directors of adass adult social services

Mental Health Drugs and Alcohol Policy Network

Mental Capacity Act 2005

A general update report on developments, including the 'Deprivation of Liberty Safeguards' to be implemented in April 2009

October 2008

1. Background

1.1 The Mental Capacity Act 2005 (MCA) was partly introduced in April 2007 and fully introduced in October 2007 - when the Court of Protection and other aspects went live. The Mental Health Act 2007, which received Royal Assent in July 2007, included an amendment to the MCA to introduce additional Deprivation of Liberty Safeguards from April 2009.

1.2 Councils with Social Services Responsibilities (hereafter, CSSRs) have played a key role to date in the implementation of the MCA. CSSRs have been in the forefront of managing local multi-agency implementation arrangements for the Act, commissioning new services such as the Independent Mental Capacity Advocate Service, and promoting the personalisation policy agenda for which the Act provides the key foundation. New 'Deprivation of Liberty Safeguards' have now been added to the MCA and are required to be implemented in order to comply with the European Court of Human Rights judgement in the HL v UK case in 2004. (This case is commonly referred to as the 'Bournewood' judgement).

1.3 This ADASS Briefing has been prepared by the Mental Health Drugs and Alcohol Policy Network to provide an update to ADASS members on general progress with implementation of the MCA but primarily on what needs to be in place to implement the Safeguards from April 2009. The Network previously produced a Briefing Report in December 2007. This is accessible on the ADASS website at:
http://www.adass.org.uk/publications/consresp/2007/Deprivation.pdf

2. Mental Capacity Act training

2.1 CSSRs across England were funded by the Department of Health for two years to lead multi-agency partnerships in rolling-out training on the MCA to their local workforces in social care, health, housing and the third and independent sectors. The development of training programmes was co-ordinated through the work of Local Implementation Networks/Groups.

2.2 There have been many good examples of training programmes. To take but one example, three CSSRs in the West Midlands (Coventry City Council, Solihull Metropolitan Borough Council and Warwickshire County Council) jointly funded and produced a DVD and Workbook entitled *'My Decision Today, Your Decision Tomorrow'* that was used as the basis for multi-agency training. The training pack can be used by individuals, in short group learning sessions or to support training of up to a day in length. CSSRs can order copies from aprice@magpix.co.uk

2.3 Multi-agency good practice protocols have developed in abundance across the country, often with partner agencies in the NHS. One example is that produced by Wolverhampton City Council in conjunction with Wolverhampton City Primary Care Trust and the Royal Wolverhampton Hospitals NHS Trust (contact: bruce.jackson@wolverhampton.gov.uk).

2.4 Many CSSRs provided exhaustive support through appointing specific training leads, funding the bulk purchase of the Information

Booklets produced by the Ministry of Justice and also supplying copies of the MCA Code of Practice. Many CSSRs also embraced e-learning, the use of podcasts, and the use of their own websites (example: www.westsussex.gov.uk/mentalcapacity) to disseminate and promote the key messages to as broad and diverse an audience as possible.

2.5 CSSRs have continued to receive funding for training on the MCA across the health and social care economy through the Area Based Grant Mental Capacity Act allocation.

2.6 The Social Care Institute for Excellence is funding a conference in December 2008 that is bringing together six CSSRs in the southeast of England and the members of their respective Local Implementation Networks/Groups. The conference will celebrate and share the learning with implementation to date. It will also explore the challenges ahead – particularly around the interface between the MCA and the Mental Health Act. John Dixon, current President of ADASS, will address delegates on the importance of the MCA in underpinning our wider aspirations around the personalisation agenda. The proceedings of the conference will be written up as a report and given to the Social Care Institute for Excellence.

3. Independent Mental Capacity Advocacy (IMCA Service)

3.1 The IMCA Service went live in England in April 2007 and in Wales in October that year. The first annual report of the IMCA Service in England was published by the Department of Health in July 2008 and can be downloaded from the Department of Health's website (www.dh.gov.uk).

3.2 Take-up has been strong across England and Wales, with 5,175 referrals made in total. For the first year the focus has mainly been on long-term accommodation moves (3,047 referrals). Some 671 referrals were made for serious medical treatment decisions. As for the discretionary additional activity, many IMCA Service commissioners embraced the need to provide a service in these additional areas of activity and this was represented in the overall figures – involvement in 675 adult safeguarding investigations, and in 782 reviews of long-term care moves.

3.3 Richard Webb, Corporate Director Adult and Consumer Care at Telford and Wrekin Council (and co-chair of the ADASS Mental Health Drugs and Alcohol Policy Network) commissioned a review analysis within his own organization of the figures from the IMCA Service Annual Report.

3.4 Weighting the figures from the IMCA Report against local population data and the number of eligible referrals per 000 population has enabled a demonstration of the total number of referrals per 000 population, and produced a new order of rankings for CSSRs. For example, in the IMCA Service Annual Report, Norfolk County Council and West Sussex County Council hold the numbers 1 and 2 rankings for the numbers of referrals to the IMCA Service. Using the revised weighted figures produced by Telford and Wrekin Council however, the ranking of these two CSSRs drops to 30

and 23 respectively. CSSRs that would like a copy of the full report – in order that they can review their own individual rankings – should contact Richard Worton, the information analyst who prepared the report for Telford and Wrekin Council (contact: richard.worton@telford.gov.uk).

3.4 This weighted data exercise has now been shared with the Department of Health and may be used to inform future allocations of funding for IMCA services. The Department of Health has welcomed the data with the proviso that commissioning CSSRs that were previously higher up the league tables and have now slipped down a bit may not be too happy to accept a future reduction in budget - particularly if they have had to increase their existing budget spend to cope with the higher volume of actual referrals, irrespective of population weightings.

4. National advocacy qualification

4.1 The national advocacy qualification is progressing, with discussions at an advanced stage with City and Guilds. It will be launched this autumn.

4.2 The Department of Health has indicated that it will pay some of the cost of getting current IMCA Service advocates qualified in this financial year. After that the IMCA Service advocacy organisations will be responsible themselves. This may become a commissioning issue and will need to be reviewed by CSSRs as part of existing Service and Funding Agreements reviews, although if there is only slow turnover of advocates then it should not become an issue for some time.

5. Impact of the Deprivation of Liberty Safeguards on CSSRs

5.1 CSSRs are currently at the forefront of developing the personalisation agenda as set out in the Putting People First Concordat (Department of Health, December 2007). The aspirations of the MCA are around enabling people to make choices for themselves and where this is not possible, for such decisions to be always made in a person's best interests.

5.2 The Deprivation of Liberty Safeguards extend these principles to the most vulnerable people in our communities – people living in residential and/or nursing homes and/or perhaps in long-term hospital environments (including continuing healthcare settings). There will be an expectation, enshrined in law from next April, that care will always be provided in a way that is consistent with the human rights of people lacking capacity who are not otherwise protected or safeguarded through the use of the Mental Health Act's powers. So, if a nursing home manager, for example, wants to stop an individual with dementia from enjoying social interaction with family and friends, or other residents, this will need to be justified as part of care. If the restriction or deprivation is disproportionate, then formal authorisation will need to be provided for it to continue. There is useful guidance on likely scenarios in chapter 2 of the MCA Deprivation of Liberty Safeguards Code of Practice, published August 2008.

5.3 CSSRs are affected primarily as new statutory Supervisory Bodies. In operational terms this means that CSSRs will receive requests from Managing Authorities (registered care and/or nursing homes) and be required to organise, complete and respond to a request for a standard authorisation within 21 days. The Transitional Arrangements have doubled the response timescale for standard authorisations to 42 days for referrals received in April 2009 only. An urgent authorisation, lasting for up to 7 days, may be issued by a Managing Authority but will need to be reviewed by the relevant Supervisory Body before the urgent authorisation expires; the Transitional Arrangements however have trebled the duration of urgent authorisations from 7 days to 21 days for April 2009 only.

5.4 From April 2009, CSSRs will be expected to:

- deliver a system that receives and processes applications from Managing Authorities (primarily registered care homes);
- appoint suitably trained staff to undertake and co-ordinate a best interests assessment and a (separate) mental health assessment in relation to each application, and provide this within certain specific timescales;
- establish an authorisation panel that will consider the outcome of such assessments;
- comply with a range of statutory responsibilities in communicating the outcome of each assessment to a range of defined parties;
- determine, following any recommendation of the best interests assessor, the length of the deprivation of liberty, the identification of a person's representative (as defined in the 'Deprivation of Liberty Safeguards'), and any conditions that should be imposed.

5.5 The Department of Health has been collating the responses from Local Implementation Networks/Groups in relation to the use of the Scoping Tool published in April 2008. There are a number of CSSRs in the south east of England (including Essex, Kent, Surrey, East Sussex, and West Sussex) where the numbers are estimated to be considerably higher than the Department of Health's own estimates. A survey undertaken by RadcliffesLeBrasseur, Solicitors, in summer 2008 cast doubt on the Government's estimates and suggested they may be too low by a factor of 10,000. However the Department of Health has advised that it does not intent to revisit any of its funding assumptions or allocations at this stage.

5.6 It is likely that some form of themed evaluation will take place in due course. In the first year of the operation of the Deprivation of Liberty Safeguards the numbers and geographic spread are likely to be centrally assessed by a benchmarking activity. A pilot scheme may determine Minimum Data Set requirements for the population affected.

5.7 Some CSSRs will be affected as both Supervisory Bodies and as Managing Authorities. Where a CSSR provides care in registered care homes managed in-house, it will need to seek an authorisation from its own authorisation panel but will need to first commission the best interests assessment from another CSSR.

6. Training on Deprivation of Liberty Safeguards

6.1 Higher education institutions across England have been working with the Department of Health, CSSRs and other partner agencies to implement the Best Interests Assessor training requirements. In total some 20 universities are now confirmed as providing this training in time for April 2009. In addition, the University of East Anglia has approved an external training provider and two more (Cumbria and Lincoln Universities) will provide the training as soon as the General Social Care Council approves their current post-qualifying training programmes. The Department of Health has agreed a process to provide these universities with development funds for the courses.

6.2 It is only possible for professionally qualified staff to be a Best Interests Assessor if they meet specific qualification requirements (as set out in Regulations); they must also first undertake an accredited course.

6.3 Training for the mental health assessor role (to be undertaken by doctors) is being co-ordinated by the Royal College of Psychiatrists and the programme has already been launched.

6.4 A small number of specialist independent training providers have been developing training packages around the use of the Safeguards. Training programmes that have been offered to Local Implementation Networks/Groups thus far include both e-learning and conference-type events.

6.5 Action for Advocacy has been commissioned by the Department of Health to provide the training required by the existing Independent Mental Capacity Advocate Service in advance of April 2009. Existing IMCA providers have already been informed about this 2-day training.

6.6 Local Implementation Networks/Groups across the country will need to start planning generic training on the Safeguards for the health and social care workforce. Of particular interest to Managing Authorities should be the process for referring for a Best Interests Assessment and the subsequent authorisation arrangements. Many Local Implementation Networks/Groups will not yet have started to develop the local infrastructure to this level of detail but will need to conclude such development by early 2009. The Department of Health has indicated it may yet provide some guidance on possible models. Many organisations represented on Local Implementation Networks/Groups will also want to consider how to embed awareness training on the Safeguards within any wider and existing single agency and multi-agency generic MCA training programmes.

7. Deprivation of Liberty applications involving cross boundary placements in residential/nursing home care

7.1 CSSRs need to consider what arrangements should be in place locally to resolve cross boundary placements in residential/nursing care

homes. The CSSR responsible for any placement is the CSSR responsible for responding to a Deprivation of Liberty Best Interests assessment request – and not the CSSR in the local area to the placement. The same applies to Primary Care Trusts. This arrangement is different to what CSSRs may be used to dealing with at the moment.

7.2 Jenny Owen, Executive Director for Adults, Health and Community Wellbeing in Essex has identified that a practice guidance protocol similar to the current ADASS Protocol for Inter-Authority Investigation of Vulnerable Adult Abuse is needed. Essex County Council has offered to take a lead in progressing this and has asked for assistance from Network members. If you are able to help please contact Emmet Perry, the Adults Safeguarding lead (contact: emmet.perry@essex.gov.uk).

7.4 The Department of Health is concurrently conducting a review of out of area guidance arrangements. Within ADASS the lead is with Oliver Mills, Managing Director of Adult Services in Kent County Council. Michael Thomas-Sam (contact: michael.thomas-sam@kent.gov.uk) is the officer in Kent who is leading the work on the detail and it has now been agreed to develop an ADASS protocol that brings both of these pieces of work together.

7.5 Some CSSRs have already been exploring the potential for reciprocal arrangements with neighbour CSSRs. Useful work has already been undertaken in Hampshire (contact: paula.hallam@hants.gov.uk) and East Sussex (contact: carol.wilkinson@eastsussex.gov.uk). These arrangements could help resolve local operational issues including providing a Best Interests Assessments service for in-house residential and nursing care homes, whilst a broader approach is still needed for placements at a longer geographical distance.

8. Joint Working with Primary Care Trusts

8.1 Many CSSRs are planning to set up joint MCA Deprivation of Liberty Safeguards assessment services with their local Primary Care Trusts. It is CSSRs and Primary Care Trusts that will be the Supervisory Bodies from April 2009 and they will be responsible for providing the infrastructure for Best Interests assessments of those people eligible as well as formally authorising any Deprivation of Liberty that results.

8.2 It is possible for CSSRs to establish partnership agreements with Primary Care Trusts for this work. Calderdale Council has an example of a partnership agreement that it has already been shared with MCA leads across England (contact: john.gibbons@calderdale.gov.uk). Whilst a joint Best Interests assessment service is possible (as is a joint Authorisation Panel) the task of agreeing a Deprivation of Liberty authorisation cannot be delegated from one Supervisory Body to another: there is therefore an imperative to establish sound governance arrangements around any joint approaches to both assessments and authorisations.

9. Area Based Grant – Mental Capacity Act expenditure by CSSRs

9.1 The Department of Health wrote to all English CSSRs on 10th December 2007 to advise on the adults social care settlement for the next three years (LASSL)(DH)(2007)(2). It was not envisaged at that time that the actual allocations in 2009-10 and 2010-11 financial years would differ significantly from those proposed. The Local Government Association is, as a matter of urgency, raising with central Government the issue of the impact on CSSRs of the 'credit crunch' in the UK economy.

9.2 By the end of December 2008 CSSRs will need to be planning ahead for their MCA expenditure in 2009-10. Representations may need to be made to elected members to ensure that the funding is actually available within annual budgets. This is particularly important for 2009-10 when there is likely to be a peak in demand for MCA activity, including the work around the Deprivation of Liberty Safeguards. The Area Based Grant allocations, although funding statutory work, are not however ring-fenced in the adults social care settlement.

9.3 CSSRs will also need to ensure that the commissioning of existing Independent Mental Capacity Advocate (IMCA) services is extended. Inevitably this means that CSSRs will need to review and extend any existing IMCA Service contractual arrangements in advance of April 2009. The extension is required in order that a person who has nobody to represent him/herself and who is undergoing a best interests assessment can also be supported by an IMCA. Moreover, the person and/or their representative has a right to seek the support of an IMCA as often as necessary when he/she is formally deprived of his/her liberty. The only exception would be where the representative acts in a paid capacity.

9.4 Ideally the representative appointed under the Deprivation of Liberty Safeguards will be a family member or friend. The appointment of the representative will be co-ordinated by the authorisation panel in the CSSR. Where no family member or friend exists, the CSSR will have to appoint another person to act as the representative; that person cannot however be a member of staff. CSSRs will therefore need to determine whom they will appoint in such circumstances. This may well require the agreement of partner agencies and/or the commissioning of another agency to undertake these responsibilities.

10. Monitoring by the incoming Care Quality Commission

10.1 The new Care Quality Commission takes over the functions of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission. For Managing Authorities (residential and nursing care homes and hospitals) registration requirements from April 2010 will include a requirement to safeguard people from unlawful deprivation of liberty. The current system regulation arrangements already include scope for the Care Quality Commission to consider some aspects related to deprivations of liberty from April 2009.

10.2 For CSSRs, the local authority performance assessment in 2009-10 and the periodic review function from 2010-11 will be the means by which the Care Quality Commission will review specific Deprivation of Liberty Safeguards activity. Whilst there are no enforcement powers attached to these functions, the Commission will be seeking to influence the adoption of good practice and to take notice of national benchmarking data. This will allow CSSRs as Supervisory Bodies to measure their own performance against others.

10.3 Many CSSRs, often with Primary Care Trust partners, have started providing awareness training briefings for Managing Authorities with a view to ensuring familiarity with the forthcoming Deprivation of Liberty Safeguards. These briefings are an important way of engaging with organisations that will, from April 2009, be the referring partners for best interests assessments under the Safeguards.

11. Personalisation, mental capacity and safeguarding

11.1 ADASS has been using the MCA to champion the personalisation policy agenda that is at the forefront of transforming adult social care arrangements within CSSRs.

11.2 The Mental Health, Drugs & Alcohol Policy Network is formally responding on behalf of ADASS to the Department of Health on the current formal consultation on extending the direct payments scheme to people who lack mental capacity. The public consultation also includes a review of the current direct payments exclusions for people subject to mental health legislation. Emerging issues in relation to people who lack mental capacity include the need for the Government to consider whether there are sufficient safeguards in place to ensure that the best interests of such persons are properly and legally promoted. This may need to extend to include some form of accreditation for personal assistants and brokers (especially where there is no-one else involved such as family or friends). A copy of the ADASS submission will be available from Lucy Butler, Head of Personalisation at Hampshire County Council (contact: elizabeth.murray@hants.gov.uk)

11.3 The ADASS Safeguarding Network is developing a Position Statement on *'Personalisation and Safeguarding'* that is expected to be adopted by ADASS Executive Council this autumn. The Position Statement incorporates reference to S.44 Mental Capacity Act as well as the Safeguarding Vulnerable Groups Act 2006 (implementation from October 2009). The major cultural change will be to ensure that the principles of personalisation are not overwhelmed by a focus on safeguarding to the exclusion of other possibilities. CSSRs will need to focus on effective risk management – as opposed to the total elimination of risk. This also reflects the context of the different lifestyles of our customers/service users. There may be a need to clarify precisely what is a CSSR's 'duty of care' when there is evident conflict between the customer/service user/carer's potentially high-risk activity and any proposed personal budget. For further information, contact Teresa Bell, Corporate Director of

Community Services at West Berkshire Council and co-chair of the ADASS Safeguarding Network (contact: TBell@westberks.gov.uk).

12. Implementation support from the Department of Health

12.1 The Care Service Improvement Partnership continues to meet with and support regional networks of local MCA leads across England. This currently includes support for local events to help resolve implementation issues as they arise, and sub-regional meetings bringing MCA Deprivation of Liberty Safeguards leads together. This autumn, the imperative is to ensure that Primary Care Trusts are preparing for April 2009 and are engaged in the development processes required, and that the relevant organisations better understand the interface between the use of the Mental Health Act and the Mental Capacity Act. The latter will have additional resonance after April 2009.

12.2 The Department of Health is still working on the development of standard forms to be used by best interests assessors. ADASS has recommended that it would be useful to have a standard form for recording reviews and the outcome of reviews. Standard forms will also be helpful for future benchmarking activity on a national level.

12.3 Additional information about the legal requirements for the Deprivation of Liberty Safeguards can be accessed online at the Department of Health's website (www.dh.gov.uk) including copies of the Regulations, the Codes of Practice and other guidance.

12.4 The Department of Health has provisionally indicated that the operational and other arrangements for the Deprivation of Liberty Safeguards are likely to be evaluated in 2010-11 financial year. This evaluation may also include a review of the existing Codes of Practice.

12.5 The Department of Health has a national 'Deprivation of Liberty Safeguards' Steering Group involving a small number of key stakeholders, and ADASS is represented on the Group, as also is the Welsh Assembly Government.

Concluding remarks

There are many good examples of work in progress and this Briefing Report has highlighted and referred to a number of these. Other examples will emerge in the coming months and it could be useful to collect, collate and circulate these as they emerge. As much of this legislation focuses on principles for practice rather than administrative processes and systems needed for local implementation, CSSRs can take pride in what they have been able to achieve to date through their leadership of multi-agency partnership approaches.

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