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Witnesses: Ms Nicola Mackintosh, Ms Katie Johnston, Professor Richard Jones and Ms Kirsty Keywood

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Members present

Lord Hardie (Chairman)
Baroness Barker
Baroness Browning
Lord Faulks
Baroness McIntosh of Hudnall
Lord Patel of Bradford
Baroness Shephard of Northwold
Lord Swinfen
Lord Turnberg

Witnesses

Ms Nicola Mackintosh, The Law Society, **Ms Katie Johnston**, Policy Officer, Liberty, **Professor Richard Jones**, Honorary Visiting Professor, Cardiff Law School, and **Ms Kirsty Keyword**, Senior Lecturer, University of Manchester

Q25 The Chairman: Good morning. Welcome to this session of the Select Committee on the Mental Capacity Act. We are grateful to each of you for attending to give evidence this morning. I should make you aware that the evidence session is webcast as well as transcribed, and that it will be possible for witnesses to correct the transcript if there are minor errors—although obviously you cannot change your evidence. I understand that Professor Jones wishes to make a brief opening statement.

Professor Richard Jones: Thank you very much, Lord Chair: it will be brief. I thought it would be helpful if I indicated some of the issues that have occurred in my practice. The Committee may wish to ask me questions about them later. I must explain that my practice does not include advice on the financial aspects of the Mental Capacity Act. My experience is limited in that respect. I thought it might be helpful to look at the Act itself and then at DOLS, because although DOLS are part of the Mental Capacity Act, in practice they are two separate pieces of legislation. That is how they are regarded. I have three brief comments on the Act itself.

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

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

Secondly, the Department of Health, in a circular of 2010, reported that DOLS had been “successfully implemented”. I think that that was a wildly optimistic judgment to make in 2010. There is a lot of evidence to suggest that the opposite is the case. Most of this evidence will be familiar to the Committee. There are huge regional variations in the application of DOLS. Fewer than 1% of patients who are subject to DOLS make an application to the Court of Protection for their release. Some cases indicate that DOLS have

been used as an instrument of oppression, where supervisory bodies such as local authorities have used DOLS to get their way, in a sense. I am thinking in particular of the Neary case, and also of a lady called Peggy Ross, who comes from Cardiff.

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

Next, I think that the protections given to patients who are subject to DOLS are far, far less than the equivalent protections given to patients who are detained under the Mental Health Act. There is a long list. I will not go through it, but it relates to patients who are sectioned having free after-care and automatic access to a tribunal if they do not apply. There are also major provisions in the Mental Health Act that protect the Article 8 rights of patients, in particular the consent to treatment provisions. There is no equivalent in DOLS. In fact, in a very recent case a judge complained that the DOLS legislation was silent when it came to the Article 8 rights of patients.

It will be clear from what I have said so far that I am not desperately in favour of the DOLS regime. Parliament did not undertake its proper duty when DOLS went through both Houses—with the notable exception of Lady Browning who, when she was an MP, was one of the few parliamentarians who spoke on the DOLS proposals. When the two schedules—AI and IA—that make up the DOLS procedure went through Parliament, there was not one word of parliamentary debate. Not one word. Those schedules comprise more or less 200 paragraphs. In statutory terms, a paragraph is the equivalent of a section of an Act. So a

major Act of Parliament dealing with the liberty of the citizen went through Parliament without one word of parliamentary debate. With all due respect, I think that is scandalous, and Parliament has a lot to answer for. But we are where we are. What shall we do? In my opinion, the DOLS regime is so complex and interlinked that it is impossible to amend.

The Chairman: I think we will probably come on to these issues, Professor.

Professor Richard Jones: I am sorry if I went on too long.

Q26 The Chairman: I want to ask the first question, which to some extent has been answered by some of your comments. However, I would like to hear any additional views you have, as well as those of the other witnesses. When the Act was passed, it was widely viewed as being a progressive and welcome piece of legislation. Has it lived up to those expectations? Have there been any unanticipated consequences? What changes, if any, would you make to the legislation?

Katie Johnston: I think Liberty would echo everything the professor said, including the fact that the Mental Capacity Act, when it was passed, was rightly seen as a progressive piece of legislation. It moved away from paternalism towards the enhancement of autonomy, which is welcome. From our evidence and what we have seen, the problem with the Mental Capacity Act is really one of implementation, and a lack of understanding among those who have to apply it on the ground.

Liberty is currently advising a lady whose father was taken into hospital when he was in his 90s after a stroke. He was given an intranasal tube to feed him, despite his expressed wishes to the contrary in the past. When his medical records were examined, it was clear that he had not undergone a proper capacity assessment for two months. Even though he was assumed to lack capacity, there was recorded evidence of him giving consent—although if he lacked capacity, he was obviously incapable of giving that consent. He was discharged. So we

think that the Act is good. We obviously have problems with DOLS, which we will address later, but the problem with the Act is one of implementation.

Kirsty Keyword: Perhaps I could add to that. One of the unanticipated consequences from my perspective, interested as I am in adult protection issues, is that it is absolutely true to say that the Mental Capacity Act had a very empowering ethos behind it. However, what we have discovered since the enactment of the legislation are the very serious harms that many vulnerable people have come to. In reviewing their experiences, many of which were profiled in serious case reviews, and perhaps most prominently in the Winterbourne View case, it is quite clear that we have had a series of developments in policy and also in law that should force us to think carefully about how we balance empowerment and provide vulnerable people who have challenges around decision-making because of their circumstances with protection. I will offer you a few examples of that.

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

I will offer one example. I was involved in a serious case review of a man called Steven Hoskin, who was tortured and murdered by a gang, many of whom were convicted following prosecution. He was entitled to a community care service and was receiving support to manage his finances. Steven lived in a bedsit that accommodated one person. At the time when he disengaged from services, a number of people were living with him. He was not capable of expressing any free choices at all, yet his decision to decline the service was not interrogated. It would be quite beneficial, if any reforms to the Mental Capacity Act are to be made, to clarify that it is simply not reasonable, where a person is exercising a choice that results in significant harm, not to undertake an assessment of capacity. That is not to say that their decision should be overridden, but we should ask searching questions about whether the decision is legally valid. That is one issue that has arisen with regard to adult protection. The other issue is that the courts have now taken it upon themselves—quite rightly, in my view, given that we have no legislation—to provide some kind of legal remedy and course of action to protect vulnerable people whose decisions are the product of considerable constraint and abuse by family members in some cases, or by friends. What the Mental Capacity Act, at least in the code of practice, needs to do is make it very clear to people working on the ground exactly how the adult protection law and the Act work together. I have seen enough horror stories involving self-neglect and abuse to indicate that those lines of connection need to be made much clearer, not just to people working on the ground but to the lawyers who are advising them.

Q27 The Chairman: Ms Mackintosh?

Nicola Mackintosh: I will echo some of what has been said. Richard and I probably disagree on a few issues, which we will come to later. I think that the Act is a good start. My practice is in community care, and was in mental health and homelessness pre-MCA. Before the Act came in, obviously there was no legal structure for decision-making and the assessment of

potentially mentally incapacitated people. My concern is at the way it has been implemented. Often in my practice, I see decisions being made by statutory agencies on behalf of vulnerable people who may or may not lack capacity, under the guise of best interests. I echo what was said about the answer being, “Does the person have capacity?”, and the outcome being led by resources. I see lots of cases where a person has been neglecting themselves, and the local authority or the relevant health agency has used the presumption of capacity to allow that to continue. Equally, I have many, many cases where my clients have been deemed to lack capacity because the outcome is going to be that the state spends less on them. That is one of my concerns.

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

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

Professor Richard Jones: Can I come in briefly? One of the themes that have come out from my colleagues is something that I very much agree with. Most decisions made on behalf of mentally incapacitated people are not preceded by a capacity assessment or a best-interests evaluation. Carers just get on with it. One of the needs that there is in terms of the

legislation and perhaps a code of practice is to identify when a formal capacity assessment and a formal best-interests judgment need to be made. The code of practice at the moment refers to complex decisions needing a formal capacity assessment. That is not sufficient. Many simple, straightforward decisions relating to a mentally incapacitated person can be extremely important for them. They can be crucial. “Who do I live with?”. That is not a complex issue, but clearly it should be preceded by a formal capacity assessment and a formal best-interests judgment. That is where the Act is in danger of coming into disrepute. The vast majority of decisions are not made in compliance with the Act. As I said, people just get on with it. So when is it that there should be a trigger for the formalities of the Act to be complied with?

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

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

watch television? When should that person go out into the garden? What should that person wear?—all the trivial decisions that have to be made. It just does not happen.

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

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

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

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

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

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

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

Katie Johnston: I will say that the problem of self-funders is exacerbated by what has become known as the YL loophole, which is that, as the law currently stands, persons who are in a self-funded care home or residential home are not subject to the same protections

of the Human Rights Act as they would be if they were in a local authority-funded care home and they were placed by the local authority.

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

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

Q30 Baroness Browning: Perhaps I might come back to the question that I was going to ask you: when this Committee concludes, our report will show, I hope, from the evidence we have received, what needs to happen to make the Mental Capacity Act more effective and fit for purpose. I am basically saying that I not think it is fit for purpose. In fact, we were told last week by officials that, “Overall, our view is that the Act has been a success”. I

would say that, like the curate's egg, parts of it may have been a success but other parts of it are seriously lacking. You have all started to outline to us where tangibly you see change and where change might make it better.

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

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

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

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

Katie Johnston: I will.

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

Professor Richard Jones: Whatever changes may or may not be recommended and perhaps translated into a new code of practice or an amendment to the Act, the current situation will still obtain, in that many people will not be aware of the new, better legislation. Perhaps

the Government should use, if not their power then their influence to ensure that all relevant professional bodies—not just health and social care professionals but housing managers, bank managers and the police—have the Mental Capacity Act as part of their basic core curriculum. It should be bedded into basic training. It is not at the moment. That could have a significant impact in the longer term, perhaps. Apart from that, I do not think that a new, very expensive training initiative will be particularly helpful. I wonder whether some consideration should be given to funding a public information campaign about the Act.

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

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

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

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

Nicola Mackintosh: I support the need for training. Training on the Mental Capacity Act and its principles should be embedded in—I agree—housing officers, but also in all nurses,

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

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

Q32 Baroness Shephard of Northwold: It would be interesting to hear the views of the panel on the different requirements of this Act, and the clients with whom it deals, and the provisions of the Mental Health Act. I come new to this, but I have some knowledge of the Mental Health Act. It seems that it is infinitely more complex because you are involving families, carers and a lot of informal settings. You have already said that there should be training for X, Y, Z and the rest of it, but what about families and carers? You are then going into the realms of unreality. It may be desirable, but there is no way that you can get into all of that. You pointed out a lacuna in the area where people are self-funding in residential settings. Again, we are dealing with families—perhaps distant families. I do not see how you

could achieve all of this. You could certainly put a lot of it into training the most obvious groups of people who might have to deal with the situation, but you are still leaving a huge area of vulnerability where people are being informally cared for, or looked after by care assistants and so on. How would you tackle that? That would be what Ministers would ask. They would say, “Okay, here is a gap. How do we fill it?”

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

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

Kirsty Keyword: Yes, and quite stigmatising.

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

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

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

Kirsty Keyword: Quite. We need a more effective scheme to regulate the professions, including care assistants. I know that work has been done to introduce and develop NVQs in

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

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

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

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

My question to you is: do you think that is right, and that the principle-based approach has given us a piece of legislation which is sufficiently flexible to deal with a changing world?

There are two changes I would point to: one is the increase in dementia. You will know about the Prime Minister's challenge—the idea that there should be dementia-friendly communities. Well, dementia-friendly communities have to have people who, in the course of their everyday work, are capable of dealing with that dementia. The other is the rise of technology. We did not think of technology when we did this legislation years ago, but technology is so much part of people's lives now. I think that throws up some very interesting questions, and I would like to hear your views on that.

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

Kirsty Keyword: I think that is right, is it not? People I speak to on the ground report really positively about the principles—there is no doubt about it. They say that they find it very useful. So on one hand I have this very positive feeling, and on the other hand I look at the research that is being done on decision-making—and that does not form a solid national picture either, but we know, for example, from the research literature, that people tend to conflate issues of capacity with best interests, as we have seen already. That is a huge problem, that in some circumstances the desire to be protective can mean that the most

restrictive alternative is not always adhered to. There will always be challenges in implementation. I am not really sure how to answer your question, except that I know that the people I have engaged with on a professional level report very positively. Symbolically, it was a very important thing that the legislation did, and I, for one, am very glad that they are there.

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

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

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

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

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

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

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

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

Katie Johnston: Yes. In the autumn.

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

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

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

other option is to section them all, get second opinions, provide Section 117 aftercare—the resources are just not there. Is this the best of a bad job?

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

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

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

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

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

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

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

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

Whether guardianship is the right way forward—and I have some concerns about a single person being appointed as a guardian, which dates back to the Mental Health Act 1959 and the paternalistic approach which was taken then, which is precisely why the powers in guardianship were narrowed in the 1983 Act—I do not know. I certainly think that the current safeguards have an important element to them. The crucial element is that there is an independent person who is funded and whose responsibility is to review with the vulnerable or incapacitated person and if necessary to assist them in bringing the case before the court. However, even so, only a very small percentage of those cases are raised before the Court of Protection.

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

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

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

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

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

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

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

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

More specifically, the Mental Capacity (Health, Welfare and Finance) Bill, as it is currently framed, is anticipating a more robust set of safeguards for certain sorts of decisions, and I

find that quite appealing in view of some of the concerns that I have mentioned here. For example, under the current Bill, where a person is objecting to an intervention that is not routine or urgent, a nominated person has to be involved—an advocate of some sort—and there has to be a referral to a multidisciplinary panel.

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

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

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

does not mean that they will always be respected, but they have to be the starting point for any kind of determination of what is best for an individual. That is a really important lesson that we have to take forward because legally we are required to do so.

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

Q37 The Chairman: Baroness Shephard?

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

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

Nicola Mackintosh: A bit like the Act, it is a good start. I have experience of very good quality service being provided by some IMCAs and not by others, but you will have that in

any system. The difficulty is that the IMCA input is severely limited at the moment. It could positively be expanded.

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

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

Baroness McIntosh of Hudnall: Which, if I have understood you, you suspect may be to do with—referring to something else you said, and forgive me for a moment, but I want to get this right; I think I wrote it down somewhere—services being “outcomes led by

resources”. So your suspicion is that the limitations you have just described are brought about by an unwillingness or inability by commissioners to commit those resources.

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

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

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

Kirsty Keyword: I think that the issues around IMCA involvement with serious medical treatment have had that impact. We know from the research that IMCAs have said that they very much find when they are advocating for somebody who is facing a serious medical

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

Q39 Baroness Browning: Two of you have now mentioned family members. Of course, I understand that there are often disputes within families and an IMCA will be very important in those circumstances. Could I take your view on where we are as far as the Act is concerned with carers and close family members being advocates? I should declare an interest, which is in the list. I am sorry that Baroness Hollins is not here today, because she would also share this feeling. We have had some pretty shocking cases, particularly the Mencap cases that have been documented, where mothers have stood by the beds of adult learning-disabled children who have died, not because of the illness they have been admitted to a general hospital ward for, but because of neglect, because the staff have had a difference of opinion with the parent—the carer—about things like nutrition and fluids; fundamental

things like that. These are not just isolated cases; there are too many of them. How do you see this Act in terms of advocacy from close relatives and carers? Is the balance right?

Professor Richard Jones: In the situation you described, the clinician has to take into account the views of the parent. The parent cannot determine the course of action that is to be taken from a medical perspective. A parent, because of their role, will advocate what they believe to be best for the child. I do not think that that needs to be given statutory form. It is what parents do.

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

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

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

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

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

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

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

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

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

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

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

Kirsty Keyword: One way in which we could and should simplify it to some extent—I am not sure that this will satisfy you—is to get rid of the diagnostic thresholds. That is to say, currently under the legislation you have to have an impairment or a disturbance in the functioning of the mind or brain before you can be found to lack capacity by struggling with one of the other decision-making elements of the test. I think that that has to go. It is in breach of the UN convention and it is also incredibly difficult to know exactly what is at the source of somebody's struggle to understand, weigh up, retain or communicate information. So that is one area where I would certainly suggest that we modify the test of capacity. I

have come across lots of people who did not have an evident mental health problem or a learning disability yet who struggled to make decisions because of the very complicated circumstances in which they lived their lives. The current frame of the mental capacity test hinders the ability of some services to provide imaginative, effective support to those individuals.

Professor Richard Jones: The task you are setting us is extremely difficult. One of the benefits of the current test, which as you know is issue-specific in the sense that somebody may be mentally capable of making decision A but not decision B, is that it allows somebody to use their maximum decision-making capability. If you simplify the test to make it more general, it will have the consequence of denying some people who could make certain decisions the power to make them. So the test is the correct one, but it just gives rise to such difficulties in practice. This goes back to what I said in my opening remarks. The Act is just ignored for most decisions. It would be a practical impossibility for all these assessments and best-interests judgments to be made for the dozens of decisions that are made in respect of a person in the course of a day. I would be against losing the central component of empowerment that the Act currently provides.

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

Katie Johnston: I will talk about one particular line of case law. The problem with DOLS is that they are not used sufficiently. One of the problems is implementation and lack of training. Another big problem is that there is a serious lack of clarity in the definition of deprivation of liberty. This is partly structural. The Act does not provide its own statutory definition. It ties it to Article 5 of the convention. That is obviously problematic in itself

because it is a constantly changing object. That then flows into domestic practice. Domestic case law is constantly changing. I have been at training sessions where social workers who are not legally trained are shown extracts from judgments of the Court of Appeal on a whiteboard and told to apply them in practice. That is obviously very difficult. So the fact that it is tied to case law is difficult in itself.

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

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

proportionate. Those are the two big problems in deprivation case law that a broad and clear statutory definition that is freestanding would help to address.

Q42 The Chairman: Ms Keyword?

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

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

have been a history of abuse, are complicated. Issues of forced marriage, removal from a jurisdiction and capacity to consent to sexual relations all come before the court.

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

The court definitely could be improved. It is more expensive and unwieldy than it needs to be. I could make a number of practical suggestions that would help. There should be very prompt access to a suitable litigation friend for the incapacitated person. We are all aware of the difficulties that the Official Solicitor's Office has had in relation to providing the services of a litigation friend in some cases—it is now operating a waiting list—because of a lack of resources. The minute you have a waiting list for a litigation friend, or you do not have prompt access to a suitable litigation friend, the case comes to a halt. That is in no one's interests. If we had very tight case management, with cases allocated to individual judges who run the case from the beginning to the end wherever practically possible, that would make great sense. We should take out the plethora of court hearings that we have. Every time you have a court hearing, you are incurring enormous expense and raising the expectations of relatives that this will be a final decision and a final hearing. Wherever possible, try to reach an agreement on the papers that is then placed before the allocated

judge. There may not be a need for a hearing at all until the final hearing to determine the underlying dispute. There may be room for a practice direction to streamline the court process, which may reduce the costs and make the court more accessible. The court needs to be much more flexible. I talked about the judge who visited my client in the care home. That made all the difference. The courts need to go to where the person and the family are. We should not have a situation where everybody has to travel very large distances to turn up for a hearing that starts at 10.30 am, only to still be waiting at 4 pm and maybe not even to go before a judge. That is not acceptable. Sometimes things go wrong, but often the whole structure of the court process can be streamlined so that the focus is on the incapacitated person and their family, on the time that the professionals are taking in attending court, and on the entire cost of the process.

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

Professor Richard Jones: I have never come across that.

Nicola Mackintosh: My experience is that Mr Justice Hedley’s comments have been largely taken to heart. I cannot speak for every local authority—there may well be cases that fall

outside that clear guidance—but certainly I have not come across the inappropriate use of the out-of-hours service.

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

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

The other thing is that legal aid is means tested. LASPO introduced new, much more stringent means tests. Previously, if the person was claiming what are called passported benefits such as income support or guaranteed state pension credit, they were, subject to a merits test, automatically entitled to legal aid on the basis of means. That has now changed. With LASPO, the new eligibility regulations effectively passport a person on income but not on capital. For example, if the person has more than £3,000, a contribution will have to be made until such time as their savings fall below that limit. There is also the latest

Transforming Legal Aid consultation paper, which was issued only seven or eight days after LASPO was implemented. It includes a proposal for a new residence test. In order to qualify for legal aid, every single person will have to prove to a legal adviser that they have been lawfully in the UK for at least a year. It is difficult enough for us to act for mentally incapacitated persons who do not have ready access to files of their bank statements that we need to show to the Legal Aid Agency to prove that they are eligible. It is difficult enough to obtain that evidence, but trying to obtain evidence that somebody has been lawfully here for a period of at least 12 months in order to qualify for legal aid is going to be impossible. It will actively provide a complete barrier to access to legal aid for many if not all vulnerable people.

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

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

of law, it will affect your ability to make an arguable, plausible case and have it executed correctly.

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

Q44 Baroness Barker: I will wind up with the Office of the Public Guardian, and LPAs. The intention with the Office of the Public Guardian was that abuse would be protected against by the use of Court of Protection visitors. Has that worked out in practice?

Professor Richard Jones: I have not come across a case where there has been a problem getting a Court of Protection visitor, but I know that there are very few of them. Certainly it has not come on to my radar.

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

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

Nicola Mackintosh: As I said, all the cases that I have dealt with involve some abuse. Perhaps local authority money-management departments—those that still exist—might be

well placed to comment on that. So might charities. My experience is that the use of appointeeships is patchy. We pick it up in health and welfare cases and try to deal with both sides.

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

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

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

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

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

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

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

Baroness Barker: The forms are enormous.

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

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

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