RCOT response to the Mental Capacity Act (England and Wales) Code of Practice and Liberty Protection Safeguards Consultation 2022

Introduction

The Government launched a public consultation on proposed changes to the Mental Capacity Act (MCA) Code of Practice for England and Wales, which included guidance on the new Liberty Protection Safeguards (LPS) system. The consultation document and the Code of Practice was also be published in Welsh.

This was a joint consultation published by DHSC and MoJ. The consultation ran for 16 weeks from the 17 March until 14 July 2022. The consultation documents were here: https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps

RCOT response:

Question 7 – Do you have any comments on the proposed updates in the Code of Practice in relation to Section One? (500 words, 268 currently)

- The purpose of Section One is unclear: some parts read like good practice guidance rather than guidance in the application of the Mental Capacity Act (the Act), and other parts describe administrative processes related to the Act.

- We suggest that administrative processes and case studies are in separate appendices or standalone documents like the Mental Health Act reference guide and supporting advisory booklets.

- The updated Code of Practice (the Code) is also now extremely long at 500 pages, an increase from the current 300 pages. Most of this extended information will be helpful to social care, but there is less that will be relevant to NHS or other settings.

- Some of this increase is due to the addition of current case law. Although this is helpful, as case law develops, the Code will quickly become obsolete, and clinicians will have to diverge from the Code.

- We recommend that a central data base is developed with updated links to new case law as it emerges, alongside suggestions about how this may affect daily clinical practice. This could build on regularly updated guidance and manuals of existing law experts such the Jones Mental Health Act Manual and 39 Essex Chambers:

Richard Jones, Mental Health Act Manual (24th edn, Sweet and Maxwell 2021) - Mental Health Law Online

39 Essex Chambers | Mental Capacity Guidance Note: Assessment and Recording of Capacity - 39 Essex Chambers | Barristers' Chambers

- The unclear format and length will make it inaccessible to busy occupational therapists who work a wide range of settings where the Act will apply such as schools, prisons, and private residential units.

Question 8 - How clear is the guidance in chapter 12 at explaining the meaning of Deprivation of Liberty to practitioners? (300 words, 157 currently)

- The guidance in chapter 12 is not clear. The description is different to the one that occupational therapists use now in everyday practice, rather than building on current understanding and practice. The guidance in the body of the draft Code is at odds with the content of the scenarios.

- For example, it describes “Advanced Consent” which in case law, only exists in a limited number of settings such as hospices and end of life care. The draft Code has broadened its application without proper legal basis.

- The definition of deprivation of liberty in chapter 12 suggestions that the only people who will meet the criteria for LPS authorisation, will be those who actively object and who are under “24/7 eyesight observation” by staff e.g., constant observation. Not only is this a very small number of people, but it appears to direct clinicians to pre-Bournewood use of the Act.

Bournewood case | Equality and Human Rights Commission (equalityhumanrights.com)

Question 10 – How clear is chapter 13 at explaining the interface between Liberty Protection Safeguards (LPS) and other health and care assessment and planning? (300 words, 157 currently)

- The explanation is modelled on social care assessment and care planning like the carers assessment. It needs to be extended to explain the interface from other perspectives and settings where the Act will apply.

- One of the purposes of LPS was to establish a less bureaucratic system. The process described in this chapter is complex and confusing. In its current form, it will be challenging to apply in social care and will not translate easily outside of social care.

- In addition, we have concerns that the pre-authorisation for LPS will be completed by a non-clinician. This stage needs someone with clinical knowledge who can review existing assessments/ care plans and challenge the decision making/ recommendations made by occupational therapists or nurses for example.

- To ensure that the pre-authorisation for LPS provides safeguards for people, it should be completed by a senior clinician with appropriate knowledge of the clinical setting and treatments where the LPS will be applied.

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Question 13 – How clear is chapter 16 at explaining the use of previous and equivalent assessments for the purposes of LPS? (300 words, 48 currently)

- It is not clear how previous and equivalent occupational therapy assessments could be used for LPS.

- The explanation is written from the perspective of registered care homes. LPS will have wide reaching implications for occupational therapist working across multiple systems and settings. Chapter 16 needs to reflect this.

Question 14 – The Code suggests a central AMCP team (Approved Mental Capacity Professional which will replace the Best Interests Assessor). Do you have any suggestions about how this model can be improved? (300 words, 191 currently)

- Setting up a central AMCP team will effectively exclude occupational therapists and other health staff from being AMCPs. This is because they already sit in existing teams and are not likely to be "loaned out" to another team.

- Many non-social work Best Interest Assessors (BIAs) are not employed by the local authority and work independently. A centralised team would exclude them from acting as AMCPs and provide limitations for them to access the conversion course from BIA to AMCP, and the on-going training required to maintain the role.

- The Code says it is important that NHS trusts put forward staff to become AMCPs but then restricts their participation with a model that will primarily operate for social workers. We propose that an Integrated Care System (ICS) wide model is adopted instead.

- To make this ICS proposal viable there would need to be a delegated authority for a single local authority to provide authorisation for the AMCP to work across the whole ICS footprint. This would provide an economy of scale and financial saving while maintaining appropriate safeguards for people's rights. Honorary contracts may be required to facilitate this centralised AMCP option.

Question 17 – The purpose of the AMCP regulations is to ensure adequate supply of trained AMCPs -will it achieve this? (300 words, 14 currently)

- No - see previous answer, it will exclude non-social work professionals from becoming AMCPs.

Question 18 – the Code and LPS regulations outline which professions can carry out which assessments -are the right professions enabled? (300 words, currently, 55)

- We agree with the inclusion of occupational therapy. However, the spirit and ethos of the original capacity legislation was for role expansion based, not on job title or profession but on capability.

- We believe that a greater number of the allied health professions should be included for completion of the capacity and necessary/ proportionate assessments.

Question 20 – How accessible and clear are chapters 3, 10, 13, 16, 17, 18 for practitioners? Is anything missing? (1000 words, currently 13)

- We think that the Code is inaccessible, please see answer to question 7.

Question 21 – Is there any part of the Code where an existing scenario or new scenario is required? (1000 words, currently 231 words)

- Scenarios are helpful for clinicians to think about practical application of the Act. But most of the proposed scenarios which do not explain the point in the Act being demonstrated. Some the scenarios are superficial, do not reflect reality and may even set up false expectations of the role of clinicians and application of the Act.

- We believe that the scenarios need to be urgently reviewed by practicing clinicians, who are representative of the range of settings in which they will apply e.g., application of LPS in a domestic setting, registered care home, hospital and for a young person aged 16-18. All the scenarios need to clearly show the point in the Act that they relate to and explain in the example what is a LPS and what is not an LPS.

- This suggested format should be followed for each scenario so there is coherence between them. We recommend that it would better and more accessible to present the scenarios in a separate appendix or standalone document that could be updated as case law develops.

- The only scenario that mentions occupational therapy on page 211 is inaccurate. It describes a social worker requests a capacity assessment from an occupational therapist specialising in sensory needs. However, there is nothing to suggest that Mr Q has specific sensory needs. He needs an occupational therapist with knowledge and expertise in autism and/or learning disabilities.

Question 23 – Will the workforce and training strategy help your organisation prepare for LPS? (300 words, 28 words)

- No - it is unrealistic, too prescriptive and does not feel applicable to health or other settings that for example, occupational therapists, police, or paramedics may work in.

Many thanks to Julie Carr, Clinical Legislation Manager at Southwest Yorkshire NHS Foundation Trust for her valuable input and guidance to this response.