



The Law Society

**House of Lords Select Committee  
Mental Capacity Act 2005  
Call for Evidence  
September 2013**



## Introduction

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

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

## Summary

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

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

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

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

We have significant concerns about the DoLs regime and agree with the Department of Health that it needs to be reviewed urgently. DoLs protections should be extended to those who are in 'supported living' placements, and there should be a mediation practice direction to encourage resolution of the issues that led to the DoLs being used. Consideration should also be given to combining the MCA and DoLs guidance to underline their inter-relationship.

We urge that the Hague Convention on the International Protection of Adults should be ratified for England and Wales.

## Responses to questions

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

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

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

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

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

#### Deprivation of Liberty Safeguards

See our response to questions 16 to 18.

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

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

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

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

#### MCA Code of Practice

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

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

The principles and definitions are appropriate.

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

Occasionally the principles can be applied perversely – such as using the presumption

of capacity to negate the need for a capacity assessment, with the implications for associated support and resources.

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

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

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

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

In the primary healthcare, hospital and private care settings our experience shows a serious and widespread lack of knowledge and understanding<sup>1</sup>.

A particularly stark example is the case of a young woman with a mild learning disability (*A Local Authority v K and others [2013] EWHC 242 (COP)*).<sup>1</sup> In this case neither the local authority nor the health professionals were aware that consent for medical treatment must be authorised by the court. Such lack of awareness is far from isolated.

The situation becomes even more serious if a patient (P) needs specialist care unrelated to their disability – for example, treatment for a broken limb. Patients who are frightened and confused are often not recognised as having capacity problems and may be regarded as simply obstructive, so that the provisions of the Act are not even brought into play.

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

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

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

The provision of information to professionals and lay carers about the Act began with a well-written but overly long Code of Practice. Although the Code is well-known among

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<sup>1</sup> This is supported by the conclusions of the recent Cambridge University study 'Understanding the Interface between the MCA's Deprivation of Liberty Safeguards and the MHA – July 2013, Dr Isabel Clare and Professor Tony Holland

professionals it is inaccessible to large sections of its intended audience. There should be abridged versions of the Code which are designed to provide relevant information to carers and family members.

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

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

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

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

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

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

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

The Law Society, interested charities, the Office of the Public Guardian (OPG), the British Bankers' Association, the Buildings Societies Association and certain of the banks have worked together to produce guidance for bank staff when dealing with for those wishing to operate a bank account for someone else<sup>2</sup>. A simpler version has been produced for use by the public which is intended to be made available in banks

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<sup>2</sup> <http://www.lawsociety.org.uk/news/documents/guidance-for-people-wanting-to-manage-a-bank-account/>

and building societies. Over time, use of these documents by bank staff will result in improved training of staff and better service to people with capacity problems.

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

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

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

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

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

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

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

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

There is evidence to suggest that some professionals evaluate capacity rigorously as they are well aware of the impact of a finding that a person lacks capacity. Similarly, there are examples of good practice by professionals who use a model of engagement and consultation with P and their family members to reach agreed decisions in P's best interests. However, there are also too many examples of inconsistent practice in consulting P or relevant family members, other paid carers or professionals from

another field. Sometimes consultation with a family member who is perceived to be in conflict with the professionals is simply avoided and no attempt made to use mediatory processes.

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

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

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

There is some research available<sup>3</sup>. The experience of our members suggests that those from disadvantaged socio-economic groups and BME groups have lower levels of awareness of and engagement with the Act. We also know that these groups are disproportionately subject to compulsory powers under the Mental Health Act and little headway has been made to address this.

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

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

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

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

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

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

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

- An opportunity to make an advance decision within a health and personal welfare LPA;
- Increased involvement of the patient in their care plan with the patient at the centre of their own care, particularly end of life care pathways, where advance decision making is encouraged. The evidence from members is that this is used to best effect where there is a recognised terminal illness such as cancer;
- Better assessment of capacity so that individuals can make advance decisions about refusal of treatment;
- More use of tools such as treatment escalation plans which help the doctor/patient agree the limits of medical treatment in individual cases (see the Devon TEP initiative<sup>4</sup>);
- The BMA/ Law Society "Assessment of Mental Capacity, a practical guide for doctors and lawyers", edited by Penny Letts published in 2010 provides a valuable guide on the Act itself and contains a useful Chapter on consent and refusal of medical treatment which is a resource for doctors
- Guidance from the Royal Colleges on end of life care and;
- DH Choices website:

<http://www.nhs.uk/CarersDirect/moneyandlegal/legal/Pages/Advanceddecisions.aspx>

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

Members' experience, particularly those working with healthcare providers is that the medical profession will respect an advance decision which is valid and applicable. However, often the difficulty is confirming that a decision is valid or applicable to the treatment which is the subject of the decision. Individuals need more support to make

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<sup>4</sup> See <http://www.devontep.co.uk/>



clearer advance decisions and medical practitioners need support in interpreting them. A greater engagement between the individual making the decision and the treating clinicians at the time the advance decision is made will support decisions being followed.

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

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

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

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

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

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

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

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

IMCAs are often involved in complex disputes involving family members and professionals, which is outside their statutory role. They may also be required to challenge local authorities in a formal court setting, for which they are ill-equipped. Adequate training and resources for IMCAs is essential, but unfortunately does not appear to be a funding priority, to the detriment of many vulnerable individuals. There is a lack of oversight on the part of commissioning bodies to ensure that where IMCA services are funded, they are able to meet the demands of the locality.

There is a question mark over how 'independent' IMCAs can be when they are commissioned by the local authority, particularly as commissioning is now centred on a

small number of providers. The need for truly independent IMCA services has been highlighted in the aftermath of Winterborne View.

We agree with the Department of Health's recommendation<sup>5</sup> that MCA leads in CCGs should monitor compliance with the requirement for making referrals to IMCAs. The Department's 5-year review of IMCA services revealed the stark variations of safeguarding referrals to IMCA services: we recommend that there should be automatic referral to IMCA services where there is an allegation of abuse or neglect.

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

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

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

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

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

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

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

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

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

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

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<sup>5</sup> The Fifth Year of the Independent Mental Capacity Advocacy (IMCA) Service - 2011 /2012  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/158009/Independent-Mental-Capacity-Service-\\_-fifth-annual-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/158009/Independent-Mental-Capacity-Service-_-fifth-annual-report.pdf)

It is important to state that the over-arching problem - as with the MCA generally- is that DoLs are not always used when they should be. There is effectively a post-code lottery for patients<sup>6</sup>. The CQC's report, '*The Operation of the Deprivation of Liberty Safeguards, 2010/2011*' found wide regional variations in the use of the safeguards.<sup>ii</sup>

The CQC also had concerns about the complexity of the safeguards<sup>7</sup>. We agree, particularly in relation to the interface with the MHA as a result of the convoluted drafting of Schedule 1A.

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

The continued uncertainty about the engagement of Article 5 is a further deterrent to the correct use of the safeguards. Section 64 (5) MCA provides that references to deprivation of a person's liberty for the purpose of the Act have the same meaning as in Article 5(1) ECHR. It has been persuasively argued that this requires the interpretation to follow the Strasbourg definition<sup>8</sup>, but it remains to be seen if the Supreme Court will provide any clarity when the linked appeals of the Official Solicitor in *Cheshire West* and *Re P and Q* are heard later in the year.

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

- *London Borough of Hillingdon v Neary & Anor* [2011] EWHC 1377 (COP)
- *C v Blackburn with Darwen Borough Council* [2011] EWHC 3321 (COP)

The lack of Article 8 safeguards was commented on in *J Council v GU (1), J Partnership NHS Foundation Trust (2), CQC (3) and X Limited (4)* [2012] EWHC 3531 COP where 'George's' placement involved severe restrictions on his correspondence and contact with others. George's placement not only constituted a deprivation of his liberty but also curtailed his rights under Article 8, and had to be 'in accordance with the law' (Article 8(2)).

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

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

The judge commented that 'not every case where there is some interference with Art 8 rights in the context of a deprivation of liberty authorised under the 2005 Act needs to have in place detailed policies with oversight by a public authority. Sometimes,

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<sup>6</sup> See Lucy Series 'Statistical Guide to the MCA'

<http://thesmallplaces.blogspot.co.uk/2013/06/your-statistical-guide-to-mental.html>

<sup>7</sup> *ibid*

<sup>8</sup> See 'Tying ourselves into (Gordian) knots?', Alex Ruck Keene 2012

particularly where the issue is one-off (such as authorising an operation), an order from the Court of Protection will suffice ...But where there is going to be a long-term restrictive regime accompanied by invasive monitoring of the kind with which I am concerned, it seems to me that policies overseen by the applicable NHS Trust and the CQC akin to those which have been agreed here are likely to be necessary if serious doubts as to Article 8 compliance are to be avoided.’.

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

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

Conditions inserted by BIAs can be useful in encouraging compliance with the MCA by managing authorities. Although arguably neither the BIA nor the supervisory body may have legal power to make or enforce them, they are valuable tools in trying to follow the least restrictive alternative principle<sup>9</sup>.

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

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

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

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

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<sup>9</sup> [http://sscr.nihr.ac.uk/PDF/SSCR-project-outline\\_4-DoLs\\_web.pdf](http://sscr.nihr.ac.uk/PDF/SSCR-project-outline_4-DoLs_web.pdf)

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

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

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

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

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

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

The COP's accessibility depends mainly upon P's financial status. For the great majority of individuals, the Court effectively provides no service at all unless, exceptionally, a public service (eg a hospital or local authority) makes an application.

For most, the cost of an application to the Court is prohibitive, so they muddle through as best they can. For those who can afford access to the Court, whether through legal aid or their own resources, proceedings are case managed by the judge and the Rules provide for a clear procedure. Hearings by telephone are popular and increase efficiency and accessibility. The Official Solicitor's involvement as litigation friend for P can be helpful in bringing parties to a solution, although he is only involved where there are sufficient assets to meet his costs from P or from legal aid.

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

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

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

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

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

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

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

The cost of registering an LPA is £130. For some, the cost of registration is off-putting. In the case of health and welfare LPAs where the level of assets is not an issue, an application can be made for a fee reduction but we understand that it is difficult to obtain this.

There are serious concerns about the LPA Registration System with a particular focus on fee remissions and delays. *We will write separately to the Clerk about examples where the delays are so long in trying to get the payment issue sorted out that clients are dying during the process.*

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

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

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

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

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

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

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

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

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

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

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

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

A person deprived of their liberty in supported living where DoLs cannot be used may well have to pay for their representation. This is an unjustifiable barrier to P's rights

under Article 5(4).

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

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

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

For obvious practical reasons, any extension of the mandatory legal aid 'telephone gateway' beyond than the existing three pilot areas (special education needs, debt/mortgage repossession and discrimination) could have a detrimental impact on access to justice for those who lack mental capacity and their families.

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

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

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

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

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

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

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

The interface between the mental health legislation and DoLs is complex, and causes



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

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

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

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

We are unable to comment on this question.

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

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

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

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