

House of Lords consultation on Mental Capacity Act 2005

August 2013

Introduction

1. Browne Jacobson LLP is a law firm with a national leading health and social care practice, and responds to the House of Lords consultation with the benefit of views expressed by a number of our clients across the health and social care sector.

Overview

2. The MCA is a good thing. The principles are important and clearly drafted, and it has had some success in raising awareness of the key issues and the competing principles of empowerment / protection of autonomy on the one hand, and safeguarding / protection of the vulnerable on the other.
3. Where criticism is made of the MCA, it often reflects frustration about its implementation and application in practice rather than disagreement with its fundamental basis or principles.
4. Rather than wholesale revision or reform (with the possible exception of the DOLS), we would encourage greater focus on the consistent implementation, and resource to improve training, and support sharing of experience and application in practice.
5. We would, however, have advocated that it not be called the “mental capacity act”, but rather the Capacity Act, (or even the “making decisions act”, perhaps), to reflect its universal application, and minimise what ought to have been avoidable conflation with the Mental Health Act.

Implementation

6. On the positive side, the MCA has raised awareness of capacity issues, but there is often frustration that it hasn't been implemented as effectively as it could have been. The withdrawal of the central funding and regional support was felt to have hindered consistent implementation.
7. Often where regional networks or other means have been developed to promote sharing of knowledge / experience, these have been ad hoc, unfunded or supported by organisations as a matter of goodwill.
8. Lots of training has contributed to greater awareness, but often it is felt that this has been at a fairly superficial level - still telling people what it says, not what it means, or really addressing the difficulties with implementation in practice.
9. Some feel that training has been arranged as a tick box exercise, and it doesn't help that it is often not quality assured. For example the statutory, mandatory DOLS refresher training does not carry any benchmarking or assurance as to either content or quality.

10. It is not clear that mandatory annual refresher training is sufficient for DOLS assessors (or anyone working with the MCA) to keep up to date with the fast moving case law produced in the Court of Protection, and so among other resources we have been producing quarterly webinars free of charge covering MCA / DOLS case law updates - see www.bjlegaltraining.com.
11. Implementation of MCA and DOLS is inconsistent across organisations, and across disciplines within organisations, often reflecting the cultural background of the organisations / professions, and their traditional structures and hierarchies.
12. Among healthcare professionals generally, our clients felt that awareness of capacity often does not yet carry the same weight that is given to “consent”, despite the fact that without capacity there can be no consent.
13. It remains the case that capacity is more often challenged where there is non-compliance with a clinical recommendation. Conversely, compliance is sometimes considered a proxy for both capacity and consent.
14. In implementation of the basic principles of the MCA:-
 - the inherent contradiction between those principles promoting autonomy, and those promoting protection is easily overlooked.
 - Those principles which are more in keeping with traditional approaches and attitudes in healthcare in particular - eg acting in a patient’s best interests - have been most readily accepted and gained the most traction in practice. However, there is still a temptation to start with action “in best interests”, before real consideration is given to capacity, or to taking all practicable steps to support P.
 - The need to care plan to support decision making and enable people as much as possible, with the same attention that we care plan for self care / medical needs, is often overlooked. “Lack of capacity” is too often treated as permanent and generic, rather than decision specific, sometimes without thought to supporting improvement to greater exercise of capacity.
 - The principle that consideration must be given to whether there is a “less restrictive option” that might meet P’s best interests is often misinterpreted as making it mandatory that the “least restrictive option” is taken.
15. The quality of documented capacity assessments can be poor - often not time / decision specific, or carried out by someone who doesn’t understand the information relevant to the decision - or done once on admission and not reviewed.
16. It is difficult to audit the use of MCA effectively, as many decisions are made informally, outside institutional care settings, and even inside care homes and hospitals data collected (even on DOLS, for example) tends to be quantitative rather than qualitative, making real benchmarking challenging.
17. MCA does now provide a framework for discussion of capacity and best interests issues, which can support reflection and learning lessons when things do go wrong, and also makes it more legitimate for different opinions to be held, taking into account factors on either side on what are essentially binary decisions - capacity or not - best interests or not - that are in reality mostly not black and white, and where there is a reasonable scope for disagreement and resolution.

Decision making

18. There is often uncertainty over the weight to be given to P’s own wishes - for example not understanding that these need to be taken into account in any evaluation of best interests.

19. The MCA, it is felt, has encouraged professionals across health and social care to take a much wider, more rounded view of best interests, than may previously have been the case, though an undue focus on narrow medical issues in such cases can still be found.
20. MCA now encourages a decision maker to consult more widely with those engaged in caring for P or interested in his welfare (where previously they may have just gone to the “next of kin” only) but in reality there is still significant deference to family and there is confusion over the role of those consulted, which ought to focus in particular on helping the decision maker take into account P’s own wishes, values and beliefs - see esp MCA s4(6) / (7). Sometimes the “next of kin” have unrealistic and inappropriate expectations that they are the decision makers, and this lies at the root of many disputes, but this misplaced expectation can also be burdensome for them if they feel expected to make a decision.
21. The MCA does not in our view do enough to make it absolutely clear that capacity to make a decision means the choice among actual available options, and so a lack of capacity does not mean that a “best interests” argument can be used to demand options / resources that would not otherwise have been offered. Though case law has recently helped to clarify this, we often find arguments put on behalf of a patient or their family that a lack of capacity should effectively confer advantage to the patient in resource allocation decisions that ought to be challenged, if at all, only by way of Judicial Review, not in the Court of Protection.
22. There is often confusion over the function of LPAs / deputies, ie the different kinds, need for registration with OPG etc, and the restrictions that remain on their decision making.
23. Effective use of Advance Decisions is a comparative rarity in our experience, and for the intention of these provisions to be fulfilled, there may need to be more support for people to help make advance decisions and to ensure that they are valid and applied.
24. The role of IMCA is valuable and “one of the best things about the MCA” in our clients’ views, though there needs to be clear boundaries and clarity of role.
 - They are not used often enough in safeguarding, and usage levels varies across local authorities.
 - Rates of IMCA referral for serious medical treatment decision referrals feel lower than would be expected, but audit and benchmarking stats are difficult.
 - There is inconsistency in their involvement - eg a P is much more likely to get an IMCA for a care plan review if there had been one involved in a change of accommodation decision as well.
 - There is a concern that the need for advocacy for P can be masked where there is “consensus”, if IMCAs are only involved in cases of dispute. What about people who do have family with clear views, which may not be P’s own views?
 - There should be a review of IMCA training, which has often been focussed on the MCA rather than the IMCA role specifically, and for which there is little quality assurance or accountability. There is a key role at a pivotal time in the lives of very vulnerable people, and it could be professionalized, perhaps with a mandatory professional qualification, or a quality performance mark?
 - There is a lack of benchmarking across various advocacy provider organisations.

DoLS

25. We should not lose sight of the fact that Stephen Neary would not have been reunited with his father if not for the (eventual) use of the DoLS system, and the challenge this allowed. Identification of an actual or potential deprivation of liberty now triggers a process of scrutiny which includes independent reviews, representatives, a plan, and often an improvement of their quality of life. However, the consensus is that this is the least successful aspect of the MCA, with the drafting complex and the system unwieldy.
26. Effective benchmarking and sharing of experience and expertise are hindered by the same issues identified above - lack of national guidance / resource, and where data is collected it is largely quantitative rather than qualitative.
27. Training is not quality assured - even the mandatory statutory refresher training.
28. There remains an inherent reluctance among providers of health and social care to identify a DOL, perhaps as a result of the negative connotations of such a pejorative phrase, in contrast to, for example, "protective care". In many cases a DOL is not identified in practice unless there is active and vocal objection by the person in question, which may operate inappropriately to deny the procedural safeguards to some of those who need them most.
29. There is real concern that this most fundamental question - what is a deprivation of liberty? - is opaque, and guidance from the courts can seem inconsistent.
30. To the extent that guidance / case law has been forthcoming, it has not always been helpful. Elements of the case law have been of concern, as apparently supporting or introducing factors which could be confusing, misleading, or construed as arbitrary or discriminatory. We would hope that the forthcoming Supreme Court judgment in Cheshire will bring some clarity.
31. There is also an issue that the Safeguards, as they currently stand, provide procedural protection only in care homes and hospitals, while some of the most vulnerable people may be in the community or in supported living. We would support the extension of DOLS, or an equivalent system, to cover those other groups.
32. The current system makes enormous practical demands on those involved, especially for urgent applications, or renewals too late before the expiry of the previous standard authorisation, when it's very difficult to get everything done in time. The supervisory body needs to scrutinise the assessments, but there isn't much time for them to do this.
33. The enormous and alarming regional variation in the use of DOLS appears to be unjustifiable and needs investigation.

Court of Protection and the Office of the Public Guardian

34. Some clients have expressed a frustration at the OPG's inability in to record a flagged concern on a system that would then be picked up again later if there were further issues. The only way to raise concerns seems to be an application to Court.
35. The introduction of health and welfare LPAs is seen as a good idea and empowering, but there is often misunderstanding about LPAs generally - that they are not operational unless P lacks capacity for the decision which is within the LPA's scope, and they are not a blanket authority to act in any way the attorney sees fit on any decision.

36. Costs of a Court of Protection application are sometimes seen by clients as prohibitive, and it is felt to be an unwieldy process. There is a view among our clients, especially those who regularly work with the Mental Health Act, that an arrangement more akin to the Mental Health tribunal system would be better.
37. LSC funding is not sufficiently available, and it feels arbitrary that DOLS appeals are LSC funded without means testing, while welfare disputes are not, when substantially similar issues may be involved.
38. But there is also nowhere near enough use of informal dispute resolution services for MCA / COP matters. This may not be straightforward, and there will be a challenge over the actual and perceived independence of any decision making mechanism if it is funded and delivered by the public body with which there is a dispute, or whether a patient or family could or should be expected to meet some of the costs, or how any such ADR could be binding, while meeting ECHR Article 6 rights. Nonetheless, we agree that it would be positive to see much more resource and attention given to alternative ways to resolve disputes, with the Court used as it should be as a last resort.
39. Having said that, there is still sometimes a lack of awareness over the kinds of cases that must go to Court - seen recently in a non therapeutic sterilisation case where a clinician was in the first instance happy to proceed on the basis of the female patient's family's wishes (A Local Authority v K, 2013). In other cases, there is uncertainty over the level of dispute that should trigger an application to Court.
40. We welcome the more open reporting of Court of Protection cases, as important for the transparency of justice, and vital to counter some of the disparaging perceptions and media coverage of the Court as some secret tribunal.
41. In the relatively early stages of development of a jurisdiction, it is unavoidable that case law can appear contradictory. High profile cases which have been critical of public bodies and others have helped to focus attention on the relevant issues, but there is a long way to go. Overall not enough cases are taken to Court.

Regulation

42. There is frustration at the inconsistency between the annual returns on MCA / DOLS and the data that the CQC want to collect. It would be sensible for this to be co-ordinated, and for all the relevant information to be collected once and once only.
43. We welcome the imminent appointment of a dedicated senior role within the CQC to lead on MCA and DOLS issues nationally, which we expect to have a very positive effect.
44. We would caution against fragmentation or duplication of regulation in this area.

Other Legislation

45. One of the most frequent issues we are asked to deal with is the relationship between the MCA and MHA. The drafting of Schedules A1 and 1A in particular does not help, and as mentioned above in our view the reference in the title of the MCA to “mental” capacity is unnecessary and prone to cause confusion with the MHA, even among health and social care professionals.
46. There is an inconsistency in approach between the principles of the MCA - that the person best placed to assess capacity is the practitioner helping P to make a particular decision, ie it could be a Discharge Nurse, OT, or a social worker - and the Court of Protection form 3 to certify a lack of capacity to start proceedings that must presumptively be completed by a doctor, psychologist or psychiatrist.
47. There are still examples of patients who are detained under the Mental Health Act being treated as if they therefore lack capacity for all decisions, and of patients whose decisions about physical health needs, where the compulsory treatment powers of the MHA cannot be applied, are not properly considered under the MCA framework.
48. There is also a significant challenge in the management of patients for their physical healthcare needs in acute hospital settings where they are also detained under the MHA but the acute Trust may not have readily available the experience or the mechanisms in place to deal with the due process under the MHA to ensure that the patient’s rights are properly protected.

for further information, talk to us

Ben Troke | 0115 976 6263 | ben.troke@brownejacobson.com

Neil Ward | 0121 237 3927 | neil.ward@brownejacobson.com

