for families and carers. I wonder if I could invite all three of you to send us what you can by way of these draft letters or pamphlets or online information, because I think it would be quite good if we could start to look at what is out there and what is made available to families. I would be most grateful if you would do that; I think we would find that very helpful. I am just going to ask Lord Patel to come in, and then I am going to move on to Baroness McIntosh.

**Q82 Lord Patel of Bradford:** Just quickly on the whole issue of access and understanding, do you know if there are any differences for particular groups—I am particularly looking at ethnic groups—throughout the organisations in terms of families and individuals you have come across? Is there any understanding in terms of access to advocates? Is there a clear disparity or not?

**Beverley Dawkins:** It is hard to comment but my instinct, if you like, about that is that I am sure there are many families who probably have no understanding that the Mental Capacity Act exists, never mind thinking of contacting one of our organisations to ask for advice. I am sure there are large parts of the population, I would think, including families from ethnic minority groups, who historically do not access organisations like ourselves or services in quite the same number as other families and would be particularly vulnerable. That would just be my reaction.

**Lord Patel of Bradford:** Is it fair to say across the board your referral rates for minority ethnic groups would be lower than you expect?

**Hannah Barnett:** Again, instinctively I would say yes, but I do not have any statistics on it; certainly I have spent my career working in and around south London so it does seem there is a disparity between the amount of people that should be accessing the services and the amount of people that do access services. A lot of that is the language and the accessibility of English being your second language, and not having the social-network environment. With more and more stuff being online and on telephones, people need to have access to that sort of equipment to be able to dip into things. Yes, I would say instinctively as well that it is, but I do not have any statistics.

**Beverley Dawkins:** Older carers perhaps as well, because there is quite an assumption that everyone has a computer and that is not the case with quite a number of the families who access us.

**The Chairman:** That is why I asked if you could send us both sets of information. Thank you.

**Q83 Baroness McIntosh of Hudnall:** This is obviously a related point, which is about the role of the IMCAs, and you have mentioned already examples of where an advocate can be a very valuable intervention. You mentioned, Ms Barnett, the person who wanted to move, and I think you said that an advocate was used in that case to resolve a problem. Broadly speaking, do you think that the introduction of IMCAs has succeeded in doing what it was intended to do, which is to give a voice to people who perhaps find it difficult to speak for themselves and have no one else? Does that therefore provide a proper safeguard or an additional safeguard against abuse or exploitation? The other issue that we have also touched on was whether the availability of IMCAs across the country is, shall we say, variable local authority by local authority. Is there a cost issue there?

**The Chairman:** Could I ask Hannah Barnett to answer, because I can see you have an answer ready?

**Hannah Barnett:** I think in our experience where we have used an IMCA they have been invaluable and absolutely fantastic. In the case I was speaking about, we had to pay for an IMCA, which does not feel right but we did, because when you need an IMCA it is like a crisis point and what we find is a lot of these situations are at crisis. It is either health, a home move, a bereavement, something like that, so it is a real instantaneous crisis and we do struggle to get an immediate response from the local authorities, from the local team. Also, in this particular case—but in a number of other cases that we have—where people are placed out of borough, the local authority do not want to give us an IMCA for that person and they say, “Go back to the local authority who is funding the placement”, who obviously do not want to send someone across the country to give us that support either.

Where we have used them, they have been absolutely fantastic. Getting them is definitely an issue, and I think also it is important to make sure that when they do turn up they have the whole picture. Again, with autism, it is important to have that understanding that it might take more than one meeting or two meetings to really get to know somebody, to understand how they are going to communicate and if they understand the consequences of any decision that they are involved in.

**Baroness McIntosh of Hudnall:** Just to go back to something that I think came up in answer to an earlier question about the serious medical condition definition, it felt to me as though there was an implication that the definition was occasionally used or not used in order to not trigger the need for an IMCA. I have put that all upside down, but I think you get what I am trying to say. Is that the case in your view?

**Beverley Dawkins:** Yes, I think it is not identifying that it is a serious medical condition that should trigger the involvement of an IMCA. So, not enough people getting that referral would be our view. To echo what has just been said, the disparity across the country about access to IMCAs is certainly a concern. If you have the right IMCA involved in a timely fashion, who has got that whole picture, they can be an incredibly valuable contribution to that decision. But thinking particularly about people with the most profound and multiple learning disabilities who may have quite complex health needs and may be presenting in quite challenging circumstances, the time that it takes for perhaps an IMCA to understand the complexity of those issues must be very challenging for them.

Sometimes family members have commented that it has not been as helpful as they would wish because it just takes quite a lot of time to get up to speed in a challenging situation. But we have a mixed experience. Sometimes they are fantastic; other times it is very difficult getting in contact; and sometimes it is just not quite on the mark in terms of what you need to do.

**Baroness McIntosh of Hudnall:** Given your range of experience, all of you, would you say, first, in absolute terms, there are enough people who are able to act as IMCAs, or are we short of people to do the work? Secondly, is enough invested in training the people who are going to do that work so that they do not have to start from too low a base in considering some of the complex issues that they might have to face?

**Beverley Dawkins:** Again, having to answer without being conversant with all the facts, my instinct would be that there probably is still a shortage of IMCAs. In particular, given the amount of training that is needed for an IMCA involved with people who, for example, have no verbal communication and are in quite complex medical situations, I think the availability of that kind of IMCA is quite limited. It would be good to see greater investment in the training of IMCAs for people in those very complex situations, and I think people with behaviour that challenges would also be in that category so that you need to be quite a skilful person to be able to do really well in that situation.

**The Chairman:** The IMCAs come up frequently. I know you have all kindly come to give oral evidence to us today, but obviously we would also welcome any written submissions you may care to make and obviously your experience of IMCAs would be an ideal thing to receive in writing, if you do not mind. Thank you very much. Could I move on to Baroness Hollins, please?

**Q84 Baroness Hollins:** Thank you. We have heard differing views on how easy it is to assess capacity in practice, and it has been suggested that some practitioners conflate the assessment of capacity with an assessment of best interests. I wondered what your experience is of your particular client groups and people within it, the particular settings, particular professionals and how they assess capacity. How easy is it in practice, do you think?

**Vanda Ridley:** From our point of view, certainly most of our experience is at the very early stages with regard to the decision-making process moving on to best interests. That is where most of the calls come to us and the issues come to us. What tends to happen is that best interest is a first base. We have a number of cases, and I have gone through our records, where families are told that there is going to be a best-interests meeting when there does not seem to have been any assessment of capacity. There is a tendency to jump to safeguarding. Although marriage does not come under the Mental Capacity Act, as far as I understand, over the last year we have had about three cases where young people have seen a registrar or a priest, been guided and found it acceptable that they know what they are doing. Yet social care have heard about it because they have perhaps an involvement with it, and they have jumped in and called a safeguarding meeting or said that that person lacks capacity. That is, first of all, ignorance of their powers, and it is also, I think, lacking the ability to assess the situation and to assess that person's capacity. Immediately they start ringing alarm bells.

**Baroness Hollins:** Rather a paternalistic approach.

**Vanda Ridley:** Yes, it is like, "Well, you do not know what you are doing". Whatever the motive for it is, it is probably based on a fear of an issue of that person being at risk. However, it is not really within their remit.

**Baroness Hollins:** But in terms of assessing capacity, how easy or difficult do you think it is for your different groups, if you are going to do it properly?

**Vanda Ridley:** Yes, with Down's syndrome in particular, there are the issues of those who are not very able, which I think Beverley has already spoken about. But young people with Down's syndrome often have quite good language skills and so they come across as being more able than they actually are because they have learnt lots of different social cues to use. We have cases of young people who have been allowed, for example, to take out contracts

and get themselves into debt because they have discussed the fact that they are able to make that decision. Parents have intervened and said, “This is not realistic, you are not understanding the abilities of this young person”, and have had to take out lasting power of attorney to be able to get control over that.

**Baroness Hollins:** Within the wider learning-disability community?

**Beverley Dawkins:** Yes, I think the people who may trouble us most would be people who have borderline capacity or perhaps even fluctuating capacity. We have come across a number of situations where the actual assumption has been that the person has capacity. They are able to make a number of decisions about large parts of their life but when it comes to perhaps a medical decision, if assessed fully, it would be shown that they perhaps could not weigh up the consequences of their decision, so they may find themselves having consented to perhaps a medical procedure without understanding the consequences.

One simple example of that recently was a young man with Down’s syndrome who was in hospital needing heart surgery. They needed him to have a number of teeth removed before the procedure could take place. The dental team had shipped up at his bedside and said, “Okay, we are going to take you down to surgery. Is it okay if we take out six of your teeth?” And he just said, “Yes, that is fine”, and his family came back to discover that he was in enormous distress. He had had no way of anticipating what that was going to be like, and indeed they had left instructions that if there were any decisions about his treatment they should be involved.

The other thing is people assuming when people apparently refuse a procedure. A blood test is perhaps a good example of that where somebody recoils from the idea of the needle and the blood test but is not saying, “I do not want treatment for this”, or, “I do not want these tests”—they are in the here and now. We have had quite a few examples of confusion there,

again from medical professionals not then thinking, “Well, perhaps we need to assess the capacity and weigh up the best interests in the circumstances”.

**Baroness Hollins:** What about with autism?

**Hannah Barnett:** As I explained earlier, I think because of the complexity of autism often the assessment of a person is done very quickly, so it could be a good day, it could be a bad day for somebody, and the language the person uses or even the colour jumper someone is wearing will have an impact on what that decision is. We believe there is real need for better understanding of autism for the people who are going to come out and do the assessments, but equally around who is triggering the fact that an assessment needs to be done, because often we find that has been us, as opposed to anybody else, and if a provider is not as conscious as we are, I would be concerned that sometimes nobody is flagging up that there needs to be an assessment or a best-interests meeting and something has just happened.

**Baroness Hollins:** It just seems as if there is a huge training and advocacy role. Beverley, you spoke earlier about the work that Mencap does, and we have heard from all of you about the work that you do to provide information, support and advocacy. Who should be doing this work, and what if, for example, Mencap or any other organisation in the third sector could not afford to do it any longer? What would happen?

**Beverley Dawkins:** Well, I think there is a huge over-reliance on a very financially stretched third sector in this regard because I think we probably all—I am sure all organisations do, too—find ourselves trying to plug some of the gaps and holes. Producing these kinds of materials and resources is an expensive and time-consuming business so, no, I think there is too much reliance perhaps on us to do that. Having said that, we are very close to the families and the client group and so we do understand very well the way these materials need to be produced. I would perhaps suggest that it is in partnership that these materials

need to be produced but perhaps the third sector could be better funded in order to be able to produce these materials.

**Q85 Lord Alderdice:** You have mentioned on a couple of occasions now problems of doctors not understanding either capacity itself or the Act. I wonder if I could press you to tease it out a little bit. There are at least three groups of doctors that would come to mind: one would be general practitioners in primary care, second would be psychiatrists who might be involved, and the third would be other specialists. You mentioned particular operative procedures and so on. Do you notice any difference with these three groups in the deficits of their understanding of assessment of capacity or indeed of the Act, or is it fairly much right across the board?

**Beverley Dawkins:** I think psychiatrists would be better placed to understand these issues and may indeed take a role in helping those other doctors to understand the issues here. Our concern is probably equally spread between GP and acute hospital doctors. I think the GP level is an area that might be somewhat neglected. It is very easy to think about these very serious decisions made by perhaps a consultant in an acute hospital but the day-to-day decisions made by a GP, for example, weighing up whether somebody should have a blood test or their blood pressure taken, are a very important step in protecting them from serious conditions developing later on.

We had a very sad case of a young man who eventually arrived in an accident and emergency department with very serious kidney failure, as was discovered, and he had never, ever had blood taken. He was quite severely autistic and everybody said, "Well, he just does not like needles", and he would not have his blood pressure taken. If that GP had thought, "Is it in his best interests to think about how we can enable him to have it?" perhaps that might have been prevented. I think those very day-to-day things that do not seem terribly serious at the time but in the long run might prove to be so are an important part, yes.

**Lord Alderdice:** Thank you very much.

**Q86 Lord Turnberg:** You spoke earlier about carers and families feeling disempowered. From the practitioner's point of view, do they have a reluctance to involve the carers because of their fear that they might be betraying confidences? Is there a barrier there or does the Act cover it?

**Vanda Ridley:** I think there is an element of that, certainly—they feel that they are acting in the best interests of the individual, but there seems little common sense. For example, again, for people with Down's syndrome, and this is across the board in a way, they have difficulties with diet and weight and making healthy eating choices. As a result, we have a number of cases, again when people go into supported living when they are allowed to make a decision about eating six pies for their lunch or eating in a very unhealthy way. I am sure it would be the same for both Beverley and Hannah. Instead of looking at it in a normal practical way, which is creating an environment whereby healthy choices can be made with regard to diet, there is an element of teaching in there, of creating the right environment. It is just, "Well, that is their choice". It is very simplistic, so they are allowed to make their own choices and their health and welfare suffer as a result. Then families feel the need to intervene and to take action.

**Beverley Dawkins:** In our experience, sometimes confidentiality has been used as a barrier to families becoming involved. So perhaps somebody is living in a residential care setting of some sort and the family are highly involved in supporting their son or daughter as much as they can; when they have wanted to question, or challenge, or just find out information about the way their son or daughter's finances are being used, they are sometimes told, "Sorry, that is confidential". We have advised, in a couple of circumstances, that the support and involvement of the family member was very likely to be in that person's best interest, although you can understand some of the circumstances where maybe a small number of

families may be excluded from some of that. But if you follow the steps in the Act and the code and properly consider those issues, you perhaps would come to the conclusion that it was in the best interests of that person for the family to be very involved and to be party to that information. I think some families feel that confidentiality is used as a way of shutting them out.

**The Chairman:** Is there anything you could change in the Act to improve that?

**Beverley Dawkins:** I do not think I can answer that here and now, but certainly we could consider that for our written—

**Lord Turnberg:** Do you think that the code of practice and the Act are okay? It is all a matter of balance and judgment at the end of the day, and that suggests to me that it might be the training that is needed rather than the Act. Is that a—

**Hannah Barnett:** I think it is about interpretation and the training when you train staff out there at the coalface, and then how they interpret that. People can use that in the two examples that were given around finances. It goes back to bad decision-making—you know, you could eat six pies maybe for the first week, you feel a bit sick, you have no money left and then you learn. But sometimes people try to jump in earlier rather than allowing people to make bad decisions. I think the training is definitely an area that could be improved for people, and then how that is interpreted and what the role is of the direct support worker, the families, the actual individual, the local authority and who holds what role and how it all comes together. I would put the stress on better training.

**Lord Turnberg:** Right.

**The Chairman:** Thank you very much indeed. As a very poor Chairman I am allowing things to overrun, so if you do not mind, I am going to have to move to Lord Patel now. Thank you.

**Q87 Lord Patel of Bradford:** I am going to take the focus on to the deprivation of liberty safeguards. As you are aware, this came later on from the passage of the Mental Health Bill. Many have described conflicting views about it but as you may have read in some of the evidence from the Department of Health transcripts, they were quite clear that they felt the DoLS were an empowering element and that the problem, if any, existed with people focusing on the deprivation of liberty as opposed to the safeguards that were there. In your experience, do you agree with that assessment?

**Vanda Ridley:** I do not really have any experience of that, I am afraid.

**Beverley Dawkins:** I think that the deprivation of liberty safeguards are quite hard to understand, so there is poor understanding. Just to start with those words, “deprivation of liberty”, seems to set them off on the wrong foot. When you take the time to understand them and see that they are very much designed as a safeguard, you can see that they have great value—indeed, they were partly generated because of the Bournemouth case and all of that, which was obviously extremely concerning. But they also get misused, and so again, families’ perception can be that they are a way of restricting sometimes their access.

Through the work we have done on the Winterbourne area, we know that people who are in assessment and treatment units sometimes have restricted access to their sons and daughters with DoLS being the reason why. So I guess this is poorly understood, especially by families. I think there was something also about the consideration of the least restrictive means of having to deprive somebody of their liberty. We have seen, certainly through the Winterbourne work, an incredible overuse of restraint and restrictive practices in the seclusion of people who may not be necessarily even detained under the Mental Health Act, and they may not be properly within the DoLS framework either. I think there are a number of problems there.

**Hannah Barnett:** I would agree and I think one of the issues that we come across in practice is that, again, applying for deprivation of liberty is very much led by the provider of the service and not by any external agent, so the safeguarding aspect lies very much with the provider until potentially an issue has occurred. Within the legislation and again the interpretation, it is quite hazy; there is no minimum benchmark as to what is acceptable and what is not acceptable. So, again across the country within different service providers the interpretation is very much dependent on a good manager saying, “Hang on a minute, this is what we need to do and this is why we are doing it”, and then flagging up to perhaps the local authority, “Can you come in and check this and where do you think we are?”

Within our organisation we have been quite proactive in doing an assessment of needs around deprivation of liberty and around someone’s kind of lifestyle and whether we feel at any point we are doing that kind of thing. It has been a really good bit of legislation for us to check our own practice out and to look at some of the stuff we are doing. But equally, the onus is very much on the provider, I feel, and that has not been implemented by the interested parties.

**Lord Patel of Bradford:** Would you change anything, either of you, if you had an opportunity to, in respect of—

**Hannah Barnett:** The deprivation of liberty is my particular interest. The deprivation of liberty does need some clarity about what is acceptable practice but it is so difficult to do. For example, if somebody was accessing the community and going out, what would be a minimum benchmark of what people think is acceptable? It could be that somebody goes out once a week. But to do that takes a week of build-up and a huge amount of resources and staffing and transport and things like that. That is really positive as opposed to, “They have only been out once a week”, which is a really negative thing. Because of the complexity of people who would fall under this legislation, it would be really difficult to set a benchmark.

But it is something that potentially should be looked at, around where that barrier is turning into unacceptable practice. I believe it sits with a manager, but nobody else is really checking out the manager's practice. Obviously we do our own self-audits of our own services so that we have those opinions of whether what we are doing is appropriate.

**The Chairman:** Thank you very much indeed. Could I ask Baroness Shephard if she has a question to put?

**Q88 Baroness Shephard of Northwold:** Yes. All your organisations provide some form of service to people who may lack capacity—support groups right through to care homes. Do you want to add anything specifically from the perspective of being a service provider? The thing that interests me is recruitment of carer staff, for example. Are there any difficulties in finding suitable people and are there differences between urban and rural areas in supply of suitable people? In particular, in rural areas what difficulty is posed by access? When I say access, I mean people getting about.

**Vanda Ridley:** We do not provide services in the way that Mencap and AS do. However, going back to a point that was made earlier by Baroness Hollins about training, I think not just training but consistency of staff is the issue, because it is the relationship, the knowledge, the building-up of that knowledge that is important in making decisions about capacity.

**Hannah Barnett:** I think one of the challenges and the barriers has been, and probably will always be, the actual salary that we can offer to people at that level. Therefore, the salary we are offering determines the kind of person who is going to apply for a role. I started out 20 years ago and always wanted to do this kind of work, but the salary has probably gone up about £1,000 in 20 years.

On top of that, there has been so much legislation that has been added on top, such as what we are talking about today and deprivation of liberty, risk assessments, Health and Safety Acts and various Acts like that, that a person of entry level coming in to be a support

worker does not necessarily have that skill set behind them already. English might be a second language, they might not have finished school, their literacy skills might not be that great, and now there is so much training we expect as mandatory. Obviously we should do, but it is about getting the right balance in finding somebody who wants to work for that kind of money and has the skill set to interpret a lot of this legislation and apply it appropriately. Getting that balance can be very difficult and in rural areas it can be even more difficult. But the advantage in some of our more rural environments is that we do seem to retain staff, which does give consistency. In some of the bigger cities, where we are just turning over staff the whole time, you do not get a level of consistency, but you might then get a higher calibre of staff at entry level.

**Baroness Shephard of Northwold:** That is interesting. But in rural areas, of course, the person has to be able to afford to get to the job.

**Hannah Barnett:** Yes, and then once you are there you can get out and about and there is not one bus a week that is allowing people to get into the community.

**Baroness Shephard of Northwold:** Thank you very much.

**The Chairman:** Thank you very much indeed. I think we have just one final question, which is specifically for Mencap from Baroness Hollins.

**Q89 Baroness Hollins:** Yes, quite a focused question. It is about the work you have done on death by indifference and the follow-up you have done. Do any of the cases you have been involved with meet the threshold of neglect or ill-treatment in Section 44 of the Mental Capacity Act, and, if so, are you aware of any prosecutions under that provision?

**Beverley Dawkins:** Yes. This has come up in a number of ways recently. There was consideration given following the Winterbourne events of charging people under the Mental Capacity Act, but eventually it was decided to charge them under the Mental Health Act, in

fact, as it was in the recent Doncaster Solar Centre case where, again, they were charged under the Mental Health Act.

The only recent case we know of is the one referred to as the Hesley Village case where sentencing took place on 8 July, where a member of staff was found guilty under Section 44 of the Mental Capacity Act. The victim had been punched four times in the head by a care staff member. Although they were charged under the Mental Capacity Act we were concerned that the staff member only received a community sentence and the behaviour that challenges had been seen as a mitigating factor when the judge passed a sentence. So, we were pretty horrified by that, I would have to say. I have a paper that I would like to give to the panel, written by a lawyer who was weighing up some of the death by indifference cases—for example, the case of Martin Ryan and whether, under the Mental Capacity Act, wilful neglect might have applied. Generally he was setting out in his paper that it was incredibly hard to prove wilful neglect in those cases.

The only thing I would like to add there is that beyond criminal convictions we have been very disappointed by the failure of the GMC to take to tribunal at least three cases that we have referred to them where doctors have, in our view, failed against the Mental Capacity Act. Indeed, probably in the eyes of the ombudsman they have failed within the Mental Capacity Act. But they have not reached the point where any doctor has been given any sort of sanction, and that I find quite concerning, in that these are, in our view, unlawful actions and they do not seem to be met with appropriate sanctions.

**Baroness Hollins:** It is quite shocking. It is a lack of understanding of what challenging behaviour is and what measures a provider needs to put in place to protect both the user and the staff member, is it not?

**Beverley Dawkins:** Exactly.

**The Chairman:** Thank you very much indeed. Could I thank all three of our witnesses for attending and answering all the questions today and, of course, repeat the invitation to you to not feel this is the end of your role in our inquiry. Please feel free to contact us at any time but particularly to make any written submissions, and we look forward to receiving the literature that we discussed earlier on. Thank you all very much.

### Witnesses

**George McNamara**, Head of Policy and Public Affairs, Alzheimer's Society, **Peter McCabe**, Chief Executive, Headway, and **Paul Farmer**, Chief Executive Officer, Mind

**Q90 The Chairman:** Good morning. Thank you all very much indeed for coming along to give evidence to our Committee this morning. I am chairing the Committee today—I am Baroness Browning—because our chairman, Lord Hardie, is unfortunately unable to be with us this morning. But a very warm welcome, and I am sorry if you have been kept waiting beyond the time we had hoped to start this session. Could I just remind you that this session is webcast, so it is being broadcast live, and there will be a transcript that will be sent to you for the usual procedure, with any corrections or alterations that you may wish to submit.

Could I begin by asking the first question of all three of you? That is, at the time the Mental Capacity Act was passed it was widely viewed as progressive and was a welcome piece of legislation. In your opinion, has the Act lived up to its expectations, and are there benefits or problems that were not foreseen at the time the legislation was passed?

I have just realised, Mr McNamara, I must declare an interest as vice-president of the Alzheimer's Society. Having got that on the record, perhaps I could ask you to start.

**George McNamara:** Thank you very much, Chair. Our view is that the Mental Capacity Act has not lived up to its expectations. In theory we think it is absolutely right in terms of producing a framework, but in practice we are not convinced this has worked most effectively to benefit people with dementia and particularly their carers as well. I think in terms of going forward and looking at some of the key areas, quite clearly for us and what we are picking up in terms of our supporters has been a lack of awareness and understanding of the Act, and that is in two main areas.

The first, in terms of the health and social care staff profession, but also secondly, and increasingly in terms of the contact we are having, is with carers and family who are affected by loved ones who have dementia as well. So, we think that needs clarification around the purpose of the Act, but also a real raising of awareness of how it can work and the benefits of it in practice can make a real difference.

**Peter McCabe:** Hello. I think our view is that the Act has generally been well received but, as with all things, you can make it better. The specific suggestions that we would have there would be to simplify the guidance on best-interests decisions; to create brain injury-specific independent mental capacity advocates with a real understanding of brain injury—that is a very specific condition—to ensure that mental capacity assessments are performed by appropriately trained staff, particularly staff with an understanding of brain injury; to simplify the process for appointing deputies; and to require more regular supervision. We have a real concern about how that is going, and we think there is a need for further training and clarification for medical professionals because, although generally we feel it has been well received, there is a significant difference between best practice and what we hear about from service users, which is worst practice.

**Paul Farmer:** Thank you. I think, like other panellists, we would agree that the Mental Capacity Act was a good piece of legislation. It promoted an enabling and participatory approach, and it created the prospect for a much more level playing field, if you like, in terms of the rights that individuals had in these often very difficult situations. So, the principles that were clear and very straightforward, including this presumption of mental capacity, I think were real positives.

Like others, I think we would also agree though, that there have been real challenges in the implementation. I think there are particular issues around the deprivation of liberty safeguards that I am sure we will get on to later on. I suppose, in particular in the context of

people with mental health problems, there is a question of the interface between the Mental Health Act that was passed subsequent—or the latest iteration of it—to the Mental Capacity Act and the Mental Health Act. Particularly from the point of view of both health and social care staff but also patients and their families, I think that has created a kind of gap in terms of the levels of understanding, but also an easy and effective pathway to both information and also to advocacy.

**Q91 The Chairman:** Thank you. When you are assessing a person, is it the case, then, that the Mental Health Act as now constituted provides—I will not use the word an “easier” route, but is it more straightforward and less time-consuming in terms of, say, an assessment of somebody than to go into the capacity where there may well be just not a “yes or “no” answer but a fluctuating capacity in some areas? What I am trying to get at is: is it the soft option to go down the mental health route rather than the time-consuming assessment of someone's capacity?

**Paul Farmer:** I would hope that the Mental Health Act was never seen as a soft option. I think it would also always be seen as a last resort and there are very appropriate safeguards wrapped around mental health legislation to try to make sure that is the case. I suppose it is conceivable that, in an environment where mental health legislation has been applied by health professionals over a much longer period of time, some professionals will be more used to the administration of it and so there will be a greater degree of usage of it.

Perhaps where there has been an underestimate is the underestimation of the culture change that has been required in terms of thinking about the nature of the interaction between the staff and the individual and their family. So, it is not so much that it is necessarily an either/or, but I think it certainly created a real challenge for staff in terms of changing some of the dynamic. When it comes to mental health legislation, for some health

and social care professionals the question for them is about which route is the best and most appropriate route for them to use. That is building in an additional layer.

For individual patients and families, at the moment the access to appropriate information and advocacy is not joined up, so your entitlement to advocacy comes in at different points, and often there is no reason why anybody who has not had any contact with the whole question of mental capacity or mental detention under mental health legislation should know which is the right group for them. So, there is not a straightforward explanation of what each Act means and what individuals' rights may be under each particular piece of legislation.

**Q92 Baroness Andrews:** We have heard quite a lot from witnesses about the challenge of the culture of change and the difficulties of implementation. One of my questions is: do you think that there is something we can do about the Act itself and the definitions, for example? I think, Mr McNamara, you talked about clarifying the purpose of the Act. Can you expand on that and give us some ideas about it?

**George McNamara:** I think that there is already the code of practice that is in place, and it is raising awareness about that document. It is quite a weighty document in itself for the lay person to wade through it and fully understand it. There must be more simple ways of doing that. Secondly, the key thing we would look at is deprivation of liberty safeguards and having a clear definition of what that means. I think they are two of the key things we would like to see.

**Baroness Andrews:** You used the term “simplification” a couple of times in your evidence. Do you think it is possible to simplify either the code or the definitions in the Act in some way as to make it more easily implementable?

**George McNamara:** I think there are two sides to that coin. One is making sure it can be more easily read, and that there are explanations as well. But I think the other side of that is having access to advice—specialist advice—so, for example, where questions may arise as a

result of reading the code of practice, that there is easy and accessible access to answering those questions, where at the moment there does not seem to be that.

**Baroness Andrews:** A further refinement, if I could ask your two colleagues, of the code of practice would be welcome: do you think it could be done effectively?

**Peter McCabe:** I think to simplify guidance would be helpful to enable people to know specifically where they stand. But then there is this whole issue of training. You can clarify things and make it as simple and easy to follow as possible, but if people are not given the time to understand the concept of what you are driving towards, then they will not do it. We find carers of survivors of a brain injury often find that they end up knowing more about the Mental Capacity Act than some of the staff that they are dealing with, and they are having to explain that to them. That surely is not right, and that has to be addressed, I think.

**Baroness Andrews:** Very interesting. May I follow up with just one question arising out of this morning's evidence which took us slightly by surprise? We were told that local authorities are also producing their own guidance and it is not statutory guidance in the sense that some guidance is, clearly. But this is supposed to be helpful advice for the practitioners who are implementing the Act on the ground. Have you come across that? We were conscious that we were receiving evidence that there might be a layer of confusion being introduced by local authority guidance, either because it was inconsistent between authorities or inconsistent between professional groups. We would like your comments on that, if you have experience of it.

**Paul Farmer:** I am not aware of that, although it would not surprise me on two grounds. First of all, local authorities do have some responsibility around the commissioning of advocacy in this area, and so you would expect them to want to try to interpret it. But I think it maybe points to a gap, and where there is a gap then different people will seek to fill that gap. Just to very briefly come back, if I may, to your earlier question about the code, I

think perhaps a particular area where clarity would be helpful would be in the definition of deprivation of liberty, and having a clearer definition of deprivation of liberty that relies on criteria that are more easily identifiable so it is easily applicable for frontline staff, I think could really help.

**Baroness Andrews:** Thank you very much.

**Q93 Baroness McIntosh of Hudnall:** Can I just follow up that particular point, because I think we have heard now several times from different witnesses that somehow the deprivation of liberty definition is unclear? Given that you have clearly given a lot of thought to it, can you see how there is a way in which the clarity that you seek could be written in, or is it one of those intractable problems that lots of people have bent their brains around and have not yet come up with an answer?

**Paul Farmer:** There are certainly areas where I think we can help. We were involved in the construction of this as part of members of the Making Decisions Alliance many years ago, so we understand the complexity around this issue and I know you have heard from other witnesses around this. But, I suppose, the advantage with looking at this legislation at six or seven years into its implementation is that you can draw on the experience of people on the frontline to help create that clarity.

What we hear is that it is the frontline staff who find that current definition quite unclear. I think it would be helpful to see an objective test that relates to the arrangements for the person's care rather than how they present. We have certainly heard of instances where a person has stopped objecting to arrangements for their care, so the DoLS authorisations have been lifted but the arrangements for their care have not changed. So, the DoLS test needs to be applied quite objectively, I think, on that.

So, there is something about the definition, but then there is also something about the guidance around the application, and I think that is where the code and, indeed, any more

consistent guidance that might be produced for or by local authorities will be important, because I think that area is where we have certainly seen that has fallen down.

**The Chairman:** I am going to ask Lord Patel to come in here because he has a question that is related to this, and we will take it now.

**Q94 Lord Patel of Bradford:** It was interesting, Paul, because you described the Mental Capacity Act as an enabling a participatory approach into use. Others would argue that the DoLS—and I think you have begun to argue that—probably has not had that enabling approach. Yet the Department of Health very clearly, in the evidence they gave us, said it was because of the focus that people had honed in on the deprivation of liberty bit and had not focused enough on the safeguards bit, and they felt that it was going in the right direction. You obviously clearly would like to change some things, but do you agree with their assessment?

**Paul Farmer:** I think quite often the word “safeguards” is left to one side, so I think there is some validity around that, and often the nature of safeguarding is not sufficiently emphasised. So, we know that when the safeguards work well they encourage the staff and the service providers to think about the restrictions that are being placed on that individual. So, they are placed on that individual in a minimum way, and I think that is a positive way to encourage staff to think about the application of this.

So, rather than think about this as being one of the times when you deprive someone of their liberty, you think about what are the safeguards that you should be putting in place. So, there has clearly been an emphasis around this. I think sometimes staff think that because they are providing care and acting in the person's best interest, they must not therefore be depriving the person of their liberty.

It comes back to my original point about the quite fundamental culture change that the capacity legislation requires for some staff who do not necessarily think about the patient as

an active participant in their families, an active participant in care. Certainly, work that was done for the Mental Health Alliance by Roger Hargreaves found that this kind of reaction was something that they have found among staff. For those safeguards to be effective, the deprivation of liberty aspect needs to be clear.

**Lord Patel of Bradford:** You would not go as far as to say that we should change it and go back to the guardianship in the Mental Health Act?

**Paul Farmer:** I am conscious that you are currently looking at the Mental Capacity Act, and I am tempted to have a longer discussion about the interface between the Mental Health Act and the Mental Capacity Act, because I think it does particularly have a role in the context of people with mental health problems. There were certainly some aspects of guardianship that I think had real strains. There is, however, a wider population that could potentially benefit from the deprivation of liberty safeguards, so one would have to weigh those two issues are quite carefully.

If you allow me just to make a very brief comment on this, in the longer distant future, we would encourage a quite careful reassessment of the interface between mental capacity and mental health legislation. We would not necessarily encourage you to be doing that now, because both pieces of legislation do need time to properly bed in and be applied. Our position, in a sense, would be unchanged, that there would be a great virtue in looking at a capacity-based mental health legislation, but I suspect that is not a task for this Committee but it may be something you might want to consider as a future recommendation for a further committee.

**Q95 The Chairman:** Thank you. There was a lot of discussion at the time as to exactly where to plug the Bournemouth gap, and it was decided eventually that it would be plugged in the Mental Health Act. I suspect that discussion still goes on. Do you feel the Bournemouth gap has been plugged adequately?

**Paul Farmer:** No, I think the message that is coming clearly from many places is that the gap is not sufficiently working. Conceptually, legislatively it looks like it has been plugged but in terms of practice it does not look as though that has really worked. We already have a number of different Government Departments with an interest in this particular area. The Department of Health and the department for justice have an interest. We also see local government having a role, and I think that is clouding the issue when it comes to effective implementation.

**Lord Patel of Bradford:** Are there any issues with brain injury and deprivation of liberty safeguards at all?

**Peter McCabe:** I am not aware of there being major issues in that area.

**Lord Patel of Bradford:** Just to pick up from what George said about seeking advice on the code of practice, when the Mental Health Act Commission existed, besides all the commissioners that went round to hospitals, we had this staff team who were administrators who used to answer the phone all the time. If any nurse had a problem or issue about the code of practice, they would pick up the phone and talk to the administrative team, who spent all their day looking at issues about the Mental Health Act code of practice, and they would have an answer. If something like that was available, do you think you it would plug the gap in terms of understanding or simplifying this code of practice issue?

**George McNamara:** I think it would go some way. From our own Alzheimer's Society helpline in the last year, just on the Mental Capacity Act, we had over 2,500 enquiries just from people concerned with dementia.

**The Chairman:** Thank you. Before I move on to Baroness Barker, could I just ask you what I asked our previous panellists, all from the charitable sector? That was, if your charities produce resources and literature that are used to advise parents, carers and others, we would be very grateful to receive them, either in electronic form or hard copy, because

we are very interested to see what the charities are doing to help, advise and give information to people. Thank you very much. Could I move on now to Baroness Barker, please?

**Q96 Baroness Barker:** Hello. Today, as with witnesses on other days, you have already highlighted for us that there are different professionals having different levels of understanding in practice of the Act. From what we have gleaned so far, people seem to think that frontline social workers probably have a fairly good understanding and awareness of the Act whereas different medical staff, and in particular GPs, tend not to. Also, Paul, I was interested in your comment about settings where people are familiar with the mental health legislation already having a bearing on their conduct and what they do. In view of all of that, do you see a need for training and different sorts of training for different professionals in order to get this Act implemented in the way that it was envisaged it should be?

**George McNamara:** I think training and awareness is absolutely vital. When you look at the number of LPAs that are being issued, if you look at the split between the property and finance and health and welfare, there is quite a distinct difference. I think only 20% have been for health and welfare between 2007 and 2012. It has been quite interesting, because the work we have been doing with particularly the financial sector, they have now recognised this is a growing need, particularly for their customers, in terms of providing a service that protects savings but also enables protection against fraud as well as access to financial services.

The work we are doing is being driven by the financial services looking at dementia-friendly financial products, of which this LPA is one aspect. A survey we did a couple of years ago found that three-quarters of respondents thought that bank staff needed a better understanding of what a LPA is, so it is not just within health and social care. It goes beyond that. There are examples we can provide in addition to what we have already submitted.

I think in terms of health and welfare, again what we are finding is that carers are being asked, for example, to make decisions and they are unsure themselves what their remit is. So, there is need to have clarity around training in health and social care and particularly when looking, for example, with dementia around fluctuating capacity where it is looking in the best interests, not necessarily solely around what safeguarding should be.

**Peter McCabe:** I think you mentioned frontline social workers having a good understanding of the Mental Capacity Act or being seen to. Our difficulty is that they do not seem to have a very good understanding of brain injury. We do not fit into the boxes, the silos within an adult social care department, so very often our service users are neglected and there are so few social workers. There is an excellent brain injury social worker group, but they are tiny. We constantly try to encourage local authorities to undertake training of their staff so that they do understand those issues. I think another issue with social workers is that a lot of our clients say they very rarely see them and have little support for adult social care from social workers, so there are big issues there.

But coming back to the issue of training, do they need training? Yes. Do other professionals need training in the Mental Capacity Act? Yes. It needs to be right across all the groups that are involved in meeting the needs of our clients.

**Q97 The Chairman:** When you have somebody who is severely brain-injured, say, for example, as a result of an accident, but they make progress, how would you feel they are dealt with when they may not have capacity or they have very fluctuating capacity but need every opportunity to make progress where they may regain almost all of their capacity? How is the Act working in respect of people who have the potential to regain capacity?

**Peter McCabe:** I think the answer to your questions is in many cases it would depend on what part of the country they were living in as to the kind of response they got.

**The Chairman:** Are you able to elaborate at all where it is a good place to live or a bad place to live?

**Peter McCabe:** I think there are more bad places to live than good places. There are some excellent examples of community-based services for survivors of a brain injury. They are increasingly under threat from all the changes that are taking place and it is seen very much as a small special interest rather than something that should be provided mainstream. But I do have some experience specifically of a case where a gentleman who was deemed to lack capacity at one point subsequently was assessed as having sufficient capacity to take on the role of looking after his own finances. He had a very substantial settlement from a personal-injury claim that followed the injury that he sustained. He has done that very successfully. There were obstacles along the way but the understanding I have is he did not have a great deal of support during that process from adult social care but an enormous amount of help and support from his wife, in particular. The burden fell very much on her.

**The Chairman:** Thank you very much.

**Q98 Baroness Barker:** Are your organisations involved in delivering training on the Mental Capacity Act?

**Paul Farmer:** Yes, we do some of that and our sense would be that there are three layers to consider this. There is what I would describe as the frontline staff culture training session, which is to really imbue that idea of supported decision-making and safeguarding. It is not necessarily about the technical aspects of the legislation, but it is about the spirit of the legislation. It is what the principles of the legislation were originally designed to create, an environment where people are able to make as many decisions as they can for themselves but there are occasions where that is not possible. That kind of culture training is really needed.

Then, secondly, there is a layer of training for those people who are involved in the decision-making processes—who are they, where to use the legislation, particularly the point you have made, Baroness Browning, around the nature of fluctuating capacity and how you manage that in individuals, which will certainly occur in people with mental health problems, conditions such as MS and so on.

Thirdly, there is a layer of training for people who are involved in both mental health law and mental capacity law to support them in being able to use each particular piece of legislation in the most appropriate way and to recognise that there are both benefits and dis-benefits to each particular form of legislation.

We would see this as a layered approach. Of course, wherever possible, it is obviously best if you can encourage that training to be taking place in a multi-disciplinary context so that the social workers who maybe get this a little bit more are able to share their experiences with clinicians. Quite often that multi-disciplinary approach can help to break down some of those barriers.

**Q99 Lord Swinfen:** Are families, carers and individuals who may lack capacity aware of and able to access their rights under the Act, including through the role of independent mental capacity advocates and the Court of Protection?

**Paul Farmer:** Not sufficiently, in our view. I suppose my initial point is that most people who are engaging with this situation in the context of their family or loved one probably do not even know the Mental Capacity Act exists. There is an information gap in terms of their engagement with the services. We have seen some very good practice. A number of local Minds run advocacy services, but they are often extremely tightly funded and susceptible to funding cuts going forward, and because of the multi-site nature of those areas where capacity legislation could conceivably apply it is quite difficult for advocates to get themselves around so that they are able to be present at the right point.

I suspect that may be one of the reasons why you are finding that local authorities are producing guidance almost to try to fill that gap. We certainly would like to see a more joined-up approach to commissioning of advocacy.

**Peter McCabe:** I would agree with Paul. There is not sufficient access.

**George McNamara:** Yes. The increasing numbers of enquiries to our helpline—just on the Court of Protection aspect, there are two things that we are picking up. One is that it is quite expensive; £400 then plus any additional legal fees as well. Also, it is quite slow in terms of the decisions to do that. One of the examples that we have had in terms of accessing information and guidance was when somebody responded to us by saying that they received the deputyship certificate last week but do not understand what they are meant to do next. Is the COP going to send any guidance regarding how to use the certificate to sort out Dad's finances? That is just one example really where people are looking for further questions beyond what has been provided.

**Lord Swinfen:** What training do you do of your staff and of those people who suffer from mental incapacity?

**George McNamara:** From the Alzheimer's Society's perspective, we support providers on dementia awareness training for specialists but also for wider sectors—for example, as I have talked about, the banking sector. So we provide it from the dementia perspective to make sure that it is part of a holistic training package, and is not just seen as a separate addition because it needs to be integral, given the high number of people with dementia who are using the health and social care system and also other services as well.

**Baroness Andrews:** Do any of you know whether the networks have taken on board the MCA and whether any groups have been involved in these networks, because they were supposed to do some of this sort of work? We have not had a reference to them yet. Maybe you could let us know in some other way.

**The Chairman:** Perhaps you could write to us on that? Thank you very much. Baroness McIntosh has the next question.

**Q100 Baroness McIntosh of Hudnall:** Yes. We have already talked a bit about IMCAs, and obviously they are a very important part of the ability of people to get the benefit of the MCA. Do you think they have succeeded in doing what they were supposed to do? I notice, Mr McCabe, you made reference earlier on to the lack of IMCAs with a specific expertise in relation to brain injury. Two particular questions: one, do you think in absolute terms there are enough advocates out there to cover the range of need that we know there is, and is there, as we suspect, quite a significant regional variation in where they are and how they are deployed? Secondly, are there enough opportunities for them to acquire the kind of specific skills that you have already referred to? That would extend to, for example, skill in dealing with people who are severely learning-disabled or have dementia, who will all present with different needs and require different kinds of advocacy. Is it possible to train advocates to cover all of that?

**The Chairman:** Mr McCabe, do you want to start?

**Peter McCabe:** I do not think there are enough. That is what I am hearing from our regional set-up around the country. Could they acquire the specific skills? Yes. In our case I think that there are some issues that would overlap across a number of conditions and there would be some that are specific. We offer training to social care staff, to health professionals, a wide variety of different groups specifically in brain injury. It is not something that takes for ever but does give them the basics to enable them to deal with our service users and meet the needs of our families.

**George McNamara:** I think they are very much valued in terms of the roles, particularly given it is independence that is important, something that we feel needs to be better promoted. There is no promotion around the roles and accessing these advocates either. I

think that is vitally important. It is really left up to the advocates themselves to promote their own service, and if you have a heavy caseload already, that would be an add-on part.

In terms of your first question around “Are there enough?”, and linking to your second question about skills, the figures we had from the Department of Health found that 38% of referrals to advocates were for people with dementia, so that is quite a big proportion of people. Looking at the current customer base, it would not be that difficult to make sure that there is a specific dementia element that could cover a significant proportion of need.

**Baroness McIntosh of Hudnall:** Just as a matter of interest, who are they? Are they lawyers generally? Are they social workers? Are they people who just have a general interest in this area? Or are they a mixture of all of those things?

**Paul Farmer:** It will depend on the provider, first of all. There are a range of different providers in this. It is a market, essentially, because it is commissioned. There will be private and voluntary and indeed public sector providers, mainly private and voluntary sector providers. Their backgrounds will be very mixed. They might be people with some relatively low-level legal experience and qualifications. They might be people who have come from a social-care background. They may well be people who do not necessarily have a formal qualification at all. In our experience the best advocates are those people who do have some reasonably good grasp of the law. I think that is really important. That quite often means paralegal-type background potentially. But we are also talking about those people who have had some proper understanding and experience of the health and social care system so, as well as being advocates, they are also navigators. They are navigating people through the system.

**Baroness McIntosh of Hudnall:** I am sorry, I have gone slightly off-piste here, but it strikes me as interesting that it sounds as though there are relatively few standard criteria

that would be applied in deciding whether somebody would or not make an effective advocate, for this type of advocacy.

**Paul Farmer:** Perhaps to bring you back on-piste, it is a very fragmented area and there is an absence of a national lead body for all advocates promoting standards and developing good practice. That may well help certainly to address this question about effective quality. We know that there are some fabulous advocates out there who do a really terrific job for their clients, but we also know that there are potentially less fabulous advocates. There is no central body to really look at this in any sufficient depth. It is partly a product of the way in which the commission of the services were created in the first place. As you know, they are mainly commissioned by local authorities, mainly with relatively small pockets of resource and the resource, broadly speaking, pays for the running of the service. Comparatively, there is very little by way of professional development, for example, for those advocates.

**The Chairman:** Providers will be in front of us next week so you have given us some useful ammunition in preparing our questions. Thank you. I am going to ask Baroness Hollins to take to the slopes now.

**Q101 Baroness Hollins:** We have heard very contrasting views about how easy or difficult it is to assess capacity in practice; also, that in some situations practitioners move straight to best-interests meetings without assessing capacity first. What I would like know is—perhaps taking into account whether it is somebody with dementia or head injury or serious mental illness—about your own experience in practice and whether there are any particular issues with respect to particular impairments and particular settings and particular professional groups. Who would like to start?

**George McNamara:** Just a couple of points; one of the areas that is often overlooked is involving families in being part of the code of practice, but families are often omitted from looking at this in terms of the best interest. Also linked to that is looking at the past

decisions and future wishes as well. That is often something that is overlooked. When it comes to capacity, obviously for people with dementia it is quite important to recognise the fluctuating capacity that, for example, somebody may not be able to deal with their finances but can quite easily do many day-to-day tasks. They are a couple of the areas that really need to be addressed in terms of best interest in capacity from the Alzheimer's Society perspective.

**Baroness Hollins:** You are describing quite a skilled assessment. There are a lot of skills from a practitioner to do it properly?

**George McNamara:** Yes, and we should not be looking at any shortcuts here. This is absolutely vital to make sure that a thorough assessment is taking place. Particularly for people with Alzheimer's disease, the progressive nature of it means that their needs and their capacity will change as they go down the dementia journey as well.

**Peter McCabe:** With our service users there are all sorts of complexities; and one is that capacity can change over a period of time, and that presents some challenges. Then issues like lack of awareness and insight, impulsivity and inflexibility can create problems for people who are trying to make those assessments. One of the issues with survivors of a brain injury can be that they can be very good in terms of their presentation and giving you the answer that they think you want to hear, whereas the carers and their families would have a very different story. That is a difficulty we have to acknowledge and recognise.

**Paul Farmer:** Just a brief point: I refer you to the comments made by the CQC around assessments of capacity in psychiatric units and also people subject to community treatment orders. I think that is an issue that they have certainly identified as an area for further concern.

**Baroness Hollins:** In in-patient and community settings do you see a difference in practice?

**Paul Farmer:** Not hugely. The question is, I suppose, for people who are in in-patient settings but who are not detained under the Mental Health Act, which is an increasingly small number of people. The skill set is certainly there to be able to carry out the assessments. The environment can make that quite challenging in terms of enabling people to make their own decisions in those settings. In a community setting there are other issues at play that may be more around the enabling of people to take their own decision, but again, recognising this question of fluctuating capacity and there, of course, there are similarities with my colleagues.

**Q102 Lord Swinfen:** Do assessments of capacity and/or best interests achieve the right balance between protection and empowerment? Are sufficient efforts made to support decision-making before moving to an assessment of capacity?

**The Chairman:** Who would like to start on this? Mr McNamara.

**George McNamara:** The answer to that is not always the case. This is very similar to the points I have made in answer to the first part of this question. One of the key things we look at, for example, when looking at staff training and awareness that we have talked about is around recognising different methods of communication for people with dementia. One of the examples we have picked up on was staff in a care home had just given residents a cup of tea with no other options as part of their day. When asked why this was the case, the staff said that the residents would not be able to answer anyway and that is why they just got a cup of tea. It was suggested to the staff that they should show residents tea and coffee and ask them to point out their choice, so little changes and a little bit of understanding about how different ways of communicating can go quite a long way to improving the quality of life and also engagement with people.

**Peter McCabe:** I think from our perspective it is difficult to strike the balance between protecting people and giving them autonomy. We heard from somebody that was involved

with somebody again who received a substantial claim for personal-injury damages, and with that comes all kinds of dangers. There is the sense in which an individual might be capable of making a decision to purchase an item at a particular point without necessarily appreciating that if it is in a sequence of decisions it could have consequences down the line in terms of managing their resources. They are capable of making the choice between this wide-screen TV or that one, but do they fully appreciate that if they continue to purchase these items there might come a point where it has an impact on their ability to do the things they want going forward? That is a real issue, I think.

**Lord Swinfen:** Are you happy to allow them to make their mistakes?

**Peter McCabe:** I think there has to be that provision, but there also is a responsibility for somebody who is looking after their finances, where they do not have the capacity, to listen to their views but make sure that they do not put themselves in the position where they are without resources or, worse still, can be exploited by sharks that swim around such folk.

**The Chairman:** Thank you. Mr Farmer, did you want to add anything to that?

**Paul Farmer:** Briefly, just to add this, certainly our legal advice staff hear from relatives and carers of people who are not being involved in decisions that they could make, when they go for meals, whether they can smoke or go outside. Just as an aside to the question of financial capacity and capability, there is some interesting work going on with financial institutions to look to see how they could use their anti-fraud systems to detect particular patterns of spending. This could particularly, for example, affect somebody with bipolar disorder, who could go and spend quite considerably when they are in a very high state. There is certainly a growing level of interest amongst financial institutions to look at this. That is quite a good example of where the environment can be created to enable people to make their own decisions but also safeguards can be put in place where their mistakes may become quite damaging in terms of the longer term impact of that. The culture change that is required to

get that balance right, which is difficult, can be achieved by some imagination and some creativity.

**Q103 Baroness Barker:** How would you clarify and simplify the code of practice in order to enable assessment and best interest, which are the bedrock of the Act, to be better understood by practitioners and carers?

**Paul Farmer:** I do not think I have a response to that, I am afraid.

**The Chairman:** We seem to have a pregnant pause here.

**Baroness Barker:** In which case, you have already highlighted in your evidence, as have a lot of people, that these things need to be simplified in order for the basic part of the Act to work. If you could go back and think about that and then, all of you come back to us in writing about it that would be good.

**The Chairman:** Could I just follow on to that? The assessments of capacity or best interests: do you think they are happening as stated in the Act? Is that happening?

**Paul Farmer:** Again, you will have identified that there is a patchy picture out there. There is some very good practice happening without doubt but we certainly do hear evidence of the phrase “cursory assessment”. It feels quite light-touch. It does not feel very in-depth, because, to do it well, as others have mentioned, it is quite a skill. Sometimes it is not done to the best possible effect, and it can be quite time consuming. We are seeing examples of it being done well but recognising that the time is required. Then we have these cursory assessments that are not really terribly satisfactory for anyone.

**The Chairman:** We heard from the previous panel of charities that there is perhaps all too frequently an attempt to decide best interest before any attempt to carry out an assessment, whereas, in fact, the best practice should be to carry out the assessment of capacity and then to deal with the best interest. A nod of the head will do; would you concur that that is what is happening in your sectors? Yes, everybody is nodding. Thank you very much indeed.

**Peter McCabe:** We find it very patchy, but here is a direct quote from somebody who experienced it for her husband: “It was actually done very well. It was not invasive and it is more commonsense questions. Everything was discussed properly to make my hubby understand it properly”. We do hear comments from the other extreme, but I think it is right to give a balanced view to the Committee and give you that direct quote.

**The Chairman:** Thank you very much indeed. Could I turn to Lord Turnberg now, please?

**Q104 Lord Turnberg:** Can I bring you back to the carers and the family, who often feel that they are kept out of the loop? Do you think that practitioners keep them out because of a fear that they might be betraying confidences, the fear of getting past some confidentiality with the patient? Do you think they are inhibited in that?

**George McNamara:** The answer to that is yes, but we do not see that confidentiality should be seen as an excuse for not including family to ensure that the best-interests decisions are made. That is absolutely crucial. It should not be seen as something to hide behind at all. Again, it just links to another aspect, which is recurring throughout this session this morning, around “Is it because of the lack of awareness and training that it is a barrier—that people are hiding behind confidentiality unnecessarily?”

**Paul Farmer:** The Carers Trust produced a really excellent piece of work called the *Triangle of Care*, which sets out that kind of relationship between the clinician, the family member and the individual patient or service user. It really resolves well this question around confidentiality. In our experience confidentiality is sometimes used as an excuse for not involving family members, yet we would certainly argue that good-quality clinical practice and good-quality care needs to involve the family because of their understanding of that individual, particularly that individual’s home life and the circumstances of their home life.

Obviously as an organisation that has always stood up for the rights of service users, including sometimes their rights not to involve their families because their families are the

problem, nonetheless, most people, including most service users, will acknowledge that that additional insight and information is helpful in getting the solution right. It concerns us, for instance, as we heard last week, that the Caldicott recommendations around access to information seem to be putting up yet another potential barrier for this. There are surely enough examples now to show that sharing of information among relevant and interested parties in an appropriate, sensible and professional way is the way to achieve not just good-quality care but also safe care.

**Lord Turnberg:** We are all agreed that it should happen.

**Peter McCabe:** Confidentiality can be an issue or it can be an excuse. We also hear that the established practice, the culture of an organisation and the structures that they have, which are rigid, can often be more of a difficulty and cause more problems for families than the confidentiality issue.

**Lord Turnberg:** Clearly there is an issue here. What is the solution? Do we need to redraft the codes of practice or the regulations, or do we need to offer better training and who should do it?

**Paul Farmer:** I think training is probably the answer. Who should do it? Those people who are qualified and able to deliver effective and inspirational training. There is always a real risk about overburdening trainers. There is a leadership issue here as well, for care providers, for trust chief executives, for medical directors. Indeed, for patient organisations and voluntary organisations as well, there is an issue around really trying to create a culture where this issue is approached in an effective way.

**Lord Turnberg:** Could you let us have the *Triangle of Care*?

**Paul Farmer:** Yes, sure.

**The Chairman:** Thank you. The final question for you gentleman is from Lord Alderdice, thank you.

**Q105 Lord Alderdice:** Thank you very much, Lord Chairman. All of your organisations, of course, are distinguished advocacy organisations but you are also service providers. Indeed, in my part of the UK, either you or sister organisations are sometimes much the largest direct providers of care—everything from support groups through day-care services to care homes. I wonder if you have any particular observations you would like to make about the Act from a service provider perspective that is a little different, perhaps. Any observations?

**George McNamara:** Just generally, as we have talked about the importance of raising awareness and accessing any advice or answering any questions on the implications or the practicalities of the Act—we are a few years into the Act now and its implementation—what is vitally important is that there is a shared responsibility here. It is for the voluntary organisations, particularly those who are working on a day-to-day basis, to really come up with some solutions with others as well—with statutory bodies as well—because that could be quite a powerful route in terms of raising awareness. But also we must make sure, for example, when statutory contracts are being redrawn or redesigned, that this part of the service—this part of the acknowledgment and experience—is absolutely vitally embedded within the delivery of the service and not seen as an add-on or something that is a specialist area because it has to be integral now to delivery of services right the way across the piece.

**Peter McCabe:** From our perspective, there is a strong commitment to the principles of the Act and therefore it has not been a particular issue because staff recognise the value of what it is that we are trying to do and are keen to deliver. That is part of the culture of our organisation. Would that it were the culture of other organisations, I would say.

**Paul Farmer:** We have asked our network to try to answer that question in a bit more detail, so we will send that on to you. I suppose our primary observation initially was that the challenges that they face in terms of providing frontline staff with the right kind of

training and support is in direct proportion to the nature of the contract that they are given. Not all commissioners for mental health services will necessarily recognise the need for the kind of quality training that is needed, so it is an area to be aware of in terms of the importance of protecting training budgets inside commissioned services. Especially at the moment, quite a lot of services are being sliced—let us put it like that. The training budget is often one that can be sliced all too easily—or indeed the potential to free up frontline staff to actually go and receive the proper quality training that they receive and still run the service. It is a relatively minor detail in the nature of commissioning of services, but, to really embed mental capacity in voluntary organisations and all providers of services, it feels as though that training issue is going to be really important.

**The Chairman:** Thank you very much. Could I thank all three of you very much indeed for giving up your time to come and answer our questions? I just repeat the invitation that the inquiry is ongoing, as you know, so please do feel free to make any further written submissions to us that you would like to. Thank you very much indeed.