Evidence Submission

Select Committee on the Mental Capacity Act 2005

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About this call for evidence

The House of Lords has established a Select Committee on the Mental Capacity Act 2005. The terms of reference of the inquiry ask the Committee to "consider and report on the Mental Capacity Act 2005". Age UK is pleased to have the opportunity to respond to the Committee's call for evidence.

About Age UK

Age UK is a charity and a social enterprise driven by the needs and aspirations of people in later life. Our vision is a world in which older people flourish. Our mission is to improve the lives of older people, wherever they live.

We are a registered charity in the United Kingdom, formed in April 2010 as the new force combining Help the Aged and Age Concern. We have almost 120 years of combined history to draw on, bringing together talents, services and solutions to enrich the lives of people in later life.

Age UK provides information and advice to around 6 million people each year, runs public and parliamentary campaigns, provides training, and funds research exclusively focused on later life. We support and assist a network of 170 local Age UKs throughout England; the Age UK family also includes Age Scotland, Age Cymru and Age NI.

Please note this submission relates to our experience in England only.

1. Summary of key points

1.1. Age UK strongly supported the development and implementation of the Mental Capacity Act 2005 (MCA), however we are concerned that despite the clear link to human rights in the legislation, in practice, application of the MCA is often divorced from a rights based approach.

1.2. It is vital that the core principle of the presumption of capacity is adhered to when assessments of capacity are being made. Assumptions must not be made about lack of capacity to make a particular decision simply because someone is older, has dementia or is frail. It is of concern that professionals responsible for implementing the Act sometimes fail to appreciate that older people may regain capacity or have fluctuating capacity.

1.3. It is taking a long time for consideration of capacity to become embedded in day to day practice across the board in social care, health and the financial services sectors. A key barrier remains the very low level of awareness of the legislation among professionals, individuals and their families and carers.

1.4. Decision making involving older people often takes place in moments of crisis, under time pressure. In these circumstances, for example in hospital settings when treatment decisions need to be made urgently, it can be difficult for the

MCA procedures to operate at the necessary pace. More effective publicity of advance decision making and improved training for all health and social care professionals would facilitate more timely access to MCA procedures.

1.5. Age UK believes that it is very positive that the requirement to involve an advocate was enshrined in the MCA, however in practice the lack of timely access to effective advocacy remains a major barrier to achieving the aims of the legislation. Independent Mental Capacity Advocates (IMCAs) are currently under-utilised.

1.6. It should be viewed as positive that the number of Deprivation of Liberty Safeguards (DoLS) applications is rising, as it shows that more people are being afforded the protections that the legislation offers. However we believe that the figures may not accurately reflect the true need for DoLS protections among the older population.

1.7. Older people may face a number of barriers in seeking to access the Court of Protection (CoP) including high costs, lack of access to legal aid, travelling distances to the court and the length of proceedings.

1.8. There is a case for professional health and care regulators to take a greater role in relation to the MCA. More emphasis also needs to be placed on the role of employers who have a clear responsibility for ensuring that their staff are aware of and confident to use MCA procedures.

2. Overview and context

2.1. Older people who lack mental capacity for some decisions have little or no voice and are among the most excluded groups in society today. They are all too frequently deprived of their human rights to freedom, respect, equality, dignity, and autonomy. Age UK and its predecessor organisations Age Concern and Help the Aged have strongly supported the development and implementation of the MCA which is designed to protect these individuals and to safeguard their human rights.

2.2. We are concerned that despite the clear link to human rights in the legislation, in practice, application of the MCA is often divorced from a rights based approach, which takes as its starting point the individual's right to be treated with dignity and respect for their right to autonomy. Practitioners frequently fail to ask themselves why they are applying the procedures mandated by the legislation and take instead a box-ticking approach. This means that application, for example of DoLS, is not closing the rights gap as effectively as it might and individuals do not feel that their rights to dignity and autonomy have been respected. In part this is also due to the lack of ability to challenge decision making easily, effectively and through channels other than the courts.

2.3. It is vital that the core principle of the presumption of capacity is adhered to when assessments of capacity are being made. In practice stereotyping often leads to assumptions being made about lack of capacity to make a particular decision simply because someone is older, has dementia or is frail.

2.4. In this context we are concerned that in practice there remains uncertainty about how to apply the two-stage functional test of capacity set out in sections 2 and 3 of the MCA. This confusion is perhaps to some extent inherent in the legislation as the sequence of 'mental impairment' and then 'inability to make a decision' in 3(1) may appear to reverse that in 2(1) that a person is 'unable to make a decision because of an impairment of, or a disturbance in the functioning of, the mind or brain'. The Code of Practice does explicitly state that the diagnostic question is 'stage 1' and the functional question is 'stage 2' but this has not always been how the test has been interpreted in the case law. Whilst the court's approach in PC v City of York Council [2013] is arguably more person-centred and in the 'spirit' of the MCA than the Code's, it demonstrates how confusion can arise for experienced MCA practitioners, let alone members of the public. Age UK recommends that the Code of Practice is updated to give greater clarity in this area.

2.5. In our experience anxiety, aggression and other 'challenging behaviours' in older people are often wrongly ascribed to a mental illness rather than to a potentially treatable physiological cause such as an infection or chronic pain that could be controlled. This can lead to wrongful determination of mental incapacity.

2.6. Professionals may also have a lack of appreciation that older people may regain capacity or have fluctuating capacity. This is particularly important where decisions are taken with long-term consequences, for example treatment decisions.

2.7. In practice the principle in the legislation that decisions are made in a way that is 'less restrictive' is frequently reinterpreted as requiring decision makers to take the 'least restrictive' option. This can cause confusion when actions under the MCA are being considered and may be especially problematic in a context in which decisions need to be taken that balance the rights of an individual with those of other people, for example staff and residents in a care home. Providing a range of statutory forms that local authorities and other decision makers could use rather than having to create their own, as exist within the context of the Mental Health Act 2007, may be one way to prevent the language being changed in this way.

3. Implementation

3.1. It is taking a long time for consideration of capacity to become embedded in day to day practice across the board in social care, health and the financial services sectors. A key barrier remains very low levels of awareness of the legislation among professionals, individuals and their families and carers.

3.2. Within older people's social care we believe that implementation of the MCA has been inconsistent across the country, with people frequently failing to have their capacity assessed and relevant procedures not being followed when it would have been beneficial to do so. In other instances the legislation is being misused to support risk-adverse practice, as in the case of 82 year old Peggy Ross who was prevented by Cardiff Council, using DoLS, from going on a holiday cruise. The court decided that it was in the respondent's best interests to go on the

cruise, and also later decided that the respondent herself had capacity to decide whether or not to go.[1]

3.3. In Age UK's experience consideration of the MCA is all too often absent within health settings and questions of capacity frequently do not even enter the equation for older patients. The erratic implementation of the MCA reflects the variation in dementia care across the country. Part of the problem is due to a deep rooted lack of understanding of older people's needs on the part of many working within health care. Trainee doctors for example spend very little time on older people's wards as a core requirement of their training. Without this knowledge and understanding it is very hard for professionals to determine the role that the MCA provisions should be playing in older people's care. In order to bring about the necessary culture shift much more needs to be done to embed knowledge about the care of older people, including mental capacity issues, into the training and assessment of health care professionals.

3.4. Age UK does not think that the MCA is as widely known and understood by retail bank and building society staff as it should be. Age UK continues to receive complaints from older people and their families about problems they experience when trying to manage their own accounts or an account on somebody else's behalf. For example, we are aware of the case of an 86-year-old customer who was defrauded of £1,650 by a customer adviser with Halifax in Middlesbrough. The original court hearing was told that when she had first noticed the unauthorised withdrawals on her statement and had complained to the bank she had not been believed. Staff thought that she had forgotten to sign the withdrawal slips. [2]

3.5. Our sense, from the complaints that come through to us, is that financial institutions have the appropriate policies and procedures in place but that individual members of staff are not always aware of them. Our view is, therefore, that more efforts need to be made to make sure that all customer facing staff are trained and fully aware of the Act and what options are available to people trying to operate an account on somebody else's behalf under their own policies and procedures.

3.6. We were pleased to contribute both to the guidance for banks and building societies and for consumers that was published in April of this year in collaboration with the British Bankers Association (BBA), Building Societies Association (BSA) and others.[3],[4] Given that this guidance has only been available for a relatively short period of time it is impossible to say whether it has successfully improved practice amongst financial institutions, although we certainly hope that it will. We would expect that BSA and BBA will want to assess the impact that the guidance has in terms of raising awareness amongst industry staff.

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[1] Cardiff Council v Peggy Ross (2011) COP 28/10/11 12063905v

[2] *'Fraudster gets suspended sentence'* 20 Jan 2010, Money Marketing

3 BSA, BBA, OPG (April 2013) *Guidance for people wanting to manage a bank account for someone else*

[4] BSA, BBA et al (April 2013) *A framework for authorising people wanting to operate a bank account for someone else: Guidance for Banks and Building Societies*

3.7. In cases of financial abuse the MCA has helped those working in adult safeguarding to decide where to draw the line between what may be an unwise financial decision and what may be financial abuse. That is to say it can help them to determine where it is necessary to intervene as it enables a specific test of capacity for certain financial transactions to be carried out. Although this can be problematic in terms of establishing retrospective capacity, it is helpful as a starting point for active cases of suspected financial abuse.

4. Decision making

4.1. Decision making involving older people often takes place in times of crisis, under time pressure. In these circumstances, for example in hospital settings when treatment decisions need to be made urgently, it can be difficult for the MCA procedures to operate at the necessary pace. Although this can be a sensitive subject, more effective publicity of advance decision making, including via GPs, social workers and solicitors could help to avoid this in some cases. Some organisations, including Age UK, are already doing this. Improved training for all health and social care professionals would also facilitate more timely access to MCA procedures.

4.2. It is enshrined within the MCA principles that people should not be presumed to lack capacity until all practicable steps have been taken to help them do so. We are concerned that this should be adhered to in situations where people could make decisions *if* they have appropriate support. For example it is proposed in the Care Bill, currently before Parliament that a suitable person could receive a personal budget on behalf of a person who does not have capacity to make decisions about their own care. We have called for the legislation to require that all practicable steps are taken to assist the person in managing their own budget before resorting to this option. This is likely to be a situation where access to advocacy is essential.

4.3. There is an information gap for families and carers about their potential responsibilities under the MCA when they, rather than a paid carer or professional, are decision makers. When required to act in this role they need to be able to access better information and guidance about the process of acting in an individual's best interests.

4.4. Age UK believes that it is very positive that the requirement to involve an advocate was enshrined in the MCA, however in practice, the lack of timely access to effective advocacy remains a major barrier to achieving the aims of the legislation.

4.5. There are certain circumstances in which IMCAs have the potential to be especially beneficial to older people but they are currently under-utilised. These include providing advocacy in adult safeguarding cases and also acting as section 39D IMCAs, supporting the relevant person's representative (RPR) in DoLS cases. In these situations the services of an IMCA are not routinely offered but in our view ought to be.

5. Deprivation of Liberty Safeguards

5.1. Recently published figures by the Health and Social Care Information Centre (HSCIC) have shown that there has been a year-on-year increase in the number of completed DoLS applications since their introduction in 2009/10. There were 11,887 applications in 2012/13, a 4% increase on the 11,382 applications in 2011/12. 55.1% of applications were authorised.

5.2. The majority (71%) of applications in 2012/13 were completed on behalf of people with mental health conditions, with dementia accounting for more than half (54%) of all applications made. As the HSCIC report goes on to point out this is likely to be related to the age profile of people who are subject to application for deprivation of liberty under DoLS (in 2012/13, 73% of applications related to people who were aged 65 and over).'[5]

5.3. It should be viewed as positive that the number of DOLS applications is rising, as it shows that more people are being afforded the protections that the legislation offers. However we believe that the figures may not accurately reflect the true need for DoLs protections among the older population. Given that the Alzheimer's Society predicted that there were 636, 099 people over the age of 65 living with dementia in the UK in 2012, of whom one third live in a care home, we think there may be many more older people who should be benefitting from them who are potentially being unlawfully deprived of their liberty. More research in this area is needed.

5.4. In its recent report on the implementation of the Mental Health Act 2007 the House of Commons Select Committee has stated that *'[i]mplementation of DOLS has proved problematic, with wide variation in their use'* . Age UK supports the Committee's call for an urgent review of the use of DoLS to be presented to Parliament within 12 months.

5.5. A major problem in securing better implementation of DoLS is the difficulty of holding to account those Managing Authorities who fail to authorise and recognise deprivations of liberty. There have been very few successful legal challenges for Managing Authorities that we are aware of.

5.6. We are also sympathetic to the view that the complexity of the DoLS legislation is a barrier to implementation. The definition of what constitutes a deprivation of liberty and the potential overlap with mental health legislation are areas in which further guidance would be helpful.

5.7. Feedback from families and carers is that where DoLS are effectively used, they can be very positive. At its best the process allows for proper consideration by families, social workers and care providers of an individual's right to autonomy and, as far as can be determined, their wishes.

[5] HSCIC (20 August 2013) Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England): Annual Report, 2012/13

6. The Court of Protection and the Office of the Public Guardian (OPG)

6.1. Older people may face a number of barriers in seeking to access CoP including high costs, lack of access to legal aid, travelling distances to the court and the length of proceedings. These may, in part at least, explain why rates of appeal to the CoP in best interests and DoLs cases remain worryingly low. Consideration should be given to developing less formal, more accessible complaints mechanisms that would allows individuals to challenge MCA decisions at a lower level before taking their case to the CoP.

6.2. The impact of the introduction of Lasting Powers of Attorney (LPA) has not been as significant as was predicted. In our experience awareness of LPAs among the general population is low and access to good quality information is not always readily available. In particular people are not aware of the two types of LPA. There appears to be a lack of understanding of the benefits of an early application as people are understandably reluctant to think about a future worst-case scenario and so put off applying.

6.3. Age UK has welcomed the opportunity to input our views into the OPG's plans to introduce online applications for LPAs. We have made clear our view that while improving the process for online applications is welcome we would strongly be opposed to any move to scrap the hard copy version and promote sole use of the online version.

7. Regulation

7.1 The lead role of the Care Quality Commission (CQC) is clearly very important in overseeing the functioning of the MCA DoLs, but it is of concern that this is currently the only route via which the Government routinely can monitor the Act's implementation. The level of knowledge and expertise in the MCA DoLS across all relevant parts of the CQC's workforce is not clear.

7.2 There is a case for professional health and care regulators taking a greater role in relation to the MCA. For example there is reference to the Act included within the GMC's 'Good Medical Practice' guidance but we would suggest that it could also be part of the revalidation process for doctors that is currently being proposed.

7.3 As mentioned above (para 3.5), it remains to be seen what impact the recently published framework for banks and building societies has and Age UK will continue to feed any complaints and concerns that we receive through to the BSA, BBA and Financial Conduct Authority (FCA). Whilst we supported the development of the guidance, if in the medium to longer term no evident improvement has been made in the practice of banks and building societies we do think that the BSA, BBA and FCA should consider taking further action to improve the customer experience.

7.4 More emphasis also needs to be placed on the role of employers who have a clear responsibility for ensuring that their staff are aware of and confident to use MCA procedures.

8 Other legislation and international context

8.1 In order to better protect the rights of older people who lack capacity it will be essential to ensure consistency between the well-being principles in the Care Bill currently before parliament, with the principles contained within the MCA. Crucially we believe the Care Bill offers an opportunity to provide this group with better access to independent advocacy. The Care Bill does not currently refer to advocacy and there is little on how local authorities can be held to account for not complying with general duties such as provision of information and advice (which in our view should include advocacy). We believe that regulations should require local authorities to demonstrate that they have been through a process of considering how it will meet general duties. This would include a requirement that a local authority has considered likely demand for advocacy services.

8.2 Age UK has called for the Care Bill to include greater powers of entry where a third party is denying access to a person who is thought to be at risk of abuse. In some circumstances such a power might be necessary in order to establish whether the person has mental capacity.

8.3 It is very important to recognise that failures to properly carry out the legal requirements of the MCA will in many instances amount to violations of an individuals' ECHR rights; including the right to private, home and family life (article 8), right to a fair trial (article 6), right to enjoyment of property (article 1, protocol 1), right to liberty (article 5), the right to life (article 2). In this context, it is especially concerning that certain groups of people receiving care services, who might fall under the remit of the MCA, are not currently directly protected under the Human Rights Act 1998. These include those who receive home care services provided by private and third sector organisations under a contract to the local authority and those who arrange and pay for their own care. Age UK is calling for an amendment to the Care Bill to designate all regulated care services as public bodies for the purposes of the HRA.

8.4 The parity principle in the Health and Social Care Act 2012 aims to promote greater equality of esteem between mental and physical health. For this to be realised for older people much greater emphasis needs to be placed on mental health. Currently mental health experience for older people is measured very poorly by the CQC, for example inpatient mental health experience is not captured at all. This is particularly important for those older people who are de facto deprived of their liberty in hospitals for long periods of time (sometimes even years) without any oversight. It is of grave concern that these individuals are ineligible for the potential safeguards of either DoLS or the Mental Health Act 2007. Clarification of the interface between the two pieces of legislation may assist in closing this protection gap.

8.5 With our partners Age International we have called on the Government to play a positive and active role in the United Nations Open-Ended Working Group

on Ageing, encouraging the development of new human rights instruments for protecting the rights of older people, including the possibility of a new convention. We have called for such a convention to include a right to be recognised as a person who has rights under the law, to access the justice system just like everyone else and to make decisions, and get support to make those decisions, about their own life. This would include decisions about their health care, where they live, whether they work or not, how they spend their money, what they do with their own property, how they participate in family, social and public life, plans for care and support if they get ill in the future and where they would like to die.