

Mental Capacity Act 2005 Deprivation of Liberty Safeguards

Response to Consultation

9 June 2008

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Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice for England and Wales and regulations for England

Response to a consultation carried out by the Ministry of Justice and the Department of Health. This information is also available on the Ministry of Justice and Department of Health websites:

<http://www.justice.gov.uk/publications/4798.htm>

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

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Introduction

This document is the post-consultation report for the consultation paper 'Mental Capacity Act 2005 Deprivation of Liberty Safeguards' which was published on 10 September 2007. The consultation covered a draft Code of Practice for England and Wales and two sets of draft regulations for England.

This post-consultation report is published jointly by the Ministry of Justice and the Department of Health. It covers:

- the background to the report;
- a summary of the responses to the report;
- our conclusions on the consultation.

Further copies of this report and the consultation document can be obtained by contacting the **Project Management Team** at the address below:

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This report is also available on the Department's website at:

<http://www.justice.gov.uk/publications/4798.htm>

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

Background

A formal consultation on the Mental Capacity Act 2005 deprivation of liberty safeguards draft Code of Practice for England and Wales (the Code), and two sets of draft regulations for England, took place between 10 September and 2 December 2007. It invited comments and views on the draft Code and regulations. The two sets of draft regulations were:

- The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008
- The Mental Capacity (Deprivation of Liberty: Eligibility, Selection of Assessors, Assessments, Requests for Standard Authorisations and Disputes about the Place of Ordinary Residence) Regulations 2008
The title of the regulations has now been shortened to Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008.

The Mental Capacity Act 2005 ("MCA") provides a statutory framework for individuals acting and making decisions on behalf of people who lack the mental capacity to do so for themselves. Schedule A1 to the MCA (inserted by the Mental Health Act 2007) provides safeguards for people who are in hospitals or care homes and need to be deprived of their liberty in their own best interests, but who lack the capacity to consent to the arrangements proposed for their care or treatment. Whilst the MCA sets out the legal framework for the deprivation of liberty safeguards, the Code provides guidance and information for people applying the safeguards in a hospital or care home setting. It supplements the guidance and information contained in the main Mental Capacity Act 2005 Code of Practice, published in April 2007, and will be issued as a separate document.

Certain categories of people have a legal duty to have regard to the main Mental Capacity Act 2005 Code of Practice and the Code, but they are intended to provide guidance for anyone working with, or caring for, adults who lack capacity, and for the families and friends of people who lack capacity.

The consultation paper was aimed at ensuring that the Code would be user friendly, detailed and accurate, through the collection, review and inclusion of the views of stakeholders and the health and social care practitioners who will apply the deprivation of liberty safeguards in practice. It invited comments on style and content from all interested parties and asked questions on the Code itself plus the

two sets of regulations and the Impact Assessment that were published as part of the consultation process. In particular, the consultation paper asked whether each chapter of the Code met its aims and whether the scenarios used in the text were helpful and realistic. Respondents were also invited to comment on any other issues of relevance.

The consultation paper was available in Welsh and in easy-read summary format.

110 responses were received to the consultation. A list of respondents is set out at Annex A. The responses were helpful and constructive. Many offered extensive, detailed comments. There was a mix between broadly positive comments and suggestions for additional content and further clarification.

The consultation paper asked a number of specific questions about the draft Code and regulations. The vast majority of respondents based their responses on these questions. The summary of responses that follows is framed around the questions that were asked in the consultation paper.

The purpose of this report is to give an outline of the responses to the consultation and the Government's reaction to them. It does not attempt to address all the individual comments offered by respondents. Many diverse, and sometimes conflicting, views were received. They were all carefully considered as part of the process of revising the Code and regulations in preparation for their laying in Parliament. The revised regulations were laid in Parliament on 20th May 2008 and the revised Code will be laid early in June.

Responses received for each question

Part A: Consultation by the Ministry of Justice on a Code of Practice for England and Wales

Question 1: general comments on the Code, including comments on format, style and ordering.

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).

Summary of responses

Most respondents felt that the Code was comprehensive and easy to read. However, there were concerns about the length, complexity and navigability of the document. A number of respondents were also concerned about not having a definition of 'deprivation of liberty'.

The majority of respondents offered several suggestions for making the Code clearer. These included:

- A summary section at the beginning of each chapter, similar to the one found in the main MCA Code of Practice.
- Greater use of flowcharts, case scenarios and checklists.
- A glossary of terms at the beginning of the document, simpler language throughout and a clearer layout to highlight key issues and roles.
- Cutting the length by removing repetitious paragraphs.

General comments

Although all respondents understood that a definition of 'deprivation of liberty' could not be included because it is defined by case law, some felt that this omission would result in problems and have resource implications. For example:

- *This may result in the managing authorities being over-cautious in their identification of deprivation of liberty cases, resulting in far more requests for assessment than envisaged in the Impact Assessment.*
- *More guidance is needed on how to apply the safeguards, as there is wide scope for providers to fail to comply whether unintentionally or not,*

and as this area is ripe for litigation, it creates significant business and commercial risk.

Question 2: guidance for assessors

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?

Summary of responses

Just over half (38 out of 73) of the respondents who commented believed that the Code provided assessors with clear guidance on their roles. Most of the comments about the assessors were proposals for changing the function of the roles, rather than suggestions for making the existing policy clearer.

Comments on the age assessment

- *The 'age assessment' is a criterion rather than an assessment – given the number of other assessments that are needed in this process it may make the process more accessible to reduce the number of 'assessments'.*
- *The age assessment should be expanded to contain advice on what would happen in the event that it does not prove possible to confirm date of birth under the age assessment.*

Comments on the mental health assessment

- *This is considered to be the role of a section 12 doctor. However, the Mental Health Act 2007 has replaced such an arrangement with that of the Approved Clinician. Will this be reflected in the final draft of the deprivation of liberty safeguards?*
- *It is not clear who carries out mental health assessments. The Code states it might be wise for this to be done by a doctor who knows the individual, but the easy-read version states that the people carrying out the 'checks' should not be giving any care or treatment to the person.*
- *It is unclear who will be responsible for providing the section 12 approved medical practitioner to complete the mental health assessment for a service user placed out of borough by a local authority. Unless this is made the duty of the local Primary Care Trust (PCT) covering the residential home, the placing local authority will have no ability to arrange the assessment. This section seems completely impractical.*

Comments on the mental capacity assessment

- *The Code states that the Mental Capacity assessment is to be carried out by a mental health assessor or best interests assessor. This conflicts with the Mental Capacity Act 2005, which states that anyone can assess capacity. Why is there a difference for the deprivation of liberty safeguards?*
- *A doctor who is deciding whether a patient has capacity to make a decision about a particular treatment will take account of the patient's capacity to understand the various implications of the treatment. In difficult cases a formal mental capacity assessment would be made, perhaps with specialist input (though not necessarily from approved mental health professionals), following the guidance in the main Code. So, requiring an additional formal assessment of capacity by a 'deprivation of liberty' mental capacity assessor seems unnecessarily burdensome to the patient and the healthcare professionals.*

Comments on best interests assessment

- *Does the supervisory body have no option but to follow the recommendation of the best interests and other assessors?*
- *The guidance regarding the best interests assessor's selection of a relevant person's representative (RPR) appears slightly confusing. Guidance is needed on the selection of an RPR, especially in relation to relatives, friends and carers. A lack of clarity exists on who takes preference in the selection process.*
- *The Code states that the BIA must seek the views of 'anyone engaged in caring for the person' and 'anyone interested in the person's welfare'. If this section refers to everyone involved in the person's care, the process may be difficult and time consuming.*

Comments on the eligibility assessment

- *It is stated that the eligibility assessor 'needs to be familiar with the Mental Health Act 1983' – does it mean they need the same level of knowledge as an Approved Social Worker (ASW) /Approved Mental Health Professional?*

Comments on the no refusals assessment

- *Could a donee of a Lasting Power of Attorney argue that the person should not be admitted to any care home? If the donee also manages the*

person's finances could there be a conflict of interest in that the donee may not wish the person's funds to be used to pay for a care home place?

Comments on the 'Mr Smith' scenario

There were a number of respondents who commented on the 'Mr Smith' scenario, which sought to clarify the issue of consulting around best interests. The majority of comments concerned the fact that the scenario broadened the concept of deprivation of liberty beyond that which is specified in the Code. For example:

- *If this case were a legal precedent, it would push the boundaries beyond JE v DE/SCC, and far beyond HL. Mr Smith is happy to live at the home, has freedom within it, has full access to his family and his friends too, if not loaded with booze, and would presumably be allowed to move to another home if he wanted to.*
- *I agree that the circumstances of the case study are very realistic but there will be many comparable situations, not the few estimated in the impact assessment.*
- *It is unclear whether this sort of scenario should result in authorisation with conditions, or a refusal based on the fact that a less restrictive alternative has been identified.*

Question 3: users, family, friends and carers involvement

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?

Summary of responses

Respondents were divided about whether the information in the Code was clear and helpful. Many people felt there needed to be greater emphasis on the role of families and carers, with a number of respondents suggesting that either a chapter for carers, or separate leaflets, would be helpful.

Many respondents endorsed the easy-read version of the consultation paper and expressed their support for an easy-read version of the final Code.

General comments

Only if families and carers are made aware of the recommendations of what should be in place – and have a written record of this - will they be able to ensure that the care plan continues to be rigorously adhered to, and thus deprivation of liberty avoided.

Question 4: Court of Protection

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?

Summary of responses

Most respondents thought that the role of the Court of Protection was clear and welcomed its safeguarding role. However, several respondents wanted greater clarity about the process of applying to the Court and the support that would be available for service users and their families/carers.

General comments

- *There is no practical assistance in the Code as to how to make an application, or even where an application form can be obtained. We are concerned that this may be a daunting task for either the relevant person or their representative, and would urge consideration of any support processes that could be developed for them.*
- *It would be helpful for the Code to make clear whether legal aid is available and whether it is means-tested and how parties can obtain a list of solicitors who specialise in this area of law.*
- *If the Code is to be published separately, more information about the Court of Protection and its powers needs to be included, and not just referenced to the main MCA Code.*

Question 5: Independent Mental Capacity Advocates (IMCAs) and the relevant person's representative

Are 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?

Summary of responses

The majority of the respondents thought that the roles of the IMCA and the RPR were clear. However, some respondents felt there was scope for confusion between the two roles. A number of respondents also had concerns about resources for advocacy services.

General comments

- *The support offered to representatives by an IMCA appears to be unlimited. I am not sure whether the intention is for each local authority to set a threshold for this support, in the same way that they have done for adult protection IMCA referrals? If this isn't the case, then maybe something should be added to the Code about the possibility of restrictions or time limits to this support.*
- *The Code states that 'people appropriate to consult' can only make submissions about a deprivation of liberty application to the best interests assessor, whereas an IMCA can make representations to each of the six assessors. Therefore, it would appear from the Code that you are disadvantaged if you have appropriate family to consult and not an IMCA.*
- *The guidance as to the appointment of RPRs seems complex and fails to clarify the type of person that would normally be expected to take on such a role.*

Question 6: guidance for commissioners of care

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

Summary of responses

A number of respondents felt further clarification would be helpful in respect of the role played by commissioners in relation to co-ordination of the best interests assessment, out of authority placements, possible conflicts of interests and the administrative side of commissioning.

General comments

- *The co-ordination of best interests assessment work is likely to be very problematic for supervisory bodies where a resident in a care home is placed outside the geographical area of the commissioning authority.*
- *Can commissioners/supervisory bodies refuse a care plan that a best interests assessor has recommended because it is considered too expensive?*
- *Contractual arrangements need to be explicit about deprivation of liberty issues, and should set standards to ensure that good practice is promoted throughout. Commissioners need to be clear about what steps they would take if standards are not met.*
- *Once all the assessments are received by the supervisory body, what procedures are anticipated for authorising or denying deprivation of liberty?*
- *It is unclear whether authorising bodies can be joint PCTs and local authorities or if they need to be separated.*

Question 7: care planning

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

Summary of responses

There was general agreement that care planning was important, with a number of respondents indicating that it should be covered in more detail within the Code. Several respondents also suggested specific mention of the care programme approach (CPA) as a good model for care planning. A number of respondents suggested making links with other guidance documents such as the best interests assessment under the Mental Capacity Act 2005, the Single Assessment Process (2002), the National Service Framework for Older People and Valuing People: implementation policy guidance, LAC (2001).

Question 8: guidance on the Review Process

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

Summary of responses

A majority of respondents felt there was sufficient guidance on the review process. However, a few respondents sought further clarification on issues such as people with fluctuating capacity, formal and informal reviews and repeat requests for reviews.

General comments

- *There is no guidance in the Code about fluctuating capacity. This should be developed further and clarity given to managing authorities, supervisory bodies and other stakeholders about how the authorisation will be affected by a person's fluctuations in capacity.*
- *The review process must be transparent. Clarification of the formal and informal review process should be sought with respect to initiation of deprivation and continued deprivation reviews.*
- *Should there be a limit on the number of reviews allowed to prevent repeated requests? Suggest timescales for reviews should be introduced, as exist in the Mental Health Act 1983.*
- *Given that a deprivation of liberty authorisation only gives authority for a managing authority to deprive someone of their liberty, i.e. it does not require them to do so, why is there any need to go through a formal process to suspend it in the circumstances given. (i.e. compulsory hospital admission under the Mental Health Act 1983). Why can the managing authority not just choose to exercise their authority without going through a formal process? Does this add unnecessary bureaucracy where none is required?*

Question 9: what is 'deprivation of liberty'

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?

Summary of responses

The question of what constitutes deprivation of liberty and how best to explain it provoked a wide range of comments from respondents. The majority of respondents accepted that it was not possible to provide a definition of deprivation of liberty and a significant number found the list of factors and the case law judgements detailed in the Code helpful. However, a number of respondents felt that more guidance, especially case examples and scenarios, would be helpful. In particular, the difference between restriction and deprivation of liberty was an area that prompted respondents to ask for greater clarity in the Code. For example, one respondent wrote:

We accept that a clearer legal definition of deprivation of liberty will not be possible, but more case scenarios to give illustrative examples are essential. Case scenarios need to identify the difference between restriction & deprivation of liberty.

A significant number of respondents felt that the lack of definition would cause managing authorities and frontline staff difficulties when it came to deciding whether patients or residents were being deprived of their liberty.

Question 10: guidance on how to avoid deprivation of liberty

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

Summary of responses

Most respondents found the guidance helpful, but felt the Code could be strengthened by more case examples. Many people mentioned issues around resources, training and multidisciplinary involvement.

General comments

- *It is important that any environmental measures agreed as part of a deprivation of liberty authorisation for one person do not restrict the liberty of others sharing the communal facilities. The people with learning disabilities that we spoke to felt the best way to manage this was to ensure*

there were enough staff at all times so that, for example, the front door could be left unlocked. This would allow other people to go out when they wanted to, whilst the person who needed to be deprived of their liberty would not be able to go out, as they would have staff supporting and watching them.

- *An additional bullet point should be added stressing the importance of making decisions in multi-disciplinary team settings that draw upon the different expertise and skills that they contain. This is important in addressing the risk of one discipline, or only health or social care professionals making the decision, and supports good practice.*

Question 11: interrelationship between the deprivation of liberty safeguards and the Mental Health Act 1983

Is the description of the interrelationship between the deprivation of liberty safeguards and detention under the Mental Health Act 1983 clear? If not, how could it be made clearer?

Summary of responses

Most respondents felt that this was a complex area, which needed clear guidance supported by flowcharts, checklists and case examples. Respondents felt they were not clear how the two pieces of legislation would actually operate in practice.

A number of respondents raised issues relating to the interaction of the two pieces of legislation. These included; cost implications of using one piece of legislation over another, the interaction of the deprivation of liberty safeguards and guardianship and the impact of changes to the Mental Health Act 1983 introduced via the Mental Health Act 2007.

General responses

- *We are concerned that, as the use of the Mental Health Act 1983 has far greater cost implications to the NHS and social services (because of Mental Health Act 1983 section 117 aftercare being free), there may well be a tendency to use the Mental Capacity Act 2005 in situations where the Mental Health Act 1983 should be used. It should be made clear in the Code that the cost implications should play no part in the judgement as to which provision to use.*
- *Clarity is required as to whether a person could be under a deprivation of liberty safeguards authorisation and guardianship at the same time. Currently this is unclear.*

- *The final version of the Code will need to reconsider how it addresses this area once the amendments to the Mental Health Act 1983 by the Mental Health Act 2007 (including the wider definition of mental disorder and removal of the treatability criteria) take effect.*

Question 12: links between the Mental Capacity Act Code of Practice and the Deprivation of Liberty Safeguards Code of Practice

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?

Summary of responses

Most respondents agreed that the links to the main Code are clear. A large majority wanted the Code to be integrated with the main Code when the latter is reviewed. However, some respondents had concerns that integration of the two Codes would result in the deprivation of liberty safeguards being lost within the main Code.

Question 13: Impact Assessment

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.

Summary of responses

Most respondents thought that the Impact Assessment had underestimated the number of people affected, the amount of time required to implement the safeguards and the associated costs. Respondents identified several groups who they believe are at risk of being adversely affected by the measures set out in the Code. A few respondents suggested changes to the safeguards that they felt would reduce the burdens of this legislation.

General comments

Commonly raised comments in relation to the under estimation of the resources and associated costs of implementing the deprivation of liberty safeguards included:

- *The cost of undertaking the assessments is not realistic and that the real cost will be significantly higher. Restricting the calculation of the real cost will have significant budget implications for both PCTs and local authorities.*
- *The Impact Assessment appears to ignore the actual costs of implementing the safeguards for care homes. In particular the need for care homes to raise awareness of the safeguards and prepare procedures (whether the home ever applies for any authorisations or not) for staff, residents and relatives, seems to have been ignored. The subsequent cost to the home of an application for an authorisation, should this be deemed necessary, is not covered.*
- *One danger of uncertainty is that managing authorities (ie care homes and hospitals), unclear whether they have 'detained residents' or not, will play safe and refer everybody who might possibly qualify.*
- *The Impact Assessment assumes that care homes have already acted upon the earlier December 2004 interim 'Bournewood' guidance in order to avoid unlawful deprivation of liberty. Anecdotal evidence would suggest that this is not the case.*
- *We are concerned that the Impact Assessment does not refer to later case law than HL v United Kingdom, eg DE and JE v Surrey County Council, which potentially hugely widens the scope of what counts as deprivation of liberty. We were also concerned that in the Impact Assessment there is reference to 17,000 people in local authority residential care. However, the deprivation of liberty provisions apply equally to those who are funding their own care. We wish to be reassured that the figures reflect this.*
- *We have general concerns about how supervisory bodies will be able to ensure they have sufficient best interests assessors to draw from – for example, many local authorities would look to their ASWs as a source of potential best interests assessors. However, in many cases, ASWs have been transferred to Mental Health Trusts, who may not agree to release them.*

Respondents felt that certain groups were at risk of being adversely affected by the way the deprivation of liberty safeguards may be implemented locally. Comments included:

- *The small levels of service provision in most parts of the country will limit the number of suitably experienced personnel in specialist areas such as acquired brain injury. In addition, the requirement for independence from the relevant person and/or line management responsibility with the professional will exclude more experienced and senior staff in what is already a small specialty where personnel often have multiple roles across service provision in the area.*
- *The impact on equality for older people with dementia is insufficient. There is already a view that people with dementia are discriminated against. It is a concern that the new safeguards could turn into something to encourage locking people with dementia away from sight.*
- *We are concerned that the additional procedures will have a negative impact on our service users [patients with brain injury], in terms of delaying placements and potentially acting as a disincentive for referral because of the additional costs/procedures involved. These clients have complex needs, and it is overly simplistic to rate the deprivation of liberty safeguards above their other needs. It would be helpful therefore to emphasise the need to consider all aspects of care planning in relation to the appropriateness of a placement, and not just the deprivation of liberty safeguards.*
- *Because members of the African-Caribbean community are much more likely to be detained under the Mental Health Act 1983, more likely to receive higher doses of anti-psychotic medication and more likely to be restrained we have concerns that if not used correctly, the deprivation of liberty safeguards may also be used excessively on African-Caribbean people. We would strongly urge that ethnicity monitoring is undertaken to assess what the impact of the safeguards is on different BME groups and to show whether there is any evidence for possible discrimination.*
- *There are concerns that people without Lasting Powers of Attorney will be disadvantaged.*
- *The Deaf who use sign language, who are learning disabled and are female are the group most discriminated against. It is a terrible deprivation of liberty to be in a non-signing environment, however poor the person's signing. Please put a paragraph in on Deaf people's rights to BSL communication, if they have had schooling or other experiences in that language, whatever their level.*

A few respondents made suggestions about how to reduce the regulatory burden:

- *It is very unlikely, where an authorisation is granted in relation to a care home resident with dementia, that their condition subsequently improves to the extent that it is appropriate for any relevant deprivation of liberty authorisation to be removed at a later date. Whilst we clearly agree that any authorisation should be capable of challenge at any time by any interested party and that it would be sensible to review the basis of the authorisation, even in the absence of a challenge, on a regular basis (probably annually), we do not think it is appropriate that the authorisation should automatically lapse and require an entirely new authorisation after 12 months. This appears to us to increase the regulatory burden on care homes operators and supervisory bodies without, in our view, providing additional protection for persons subject to an authorisation.*
- *The Impact Assessment should reconsider whether there should be a statutory duty upon commissioners to provide care packages (a) to people at risk of deprivation of liberty in order to remove that risk and (b) to people whose liberty is deprived in accordance with an authorisation – particularly when conditions are imposed.*
- *Is it possible for the local authority and the Local Health Board to have one supervisory body within a location? This may reduce some of the demands on capacity for both organisations.*

Part B: Consultation by the Department of Health on regulations (England only)

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: eligibility requirements for assessors

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?

Summary of responses

The majority of respondents supported the eligibility requirements. A few respondents sought clarification on apparent discrepancies between the wording in the regulations and the wording used in the Code. There were also a number of comments about the resource and training implications of the regulations on supervisory bodies.

General comments

- *Regulation 5(1)(b) allows a social worker to carry out best interests assessments. However the Explanatory Notes appear to contradict this by suggesting that in relation to social work staff, only social workers who are ASWs/AMHPs can act as best interests assessors.*
- *It is stated that the Mental Capacity assessment is to be carried out by a Mental Health Assessor or Best Interests Assessor which conflicts with the MCA which states that anyone can assess capacity. Why is there a difference for DOLS?*
- *We suggest that in keeping with the Mental Capacity Act, 3(c)(i) should be amended to read ‘understanding and respect for individuals wishes and feelings, beliefs and values, qualities, abilities and diverse backgrounds.’*

Question 2: professional qualifications and experience requirements for assessors

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?

Summary of responses

The majority of respondents supported the qualifications and experience requirements. Several respondents thought that regulation 4 should be brought in line with the Mental Health Act 1983, which allows 'approved clinicians' to assess if an individual should be treated under the Act.

Several respondents expressed concerns about the availability of staff with sufficient experience, and the need for good quality training. Respondents from professional and user-led groups also emphasised the need for assessors to have experience of working with particular client groups.

General comments

- *Feedback from service users and relatives in relation to service provision is that the professionals concerned should have experience of working with the client group.*
- *The requirements must state that the assessor should have knowledge, skills and experience with the relevant client group. Indeed, this cannot be stressed too strongly, and has been one of the main points of feedback from the Society's specialist areas of autism, learning disability and brain injury.*

Question 3: exclusions for assessors and best interests assessors

Do you support the exclusions as 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?

Summary of responses

The majority of respondents supported the exclusions detailed in regulation 7. Respondents had more concerns about regulation 8. In particular, the concerns focused on the ability of supervisory bodies to identify and recruit sufficient assessors given the restrictions of this regulation.

General comments

Several respondents either disagreed or wanted more clarity about the selection of best interests assessors. For example:

- *There will be difficulties in recruiting assessors in large parts of the country where service provision is minimal. We feel that it would be more appropriate to compromise on independence, by suggesting that Supervisory Bodies should 'normally' seek an independent Best Interests Assessor, than to compromise on the requirement for the Assessor to have relevant professional experience with the client group.*

Some respondents were unclear about how to apply the rule related to 'employed by the care home' and 'employed to work at the hospital'. For example:

- *It isn't clear, what 'employed by the care home' means where the home is part of a group. If it means 'employed by the group', why should groups of care homes be treated differently to groups of hospitals? The large provider groups now run literally hundreds of both.*
- *The regulation says that the BIA must 'not be employed to work at the hospital' but the Code says it would be OK for them to be working elsewhere for the same Trust. It then follows that it would apply to employees of an independent hospital group with multiple sites. Any attempt to bar them on the grounds of 'financial interest' if they are just an employee and not a shareholder or director, would be likely to fail since it would be difficult to draw a clear legal line between them and employees of Foundation Trusts.*
- *We are concerned that it appears where a Hospital Trust is the Managing Authority and employs nurses then the Supervisory body i.e. PCT will not be able to use those experienced nurses to carry out best interests assessments. This would appear to be an anomaly.*
- *The best interests assessor exclusions are extremely limiting and will become almost inoperable within most mental health hospital Trusts. In our mental health Trust, as in many others, social workers are now either directly employed by us or seconded to us. Our Trust covers two counties and the exclusions under the proposed regulations would mean that it will be almost impossible for us to organise best interests assessments using assessors who work in the two counties.*

Several respondents also had concerns about the selection of an assessor in cases where the managing authority and the supervisory body are both the same body.

- *In we have merged services so that the PCT and the LA have jointly managed services. This means that a senior manager will have responsibility as both a supervisory body and a management authority; i.e. managing the residential home/hospital as well as managing the social care therapists who might carry out the assessments. There are more than a 1000 staff and separation of duties could be achieved without compromising the independence and integrity of the decision making. Recommend that the regulation is redrafted to cover how separation can be achieved. At least an interim arrangement of a couple of years to achieve this.*
- *It may be that it would be appropriate to build in a measure of organisational independence for the assessor, in the same way that the Approved Social Worker cannot be instructed by their employer as to the outcome of an assessment under the Mental Health Act.*
- *8(3) is impractical. It means that local authorities would have to commission independent assessors to complete DOLS assessments for the residential homes within the borough run by the authority.*

Question 4: timeframe for assessments

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

Summary of responses

Approximately half of the respondents supported the time limits set out in regulations 9 and 10. All those who disagreed with the time limits felt that they were too tight. Several respondents wanted clarification as to whether the number of days specified in the regulations refer to calendar days or working days.

General comments

- *The assessment process is too complex to complete in the time allowed (especially for the urgent authorisations)*
- *Services are understaffed and getting enough assessors will be very difficult.*

Question 5: information to be provided in a request for a standard authorisation

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?

Summary of responses

Most respondents agreed with the information requirements for a standard authorisation, although there were requests for extra information to be included, such as:

- Email address to help speed up the process
- Details of recent relevant capacity assessments and/or existing best interests case discussions, as well as any documented evidence regarding mental health assessment/eligibility assessment
- Speech and language needs
- Agreed point of contact e.g the ward on which the proposed deprivation of liberty is to occur
- Requirements should also include the name of an individual identified to have the responsibility of dealing with the authorisation to coordinate the application and reviews.
- Risk assessment should also be added to the list of information requirements.

A significant number of respondents also requested standard forms for the collection or provision of information.

Question 6: proposals for provision of local assessors and funding formula

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?

Summary of responses

The majority of respondents agreed that assessors should be used who are based in the area where the person currently is. Most respondents, including the

Association of Directors of Adult Social Services, supported using the IMCA funding formula for local assessors. However, some respondents felt that the IMCA formula was not appropriate because the numbers of authorisations would be more influenced by the presence of specialist services/homes than population.

Comments on alternative proposals included:

- *You may also wish to consider a formula based on appointing Second Opinion Appointed doctors provided from the Mental Health Act Commission.*
- *It may be better to ask all LAs & PCTs to calculate potential numbers of DOL cases in their locality. e.g. Numbers in EMI homes & LD homes, although this will not give the full and final figure.*
- *Some authorities are net 'importers' of people in registered care, others 'export' people. These factors need to be taken into account, and the IMCA funding formula will not do this.*

Question 7: disputes regarding which local authority should be the supervisory body

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?

Summary of responses

Most respondents agreed that the arrangements for resolving disputes would be practical and workable. However, there were concerns about confusion over ordinary residence, the role of PCTs and compensation for local authorities subsequently found not to be responsible for assessments.

General comments

- *Some Learning Disabled clients have been moved out of area to specialist placements; issue of ordinary residence could be complex and problematic. What will the mechanism be for resolving residence disputes?*
- *Disputed ordinary residence should encompass establishing which NHS body is responsible and how NHS bodies deal with any disputes on this matter.*

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

Question 1: eligibility of a person to be a representative

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

Summary of responses

The majority of respondents supported the eligibility criteria. However, some felt greater clarity was needed to identify those people who were eligible to act as representatives and those people who were excluded.

General comments

- *Can a donee or deputy select themselves as a person's representative, if they are eligible?*
- *We suggest that 'in laws' should be added to those people who are close relatives, otherwise it would be possible for the representative to be an 'in law' of the care home owner/manager or employee.*

Question 2: appointing a representative

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?

Summary of responses

The majority of respondents supported the requirements for appointing RPRs. Respondents made several suggestions and comments regarding the IMCA service.

General comments

- *We have concerns about the use of family and friends without automatic support of an IMCA as appropriate.*
- *Where the supervisory body wishes to terminate the appointment of the RPR, an IMCA or best interests assessor should be involved.*
- *If the IMCA service is asked to take on the role of RPRs, there will be a substantial change to the remit of the IMCA, who currently has a short*

term focused role. This could potentially be long term and therefore time consuming and costly.

Question 3: termination of representative's appointment

Do you support the requirements in regulation 14 for terminating the appointment of a representative?

Summary of responses

A large majority of respondents supported the requirements for terminating the appointment of a representative. Greater clarity was sought in two areas in particular: firstly in relation to the term 'maintaining sufficient contact', secondly with regard to the grounds in which a representative could be removed from their role.

General comments

- *The list of scenarios in which a representative can be terminated should also include reference to when that representative has had limited, or ceased to have contact with the person being represented.*
- *As it stands, as long as the person keeps in regular contact with the person they cannot be removed from this role due to bad practice.*
- *It is not clear what would happen in the situation where a representative becomes unsuitable on grounds such as visiting but not supporting, becoming vexatious, being found to have an abusive relationship with the person concerned.*

Question 4: Impact Assessment

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.

Summary of responses

Few respondents answered this question and those that did often referred back to their response to the question about the Impact Assessment at the end of the Code section of the paper. As a result, no new issues were raised in the answers to this question.

Most respondents chose to emphasise the following issues again:

- The underestimation of the resource implications of undertaking assessments and reviews.
- Insufficient allowance made for the impact of demography in delivering the safeguards.
- Shortages of staff in key areas such as advocacy.

Conclusion – our response

Question 1: general comments on the Code, including comments on format, style and ordering

We welcomed comments that the Code of Practice was comprehensive and easy to read.

It was agreed that the use of flowcharts, case scenarios and checklists was helpful. In the final Code supplement we have increased the number of flowcharts from two to four. We have also revised the scenarios with the aim of making them more relevant.

We have introduced a 'Key words and phrases' section at the end of the Code to help readers to find what they are looking for. We have also re-structured the Code to split up what had been a very long Chapter 3 into more user-friendly shorter chapters. We have had the Code edited with the specific aim of making it as clear and concise as possible and to avoid repetitious paragraphs.

Question 2: guidance for assessors

The Government response on this question is incorporated into the response on the consultation questions about the 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 3: users, family, friends and carers involvement

The Government attaches great importance to the role carers, family and friends play in supporting people with care needs. This is particularly true where people are being, or are at risk of being, deprived of liberty in their own best interests. We have aimed to make this clear throughout the Code and to present the information in a format and style that is clear and helpful to both families and carers, and professionals, alike.

The involvement of family and friends is particularly important in relation to the best interests assessment. The Code sets out that, in carrying out the best interests assessment, the best interests assessor should consult with anyone involved in caring for the person at risk of deprivation of liberty or anyone interested in their

welfare, including family carers and other relatives. We have also revised the chapter on urgent authorisations (Chapter 6 in the final Code) to make it clear that managing authorities should consult with carers and family members before taking a decision to grant an urgent authorisation.

The Code also makes clear that the RPR should usually be a family member, carer or friend.

Question 4: Court of Protection

The chapter on the Court of Protection (now Chapter 10) in the Code has been significantly revised to reflect comments raised in response to the consultation. In particular, we have included information on how to make an application to the Court of Protection and we have made it clear that both the person deprived of liberty and their representative have automatic rights of access to the court.

Question 5: IMCAs and the relevant person's representative

Following concerns about the confusion of the two roles, we have added further guidance on the respective responsibilities of the IMCA and the RPR. In particular, we have expanded the sections on instructing an IMCA in Chapters 3 and 7 in the Code to make it clear that the RPR and IMCA roles are not mutually exclusive: the RPR is entitled to have an IMCA to provide additional advocacy support as and when needed.

Question 6: guidance for commissioners of care

The majority of responses regarding this question concerned the co-ordination of the best interests assessment by the supervisory body. We have revised and restructured the chapters in the Code that provide guidance on the assessment process for, and the authorisation of, deprivation of liberty with a view to providing more detailed and comprehensive information on these areas. As part of this process, we have clarified the role played by the supervisory body in relation to the co-ordination of the best interests assessment.

Question 7: care planning

As referred to in the response to question 6, we have revised and restructured the chapters in the Code relating to the assessment process for, and the authorisation of, deprivation of liberty. We have aimed to emphasise the importance of care planning throughout these chapters and, in particular, have highlighted that effective care planning can help avoid deprivation of liberty (Chapter 2).

A number of respondents provided advice on the links the Code should make to other guidance and we have aimed to signpost these in the Code where relevant.

Question 8: guidance on the Review Process

We have expanded the chapter (now Chapter 8) of the Code that covers the review of deprivation of liberty safeguards authorisations. This includes the incorporation of guidance on fluctuating capacity. We have also introduced Annex 4 to the Code, which sets out the review process in flowchart form.

Question 9: what is 'deprivation of liberty'

It remains the position that is not possible to give a concrete definition of deprivation of liberty in the Code because, ultimately, it is a matter for the courts to determine. We have, however, extensively rewritten Chapter 2 of the Code with a view to clarifying factors that need to be taken into account in determining whether or not a deprivation of liberty may be occurring. We have also expanded the information about case law to date.

Question 10: guidance on how to avoid deprivation of liberty

An underlying intention of the amendments that we have made to the Code is to encourage those providing care or treatment for people lacking the capacity to consent, to carefully consider whether or not it is essential for the care or treatment to be provided within the context of a care regime that amounts to a deprivation of liberty. We have sought to strike an appropriate balance between discouraging deprivation of liberty and making it clear that the safeguards, properly used, are an important way of protecting the rights of vulnerable people.

Question 11: interrelationship between the deprivation of liberty safeguards and Mental Health Act 1983

We acknowledge the importance of ensuring that there is clarity around the interrelationship of the deprivation of liberty safeguards and the Mental Health Act 1983. This is a topic that was also raised by respondents to the consultation on the

Code of Practice for the Mental Health Act 1983, which is being amended in the light of the changes introduced by the Mental Health Act 2007. Both the revised Mental Health Act 1983 Code of Practice, which was laid in Parliament in May 2008, and the Code have been revised to clarify the interrelationship between the two sets of statutory provisions.

Question 12: links between the Mental Capacity Act Code of Practice and the Deprivation of Liberty Safeguards Code of Practice

Respondents generally thought that the links to the main Code were clear. They have been little altered in the Code. There were mixed views on whether the Code should be integrated into the main Code. For the time being, the Code will remain separate from the main Code. The situation will be reconsidered when a review of the main Code is undertaken.

Question 13: Impact Assessment

The Government has reviewed the estimates of the likely impact of the introduction of the deprivation of liberty safeguards in light of the views expressed by many consultation respondents that the Impact Assessment published with the consultation documents did not fully reflect the probable situation.

The Government remains of the view, on the basis of the legal advice it has received, that the number of people who lack capacity to consent to the arrangements made for their care or treatment, and who need to be deprived of their liberty in their best interests in hospitals (excluding people who are detained under the Mental Health Act 1983) or care homes, should be relatively small.

The Government does, however, accept that there is uncertainty about the number of people who will need to be assessed for deprivation of liberty safeguards purposes, and thus the additional work that the introduction of the safeguards will create. It will therefore keep the matter under ongoing review.

Although the overall scale of the estimates have not been revised, some changes have been made to the Impact Assessment. The revised version can be accessed via:-

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_084982

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

The title of the regulations has now been shortened to Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008.

This response covers the consultation questions on assessors in Part A of the consultation paper (the draft Code) as well as those in Part B of the paper (the regulations).

We welcomed the positive responses received in respect of the assessor regulations and the information relating to assessors in the Code. We agreed with those respondents who felt that, although the Code provided clear guidance on the role and responsibilities of the assessors, there was a need for greater clarity in relation to procedural issues. Where possible, we have sought to address these.

Similarly, we have aimed to address the main concerns raised by respondents to the consultation on the regulations, where the MCA permits us to do so.

One of the main concerns raised was the number of assessors needed to complete the six assessments. The regulations require a minimum of two assessors. Although it is still possible that there may be more than two assessors in any given case, it is important to point out that two assessors can carry out all the assessments as long as they meet the eligibility criteria. By reducing the number of assessors required to complete a full assessment the demands on staff resources and time will be reduced; requiring only two assessors will also make it easier to complete a full assessment within the required time limits.

We have relaxed provisions in the regulations in relation to eligibility criteria for independent assessors. We have moved from a position of preventing a person from being a best interests assessor where they work in the same hospital or care home as the relevant person, to one where a best interests assessor is prevented from fulfilling the role where they are actually involved in the care of the relevant person. This is in response to concerns raised by respondents that preventing best interest assessors from working in the same hospital or care home as the relevant person would place too great a restriction on the number of best interests assessors available. Similarly, it was felt that, where possible, best interests assessors should have knowledge and expertise of the client group to which the relevant person belongs and it would restrict the availability of suitable best interests assessors if they could not be drawn from staff within the care home or hospital where the relevant person is accommodated.

Other safeguards as to who can be best interests assessors stipulate that the person:

- has an applied knowledge of the Mental Capacity Act 2005 and related Code of Practice
- has the ability to keep appropriate records and to provide clear and reasoned reports where required in accordance with legal requirements and good practice.
- has the skills necessary to obtain, evaluate and analyse complex evidence and differing views and to weigh them appropriately in decision making
- has at least two years post registration experience
- is someone in respect of whom an appropriate criminal record certificate exists
- has successfully completed training to be a best interests assessor as approved by the Secretary of State for Health
- is not suspended from the register or list relevant to the person's profession

In setting out the information requirements before an assessment can begin we have tried to strike a balance between ensuring all relevant information is made available while at the same time ensuring that the process for submission of information does not cause undue delay in starting the assessment process.

Whilst we have attempted to address the majority of concerns raised by respondents, there were some concerns which raised issues outside the scope of the MCA. For example:

- Assessors not being approved in the same way as registered medical practitioners and AMHPs are approved under the Mental Health Act.
- What can and cannot be included under training requirements (e.g. listing of competencies, refresher training, etc).

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

There have been some minor amendments to the regulations and Code in response to feedback that greater clarity was needed in relation to the eligibility criteria for the RPR. There was some uncertainty as to whether donees of lasting powers of attorney and court appointed deputies could select themselves as the RPR and we have amended the regulations to make it clear that deputies and

donees can, if acting within the scope of their authority, select themselves to fulfil this role. We have reflected these changes in the Code.

We have amended the definition of 'close relative' in the regulations. This is in response to concerns raised by a number of respondents that the definition of 'close relative' was not sufficient to prevent certain people with a financial interest in the managing authority, such as in-laws and cousins, from becoming representatives. This brings the definition in line with that found in the assessor regulations (above) and certain regulations under the Mental Health Act 1983.

We have also given the supervisory body a power to terminate the appointment of an RPR if it becomes apparent that the representative is not acting in the best interests of the relevant person.

Consultation Co-ordinator contact details

If you have any complaints or comments about the consultation **process** rather than about the topic covered by this paper, you should contact Gabrielle Kann, Ministry of Justice Consultation Co-ordinator, on 020 7210 1326, or email her at consultation@justice.gsi.gov.uk

Alternatively, you may wish to write to the address below:

Gabrielle Kann
Consultation Co-ordinator
Ministry of Justice
5th Floor Selborne House
54-60 Victoria Street
London
SW1E 6QW

If your complaints or comments refer to the topic covered by this paper rather than the consultation process, please direct them to the contact given on page 2.

The Consultation Criteria

The six consultation criteria are as follows:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
2. Be clear about what your proposals are, who may be affected, what questions are being asked and the time scale for responses.
3. Ensure that your consultation is clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.
6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

Annex A - List of Respondents

Vicki Addison	Cumbria County Council
Adult Protection Committee	Rochdale Borough Council
Dr Ann Alderton	Cambridge University Hospitals NHS Trust
Sarah Allport	British Geriatrics Society
Caroline Bielanska	Solicitors for the Elderly
Anna Bird	MIND
Nick Blackledge	Manchester Mental Health & Social Care Trust
Carol Blakeman	South London & Maudsley NHS trust
Rachel Booth	BUPA Care Homes
JE Brennan	South Tyneside NHS Foundation Trust
Policy response	BUPA
Sharon Burton	GMC
Lucy Butler	Hampshire County Council
Andy Butler	Surrey County Council
A P Capps	Individual response
Leslie Carr	Individual response
Julie Carr	College of Occupational Therapists Specialist Section Mental Health
Dr Peter Carter	Royal College of Nursing
Janice Chang	West Essex PCT
Ian Chennery	Leicester, Leicestershire and Rutland LLR LIN
Pat Clow	Newham PCT
Paul Collin	Cambridge & Peterborough NHS Trust

Diane Collins	CSCI
Guy Collis	Mental Health Coalition
David Congdon	Mencap
Consultation Workshops	Durham County Council
Stephanie Croker	Medical Protection Society
Heidi DeWolf	Individual response
Linda Doherty	Association of Directors of Adult Social Services
Karen Edwards	Cambridge House
Maeve Egan	Bristol City Council
Wendy & Graham Enderby	Individual response
John Farmer	Walsall PCT
Barry Fitzgerald	St Helens Council
Chris Gajawicz	City of York Council
Ruth Garry	Islington MCA Local Implementation Network
Sue George-Puce	London Borough of Hillingdon
Brian Goodrum	Dorset PCT
Teresa Gorczynska	Advocacy Partners
Sarah Greenwood	MHA (Methodist Homes for the Aged)
Rob Grieg/Nicola Smith	The Government's Learning Disabilities Task Force
Carl Griffiths	Shropshire PCT
Elsbeth Guthrie	Royal College of Psychiatrists
Roger Hargreaves	Individual response
Bill Harland	Individual response
Pat Haslam	Stockton on Tees Council
Malcolm Hepplewhite	Leicester City Council
CJ Herbert	Worcestershire County Council

Tony Holland	Royal College of Psychiatrists
Mark Howe	Cambridge County Council
Dr Marcus Hughes	St George's Hospital
Richard Jackson	Rescare
Stuart Jackson	5 Boroughs Partnership NHS Trust
Lynne John	Swansea Local Health Board
Hassen Joomraty	Pembrokeshire & Derwen NHS Trust
Policy response	KAG Advocacy
Amanda Kent	Speakeasy Advocacy
Robert Keys	NE London MHT
Mat Kinton	Mental Health Act Commission
Louise Lakey	Alzheimers Society
David Lamere	Individual response
Simon Land	Royal College of Physicians
Kate Lawrence	Individual response
Susan Lea	The Avenue Trust
Jennifer Lewis	Central and North West London NHS Trust
Hilary Lloyd	City Hospitals Sunderland NHS
Ann Mackay	English Community Care Association
Jill Maehle	MIND - Hartlepool
Claire Mallett	NHS Confederation
Terri Mannion	Oxfordshire & Buckinghamshire NHS Trust
Sylvia Manson	CSIP
Stuart Marchant	Ridouts LLP
MCA Leads Workshop	CSIP/NIMHE
Fiona McClelland	RNID

Policy response	Mental Health Lawyers Association
Linda Metcalfe	Nottinghamshire County Council
Jess Mortimer	Lancashire County Council
Dominic Nasmyth-Miller	Suffolk County Council
Joanna Nurse	Anchor Trust
J Barrie Oldham	Disabilities Trust/Brain Injury Rehabilitation Trust
Dr Ana Padilla	The British Psychological Society
Mike Paul	POhWER
Nicholas Peacock/Sydney Chawatama	The Law Reform Committee of the Bar Council of England and Wales
David Pennington	Care Services Improvement Partnership South West Development Centre
Emmet Perry	Essex Mental Health Commissioning Team
Policy Response	Age Concern
Jenny Priest	Royal British Legion
Mia Rosenblatt	National Autistic Society
Dr Mathew Sargeant	Pembrokeshire & Derwen NHS Trust
Peter Scanlon	Individual response
Mark Sheldon	Individual response
Mick Skipworth	Lincolnshire County Council
Lindsay Smith	Halton Borough Council
Tim Spencer Lane	The Law Society
Julia Svennevig	Redcar & Cleveland Borough Council
Andrew Swan	Wirral University Teaching Hospital
Susan Thompson	Beachcroft LLP
Dr Jane Volans	Oxleas Mental Health Foundation Trust

Chris Watson	Lancashire County Council
June Wesley	Cheshire County Council
Michael White	London Borough of Hammersmith & Fulham
Jo White	North Essex Partnership NHS Trust
Lindsey White	Dorset HealthCare NHS Trust
Diane Whitehead	Hartlepool Borough Council
Karen Williams-Jones	North East Wales NHS Trust
Toby Williamson	Mental Health Foundation
Barbara Wilson	Individual response
Paul Yeomans	British Association of Brain Injury Case Managers
Paul Yeomans	Brain Injury Social Work Group - British Association of Social Workers
Mike Young	Kirklees MCA Local Implementation Network