



**MCA Leads Meeting 20<sup>th</sup> November 2007 – City Conference Centre  
Draft Addendum to the Mental Capacity Act 2005 Code of Practice: Deprivation of Liberty Safeguards**

**Comments from the London wide DOLS / MCA leads network: a London wider response to the consultation process**

**We would welcome general comments on whether this Code will give Primary Care Trusts, Local Health Boards, Local Authorities and hospital and care home managers clear guidance on how to deliver the deprivation of liberty safeguards and how it could be improved (specific drafting suggestions and general comments on format, style and ordering would be welcomed).**

Comments:

COP was clear and well written. Serves a purpose. Some leads expressed concern about whether the lay out was clear enough for lay people – easy read version and leaflets would support this.

Some discussion around the influence of the MHA with it's strong medical model, rather than looking to the MCA aspirations.

Whilst we understood the reluctance to use examples of what deprivation definitely was, we did feel that examples of what it WASN'T might be equally helpful.

With regard to the circumstances and process by which an authorisation request might be made, we felt that an example – linked to a case studies, would be helpful. This could be in the in COP or training materials.

Having examples of standard forms in the code (either integrated or in an appendix) would be advantageous. The group felt that the use of standard forms would help where people had to share assessments across authorities, to ensure that all supervisory bodies, for example, would be willing to accept an assessment undertaken by a Best Interest Assessor who lives in a different area.

Question 1. Will the guidance give the assessors in the deprivation of liberty safeguards process a clear understanding of their role and how they should fulfil it? If not, how could the guidance be made clearer?

- Comments:

Leads felt the code needed to acknowledge that assessors would need a greater degree of detail compared to other people. Others would need an overview of the roles, assessors needed to understand the role in detail.

There were concerns about how prescriptive the structure for assessment in COP – for example the numbers of assessments and whether the areas of assessment could actually be covered by fewer people.

Some concern was expressed about the difficulties for the eligibility assessor in identifying whether to use the Mental Health Act or Mental Capacity Act was most appropriate. Understanding and knowledge about the Mental Health Act was felt to be essential. Identifying when to use Guardianship as opposed to DOL in a residential care situation was felt to be particularly problematic.

Leads also felt it was important to have the same advice in both mental Health Act and Mental Capacity Act COP

Whilst this may not be a function for the Code of Practice, developing a system so that supervisory bodies could access local assessors would be very beneficial for example, avoiding having to send BIA's long distances or accessing BIA's with special knowledge.

Question 2. Has the information in the Code for service users, family, friends and informal carers been presented in a clear and helpful way? Has the correct balance been maintained between the best interests of the individual and the importance of involving family and carers in decision-making?

Comments:

Easy read needs to be available – good feedback from MCA COP

Question 3. Is the role of the Court of Protection in the operation of the deprivation of liberty safeguards clear? If not, how could the guidance be made clearer?

Comments:

The code needs to be clear about whose responsibility is it to ensure the person and/or their representative understands appeal process.

It also needs to be clear about the difference between rights to 'appeal' to the Court of Protection and the rights to ask the Supervisory Bodies to review a part of the assessment. More detail is needed about how processes for review should work (good practice examples), and in what circumstances it would or would not be likely to agree to review a decision.

The processes for appeal is not sure clear enough. There was a need for more advice: for example: does it come under legal aid or not?

COP refers us to the dispute resolution processes of each organisation. Ombudsman and Supervisory Bodies needs to be clear when need to move complaints onto Court of protection. Ideally this should be more clear in the DOL COP...

Question 4. re the roles of IMCAs and relevant person's representatives in the operation of the deprivation of liberty safeguards clearly expressed? If not, how could the guidance be made clearer?

Comments:

We would like to see clarity over whether an IMCA service also be a representative service? Would this affect the role of the IMCA and would it affect their independence?

IMCA role is likely to have a longer term role than at present when supporting those under DOL. Need to ensure that a time limited IMCA role is clear versus the personal representative. There are also some concerns that the PR is more like the traditional advocacy role, and that this might confuse people who are already unsure of the difference between advocacy and the best interests role of the IMCA.

More clarity about the professional representative would also be helpful – in particular when to use this person where there are concerns about the choice of relevant person. This might also need to include the role of the Supervisory Body in checking ensuring that the PR is working in best interests of individual.

Question 5. Is there sufficient guidance in the Code for the commissioners of care? If not what additional points need to be made?

Comments:

- Does this need to be clearer? What should be in contracts?

Leads felt that it appears a bit lacking in solid description on this role. There is clearly a role for commissioners who have a working relationship with the providers, and should therefore be supporting providers to identify situations where deprivation of Liberty may be occurring..

More advice on contents of contracts with providers would be helpful, for example, should they be set up to draw MA into the arrangements? This is done in Safeguarding Adults, where providers have contractual obligations to identify and report concerns. Such issues could be dealt with in the Code of Practice or elsewhere.

Question 6. Does the Code address the necessary practical points relating to care planning? Are there links to other guidance that need to be made?

Comments:

Leads felt that advice on including a 'trigger' in Care planning forms to prompt thinking about DOLs, and in paperwork for continuing care applications would be useful.

On a practical point, a lot of information is requested from Managing Authorities, much of it is basic and should be part of the basic information set provided to the MA when someone is admitted. Having forms that include all relevant information as part of the admission paperwork would be helpful. Some standard forms for 'good practice' might be useful.

- Leads noted that regulations on assessors not being able to assess their own clients runs counter to the SAP and Person Centered planning processes, as well as the processes of the Mental Health Act.

Question 7. Is there sufficient guidance on the review process and, if not, how could the guidance be made clearer?

Comments:

There was felt to be confusion currently in the document about when a review should be called. In one instance (5.1) the states AB must review if instructed by person. Elsewhere says review due to change. Without clarification on when it might be appropriate or inappropriate to agree a review, there could be many reviews without evidence of change.

MA can allow the DOL to relapse, does this, or should this trigger an automatic review? Can the MA allow DOL to lapse without informing the SB?

The responsibility given to the Managing Authority with regard to monitoring was considered. Last chapter about monitoring was felt to be weak it depends on the MA doing their job well. This would especially be the case for self funders who would not even have the benefit of monitoring by commissioners of Care. Clarifying the responsibility of professionals towards others within a care situation where there are concerned about DOL might be helpful – ie if a professional views someone else's care as overly restrictive, what professional obligations do they have to pass on these concerns?

Question 8. It is not possible to give a definition of deprivation of liberty in the Code because it is defined by judgements of the Courts. Is the summary of case law and list of factors to be taken into account helpful? If not, how could it be made clearer?

Comments:

The group discussed the possibility of using the term 'detention' rather than deprivation of Liberty, and felt this was a harder definition to make. They were also concerned in was very late in the process to change anyhow, as too far down the line.

Again, leads wondered whether listing factors which were not providing examples of what wouldn't amount to a DOL. Restrictions on quality of life freedoms might also be usefully included in this debate.

Question 9. Is the guidance on how to avoid deprivation of liberty useful? How could it be strengthened?

Comments:

There needs to be a more explicit expectation on the MA of keeping the need for the use of DoL powers under review. Ensuring not continue to use DOL when no longer required. Care Plans should be reviewed monthly for example Advice on how often to review internally would be helpful, as well as encouraging including in current processes, like care management.

Where fluctuating capacity is an issue more advice on whether to maintain a DOL would be useful. For example, if due to epilepsy a person regularly needs to be restrained or cared for in a very restrictive way, would it be appropriate to use a DOL to review and monitor the process?

Page 21 – there should there be more about hospitals not detaining, as well as care homes.

Question 10. Is the description of the inter-relationship between the deprivation of liberty safeguards and detention under the Mental Health Act 1983 clear? If not, how could it be made clearer?

Comments:

The group felt strongly that Guardianship could be an alternative in some cases to a DOL (where restrictions rather than deprivation was an issue), and there does need to be clearer advice that focuses on when to use each process, and when to use both. This also means the statement that an eligibility assessment wouldn't be needed in most care homes overly optimistic if not wrong. Similarly, advice in this code also needs to be reflected in the MHA code. This section needs a lot of revision.

Question 11. This Code will initially be a standalone document, to be used alongside the main Mental Capacity Act 2005 Code – are the links to the Main Code clear? Should it remain as standalone or would it be more appropriate to integrate it into the main Code when that is reviewed?

Comments:

The group felt the DOLS code should be part of MCA

Question 12. The Impact Assessment is intended to cover issues arising from the draft Code. Have we covered all of the significant areas of impact of the deprivation of liberty safeguards? Do you have additional evidence to submit? Would you propose changes that would have a positive impact on equality or which would reduce burdens? We would be particularly interested in any comments on ways in which the draft Code may impact adversely on people because of their age, disability, race, religion and belief, gender or sexual orientation, and on any ways in which it could be used positively to promote equality.

Comments:

The group were not sure how helpful at local level as not deal with local level. So much depends on definition of DoL. One London Borough has since the meeting been scoping it's needs, and feels that the majority people in the care homes it runs (whose care focuses on the most challenging cases) would need assessment and may be eligible for a DOL. Without the hospital cases, this alone would amount to 350- 400 cases needing assessment.

**Mental Capacity (Deprivation of Liberty: Eligibility, Selection of Assessors, Assessments, Requests for Standard Authorisations and Disputes about the Place of Ordinary Residence) Regulations 2008**

Question 1. Do you support the general eligibility requirements for assessors? (These eligibility requirements need to be read in the light of paragraph 129(2) of schedule A1 to the Mental Capacity Act 2005, which requires the supervisory body to select an assessor who is both eligible to carry out that assessment and suitable to carry out the assessment having regard to the type of assessment and the person to be assessed). If not what changes would you propose?

Comments:

Broadly in support of these requirements, that the assessor should be suitable to the case. However, there were concerns about the practicability of this, especially in the short term.

People did also feel that there may be some discreet activities (such as searching for advanced decisions and LPA's) which could fall to administrators. Professional assessors could therefore focus on situations where there was a clear opposition to a care plan.

There was support that BIA can be someone beyond an AMHP, especially for practical reasons, but concerns about people having

sufficient knowledge of the mental health act.
Question 2. Do you support the professional qualifications and experience required for mental health, best interests and mental capacity assessors (regulations 4,5,6)? If not, what changes would you propose?
Comments:  There were clear concerns about the use of Sec 12 doctors – supervisory bodies who are not PCTs will have no control over Sec 12 doctors availability, and there were doubts about the PCT's responsibilities for ensuring that there were enough s12 doctors to undertake the different roles. More explicit guidance in the code on practice on this issue would be helpful.  Market forces (ie money) was felt to be a key issue for people in terms of undertaking training and assessment work.

Question 3. Do you support the exclusions to who can be an assessor in regulations 7 and 8? If not, what changes would you propose? Given these exclusions, and any others you wish to propose, what are your views on the issues for supervisory bodies in identifying suitable assessors?
Comments:  Although the group understood the aspirations of the drafters of the regulations, they felt that the actual logistics work against it.  A better definition of independence is needed, esp with regard to 'power' relationships.  Also concern about practical issues –a Trust can have large number of employees, and joint arrangements have led to merged health and social care organisations, such that no employees might be eligible to do assessments in some cases. The restrictions imposed where an organisation were both MA and SB was felt to be particularly difficult and unworkable. This might be a case where more independence from the care team providing care or decision making might be most appropriate, but not outside of organisations. Concerns were also expressed about not being able to use assessors from within care team in situations where specialist knowledge or support were in short supply – eg a head injury unit might be the only similar resource for 100's of miles.  More clarification about independence for care homes is needed, as is clarification about what 'working in the hospital' means. Is a hospital social work team, employed by a different organisation, 'working in the hospital'?  LA Care Homes- because of the move to bring complex (and expensive) care 'in-house', there will be many cases in such care homes that

need independent assessors will be highlighted. Where to get such assessors will be a difficult issue both within and outside of London.

The group recommended a transitional period where rules about independence were more relaxed, and systems etc could be more easily defined.

' being suitable for the case' - What is enough expertise in an area needs to be defined – e.g. worked in that area in the past, or has received training in the area.

There was a question about the legal status of the assessor – are they as independent as the AMHP? Do they take on personal liability when they undertake assessments? Is there a move more towards personal responsibility/liability ( like ASW warrant)?

The group discussed whether the SB have to “accept” the BI assessor – what happens if BI decision flawed? This discussion emphasised the need to have competent BIAs . However, advice on the circumstances in which a SB (or other professional) might challenge the views of BIA, if they are able to do so, might be helpful. The contrast with the role of the AMHP was considered, as it would not be seen as good practice to challenge an AMHP’s decision, unless the process had been clearly flawed or the information that the AMHP had available had been incomplete.

Question 4. Are the time-frames in regulations 9 and 10 appropriate and practicable given the nature of the assessments to be carried out?

Comments:

Concerns were expressed about the 7 days timeframe in particular, and whether this was practical in situations where assessors might be difficult to locate. More advice on when it is appropriate to extend the time frame would be helpful, as would the role of the MA as opposed to the SB in deciding to extend to 14 days. Some felt it should be the SB’s decision that counted with regard to the extension, not the MA. Perhaps an extension can only be granted at the request of a SB.

More advice on how these assessments might dovetail with other social care processes would also be useful.

Question 5. The aim of regulation 12 is to promote both the quality and the timeliness of the assessment process by ensuring that the supervisory body has the necessary information to appoint the right assessors and that the assessors have the information that they need to carry out the assessment. Do you agree with the proposed information to be provided with an application? Would you suggest any changes?

Comments:

The need for info will vary e.g self funders would require more information than those whose care is commissioned (and therefore most practical information should be available already .

The data required was not thought to be particularly contentious, but leads were concerned that MA were not discouraged from either accepting or referring people who needed to be assessed.

Question 6. It is the government's intention, as far as possible, that assessors should be used who are based where the person currently is. This will mean in some cases that a supervisory body uses assessors from another area, rather than sending assessors to travel to the place where the person is receiving care. Therefore, the assessment workload will need to be reflected in the allocation of funding. We are considering how this should be done and currently favour the allocation formula used for the Independent Mental Capacity Advocacy service for this purpose too. Do you agree with this approach? If not what formula would you propose?

Comments: What are the London specific issues that need to be considered?

Assessment should be where people ordinarily reside – however, the law around this was felt to be complex, and more explicit guidance as to what this would mean in practice is required. London is a net 'exporter' of residential care (but may be an 'importer' of complex medical care where DOLS may also be required). A funding formula that reflected the realities of the situation would be required, if this system were to work effectively.

There may also be 'short term' and 'long term' issues to consider.

In the short term, people already out of borough in placements would be best assessed where they are in care homes. In the longer term, as more people come into the system (and have to be assessed prior to admission to hospital or care) the burden may be more evenly spread-except for 'repeat' reviews. This may make timescales more difficult when assessments/reviews are due for someone placed miles away.

Also, the issue of when self funders become ordinarily resident needs to be considered. If when the person moved into the care home, they already didn't have capacity, could it be said that they had 'chosen' to move? Can ordinary residence be implied in such circumstances?

Question 7. These regulations also cover what should happen if the local authority that receives an authorisation disputes that it should be

the supervisory body. The aim of the regulations is to ensure that this does not delay the assessment process. Do you consider that the arrangements in regulations 13 to 15 will be practical and workable?

Comments:

More detail about how the borough of ordinary residence (or the PCT with commissioning responsibility) might be charged in situations of dispute would be helpful, and would speed up this and possibly other issues of contention. Whether having standard 'set' fees for this work would also be useful should be considered.

**Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008**

Question 1. Do you support the eligibility criteria in regulation 5 for appointment as the relevant person's representative? If not, what changes would you propose?

Comments:

Question 2. Do you support the requirements for appointing the representative in regulations 4 and 6-13, read with the guidance in chapter 4 of the draft Code? If not what changes would you propose?

Comments:

<b>Question 3.</b>	Do you support the requirements in regulation 14 for terminating the appointment of a representative?
Comments:	
<b>Question 4.</b>	The Impact Assessment is intended to cover issues arising from the draft statutory instruments. Have we covered all of the significant areas of impact of the deprivation of liberty safeguards? Do you have additional evidence to submit? Would you propose changes which would have a positive impact on equality or which would reduce burdens? We would be particularly interested in any comments on ways in which the draft statutory instruments may impact adversely on people because of their age, disability, race, religion and belief, gender or sexual orientation, and on any ways in which they could be used positively to promote equality.
Comments:	

