CARE ENGLAND
Representing independent care providers

Suggested amendments to enable the Mental Capacity (Amendment) Bill to achieve its aims in practice.

Aims of the Bill

1. **To protect the human rights of extremely vulnerable people who may lack capacity to consent to arrangements thought necessary to protect them or others, where those arrangements amount to a deprivation of liberty**
2. **To achieve (A) in a less bureaucratic, less confusing and less resource-heavy way than the current schemes**
3. **To improve the confidence and competence in providing human rights-based and MCA compliant care of care providers (particularly at the level of front-line managers: these are the people whose actions must put into practice the principles of the MCA)**

Suggestions to enable the above aims to be integrated in practice

1. Bring back into the Bill the well-received suggestion from the Law Commission to strengthen the effect of MCA ss. 4 and 5: see http://www.lawcom.gov.uk/app/uploads/2017/03/lc372_mental_capacity.pdf discussion and Appendix A clause 9.

1.1 This would make it mandatory that, as soon as the initial decisions *appear likely* to place a person lacking capacity in a setting, and/or for a purpose, that is not in accordance with their wishes and feelings, the likelihood of the care plan depriving the person of their liberty is recognised. It is the responsibility of **the decision-makers** at this point to lay out

- the evidence in terms of the person's lack of relevant material capacity why the proposals are in compliance with their wishes and feelings or, if not, the reasons why no less restrictive option can be identified
- the necessity and proportionality of these arrangements in terms of risk of harm to the person and/or others
- evidence of who has been consulted as well as the person in order to ascertain the above

This strengthens the ability of the new system to meet aims (A) and (B) above, while meeting the underlying requirement of (C) throughout health and social care.

2. This evidence then forms the basis of the draft authorisation in cases where there is no objection on the part of the person.

- The same process would apply whatever the proposed setting for care or treatment across health and social care, preventing the inevitable confusion when the systems would vary according to whether the setting selected for care was a hospital, a care home or supported living/other community setting (the latter variability, if retained,

is sure to cause confusion as it has done with DoLS, on the same grounds of purposeless complexity). It addresses the risk of a perverse incentive leading some care homes to seek a change in registration to supported living (cf. similar widespread actions a decade ago to take advantage of Housing Benefit rules).

- Working within the wider MCA – which has been clarified by Government as unchanged by the Bill – lays on the decision-maker in essence these responsibilities: it is illogical to transfer them to the care provider who is not responsible *prima facie* for the decisions about placement, care and treatment. As providers point out, they are impossibly placed to know for example about proportionality and necessity when someone is deemed a risk to others within their own community or family, or whether a less restrictive option could be identified. **This meets aims (A) and (B) above.**

- It also enables rapid identification of objection to proposed plans by the person or those close to them, again **meeting aims (A) and (B) above**.

- This process builds on the recognition in the current Bill that these decisions must have been already made, in order to decide on a necessary and proportionate deprivation of liberty: but puts back a stage the responsibility for commissioning the assessments and drafting the authorisation to where, in practice, this responsibility must sit. This would go a long way towards meeting the House of Lords recommendations for embedding the MCA correctly within decision-making. **This meet aims (A), (B) and (C) above.**

2. Process where the person objects

3.1 The responsible body would, on receiving the draft authorisation request from the decision-maker, be alerted to involve an AMCP as currently envisaged. This would enable cases of objection to be properly assessed before a placement takes place: the longer the delay the more likelihood is that the person's options are cruelly limited by circumstance (such as the selling of their home to fund care which the person is resisting). **This meets aims (A) and (B) above.**

3. There would be no change, apart from bringing in a procedural simplification, to the proposals that hospitals and CCGs as well as local authorities should be responsible bodies

4.1 This simplification of requiring an initial authorisation to be drafted by the decisionmakers
reduces the burden of the responsible bodies, by removing the explicit expectation that they will carry out the initial assessments in all community settings where a person is deprived of their liberty. **This meets aims (A), (B) and (C) above.**

4. The provider becomes explicitly responsible for carry out reviews, both when they think it necessary (as their knowledge of the person evolves) and also, whether or not there is objection by the person, in accordance with the time schedule proposed in the Bill.

5.1 Their assessments will initially be based on the primary assessment record achieved by

recording the elements described in 1.1 but as their knowledge of the person deepens they will gain the necessary expertise to assess the person's situation themselves or form a view on the implications of relevant assessments which should be carried out anyway: it would be extremely poor practice for health care professionals, such as the GP or other community staff, to fail to assess the health needs at least annually for a person lacking capacity who is receiving care. **This meets aims (A), (B) and, crucially, (C) above.**

5. Costs and bureaucracy are minimised by being the responsibility at each stage of the most appropriate person or organisation with the required knowledge of the situation.

6.1 Reduplication of activity is avoided: assessments of capacity, mental disorder or disability (currently 'unsound mind'), and 'necessity and proportionality' are an essential part of initial planning, and with forethought can be built in to an ongoing review process. This will undoubtedly save the money and bureaucracy that, in the current Bill, risk simply being transferred from the local authority to the care provider – and thence, in many instances, to the very population of vulnerable people, those lacking relevant mental capacity, whose rights the systems are intended to protect: a perverse outcome indeed. **This suggestion meets aim (B) above.**

6. Conclusion: these suggested amendments are closely based on the proposals within the Bill, but they avoid placing onerous responsibilities on providers at a stage when they lack the knowledge to carry them out adequately. They protect the rights of the person within a less bureaucratic and far simpler procedural framework than either the somewhat discredited and certainly expensive DoLS or the processes currently envisaged in the Mental Capacity (Amendment) Bill.

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