The Mental Capacity Bill
FULL REGULATORY IMPACT ASSESSMENT

Title

1. The Mental Capacity Bill.

Issue

2. There is currently no statutory framework for making decisions on personal welfare matters on behalf of people who lack capacity to make decisions for themselves. These people may lack capacity for a number of reasons: because they were born with a learning disability, suffer from a mental illness, develop dementia, or a similar condition or because they have suddenly acquired incapacity through a road traffic accident, stroke or some other trauma, or as a result of a long term degenerative condition. The lack of a statutory framework means that:

(a) many people who lack capacity to make certain decisions at certain times are wrongly thought to be incapable of making any decisions at all and are given a blanket label of being incapacitated;

(b) people who voluntarily help or care for people who lack capacity, taking day to day decisions for them, have no protection in law if someone complains about something they have done for the person they care for – technically, for example, touching someone without their consent to dress or wash them leaves the carer open to claims for damages under the law of tort;

(c) health and welfare professionals often have to exercise personal judgement when working with people who lack capacity, rather than all parties having the reassurance and safeguard of a universally understood legal framework to follow;

(d) medical professionals can face particularly difficult situations where a living will, advance directive or advance refusal of treatment has been made by a patient who lacks capacity, as their legal status is currently enshrined only in common law and is unclear, limiting people’s ability to plan ahead for a time when they may lose capacity; and

(e) there is no way of acting on suspected abuse of people who lack capacity unless this is so serious that it results in criminal proceedings. There are particular concerns about financial abuse of the existing Enduring Powers of Attorney (EPAs), estimated at around 10-15% of EPAs that are registered, and likely to be much higher amongst those that are not1.

3. These issues reflect the kind of problems that the Government as a whole is seeking to tackle in this legislative session, some of whose themes are greater opportunity,

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1 Denzil Lush, Master at the Court of Protection, giving evidence to the Joint Committee on 14 October 2003. An EPA enables the nominated attorney to look after the financial affairs and property of someone who lacks mental incapacity or expects to lack it in the future. The EPA is registered at the time the donor loses capacity.
social justice and protection. There is a perception amongst stakeholders and the public that the Government has been too long in fulfilling the commitment made with the 1999 publication of *Making Decisions*, to legislate on mental incapacity when Parliamentary time allows. The provisions of the Bill are the result of a long discussion and consultation process even before that. The Green Paper *Who Decides?* in 1997, which took as its starting point the Law Commission’s work, begun in 1989, and culminating in their draft Bill *Mental Incapacity* in 1995.

4. The Government’s publication of a draft Mental Incapacity Bill in June 2003 and the broadly supportive report of the Joint Parliamentary Committee on it have heightened the expectations of those who have awaited legislation on mental incapacity since 1995. The Adults with Incapacity Act 2000 passed by the Scottish Parliament has led to unfavourable comparisons with the situation in Scotland. These are pressures that the Government cannot resist indefinitely, and the people whom the legislation would benefit are from a wide range of vulnerable groups. Some of their number, notably those with learning disabilities are becoming better informed and more vocal about their rights to be heard and have fair treatment and to be included, partly through the steps the Government has taken with disability legislation and measures such as *Valuing People*.

**Risks that the Bill is addressing**

5. The scale of all the risks below is reflected in the size of the population of people who may lack capacity. This includes a wide range of people:

   (a) more than 700,000 people in the UK are estimated to suffer from dementia and, in an ageing population, this is projected to rise to around 840,000 by 2010;\(^2\);

   (b) around 145,000 adults in England have severe and profound learning disabilities, and at least 1.2 million have a mild to moderate learning disability. In Wales, over 12,000 people were registered as having a learning disability in 2001;\(^3\);

   (c) at some point in their lives, approximately 1% of the UK population will suffer from schizophrenia, 1% will be subject to bipolar disorder and 5% will have serious or clinical depression;\(^4\) and

   (d) 10-15 people per 100,000 of the population will suffer a severe head injury each year, and there are currently an estimated 120,000 people in the UK suffering from the long-term effects of severe brain injury.\(^5\)

All of these people and others too, are likely to lack the capacity to make some or all decisions, for at least some of the time. The ageing population and advances in medical treatment mean increasing numbers of vulnerable people are unprotected by

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\(^2\) The Alzheimer’s Society (January 2004)

\(^3\) *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Dept of Health, March 2001)

\(^4\) The Dept of Health

the law. Indeed, the provisions of this Bill could well affect a very high proportion of
the population at some point in their lives. Many people will find themselves caring
for or in close contact with, a friend or family member who lacks mental capacity for
some reason. There are currently an estimated 5.7m carers in England and Wales
(10% of the population). For those who are taking care of someone who may lack
capacity, their legal position in doing so is uncertain. And some people will feel that
they want to use a Lasting Power of Attorney (LPA) to plan ahead and decide who
they would like to help them with decision making on their finance, health and
welfare if they should ever lose capacity.

6. Given the issues in paragraph 2 above, the risks that this Bill is addressing are:

(a) increasing financial and other abuse of vulnerable adults that is difficult to detect,
because there are no legal processes to bring the relationships between people
who lack capacity and their attorneys or people who take major decisions for
them into the public domain, and insufficient legal deterrent;

(b) increasing numbers of vulnerable people unprotected by the law;

(c) inadequate legislative framework to support the Government’s non-legislative
measures to protect vulnerable people, e.g. No Secrets and Valuing People in
England and the National Assembly for Wales guidance, In Safe Hands;

(d) inconsistent, and sometimes poor, decision making in the absence of clear legal
guidance;

(e) social exclusion: manifested in distress, anger and feelings of disempowerment
amongst people who lack capacity, that they are unnecessarily and improperly
excluded from decisions about their own lives;

(f) worry and vulnerability of informal carers who have contact with people without
capacity that the actions they take may leave them open to criticism or even
prosecution. There is no legal framework to help them explain actions taken in
good faith;

(g) serious healthcare decisions about people who lack capacity can be
unnecessarily drawn out or taken precipitately because the clinician is not always
clear about his or her legal ground. There is anecdotal evidence that, in the
absence of patient consent, clinicians may be reluctant to carry out routine health
treatment and defer it until it becomes urgent or an emergency. This is
distressing for professionals, patients and families alike, and wasteful of health
resources – and may well not reflect the wishes of the patient;

(h) social care decisions can take longer and require some difficult persuasion when
a mentally incapacitated person resists e.g. a move into residential care when it
is obvious to people who care for/about them that it is dangerous for them to live
alone;

(i) distressing legal action against health and care professionals who acted in good
faith, this directs precious resource towards contesting such action rather than
caring for vulnerable people;
(j) no opportunity for individuals to plan, if they wish, for someone they trust to take health and welfare decisions on their behalf if they lose capacity in the future;

7. These risks have a clear human cost, often to some of the most vulnerable and socially excluded members of society, whom Government is committed to helping. But there are also financial costs. There is no database of national costs when decision making goes wrong. However, illustrative examples include a financial abuse case known to the Public Guardianship Office in which solicitors’ costs of £38,000 were incurred to recover a sum of £8,000. Drawn out social care decisions can have considerable costs as well; for example, if a client does not accept the assessment that he or she should move into residential care. One such case, where the client was in hospital and then respite care, lasted two years, with a total cost of about £20,000 in housing and social worker costs. There is, of course, no means of assessing the human and emotional costs in such situations, but they are obvious.

Options

8. Since the 1999 commitment to legislate, the Government has published a draft Bill, which has been subject to pre-legislative scrutiny by a Committee of both Houses. The Committee concluded ‘On the whole, we endorse the principles and general direction of the draft Bill…We believe that there is a clear need for the Bill and our report, whilst critical, should be read accordingly…Those it is intended to help have waited long enough.’

9. The themes of the current legislative programme include giving new rights for people where currently none exist, and making society more inclusive. In debate on the Queen’s Speech Peter Hain said that a Mental Incapacity Bill would be introduced this session. The Making Decisions Alliance – a consortium of about 30 voluntary organisations – is also pressing hard for introduction. DCA is working on a revised Bill in order to be ready for introduction in the third legislative session, around early summer.

10. Against this background, this full and final RIA considers in some detail the benefits, costs and risks of proceeding with the Bill so as to set up a statutory framework for decision making. The costs of other options are also considered, but in less detail.

11. The options for action are as follows:

(a) do the minimum – encourage those who have or hold enduring powers of attorney (EPAs covering finance only) to register these;

(b) encourage professional organisations to establish voluntary codes of practice for specific areas of mental incapacity (no single body covers all potential groups of incapacitated people);

(c) produce clear Government guidelines about decision making on personal welfare and financial matters for adults who lack mental capacity; or
(d) introduce the Mental Capacity Bill.

**Business sectors affected**

12. The two sectors affected by the Bill are private care/nursing homes and voluntary sector organisations. The financial sector will be affected in so far as EPAs, which already exist for financial decisions, will be replaced in future by LPAs. But the requirements on financial institutions will be essentially the same as at present in terms of checking that a document is genuine and assessing the capacity of a donor who appears in his or her own right as a customer. This is therefore a matter of ensuring that the financial sector is informed in good time, rather than a cost/benefit issue.

**Care homes (and provision of care in the community)**

13. There were 24,975 care homes in England in 2001. In that year, 92% of all homes (accounting for 85% of all places in residential care homes) were provided by the independent sector.\(^6\) The independent sector also provides support in people’s own homes. Around 367,000 households received such care in 2002, of which 22% received intensive support. This sector provides an increasing proportion of such support. In 2002, 216,000 households received care from the independent sector, as compared with 144,000 in 1997.\(^7\) In England the Government is currently developing extra care housing, as an alternative to care homes for the elderly. Here people live independent lives, and are encouraged to take responsibility for themselves, but have access to 24-hour care.

14. Care homes will be affected because many of their clients lack capacity, and their staff take many day to day decisions on their behalf. For some, however, the changes will be less than for others. This is because much of the Bill is about enshrining in statute best practice that already exists in helping incapacitated people to take decisions, e.g. starting from an assumption of capacity, good consultation. DCA has met representatives of care home managers, who welcome the legislation, and agree that it represents existing best practice. They consider that many care homes are already operating in this way, but that it would be important for them to be informed about the requirements of the new law.

15. For those care homes that are not already following this best practice, there will be a cost in terms of training and, potentially, in consulting others about a resident’s best interests when appropriate. But this cost is not likely to be great and should not affect a large number of private care homes. As businesses, awareness of the Bill will mean that in order to compete, compliance with best practice will increasingly become an expectation even before implementation in 2007.

**Voluntary organisations**

16. A very wide range of voluntary organisations have an interest in mental incapacity. There are 84 on DCA’s own consultative forum, e.g. Age Concern, Mencap, Mind, People First, Sane, Scope, to name but a few at random. We know of at least a

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\(^6\) Community Care Statistics 2001 – *Residential Personal Social Services for Adults, England*

\(^7\) Community Care Statistics 2002 – *Home care services for adults, England*
dozen more with very narrow interests in the Bill. There are also numerous local organisations.

17. The main cost to many voluntary organisations will be in acquainting themselves with the Bill and raising awareness of it with their members. We would expect and encourage them to use Government literature to give accurate information, and refer people to the website of what would become the Office of the Public Guardian. Set up costs of this sort for the sector should therefore be minimal, save where they see a need to put their own gloss on the general information because they represent a particular group or where they choose to alter their own material. The estimated cost varies between organisations – they are of different sizes, and will want to handle their advice and public relations in different ways. In some cases, simple updates to websites represent virtually no additional cost from their current day to day budget. Estimates from some key stakeholders of the cost of the Bill to them vary from virtually nothing to £25,000 for their own organisation. However, voluntary organisations generally see providing advice and guidance to their members as part of their on-going activity so consider that the need to give guidance on the new law would not impose new costs. The more we can spread information ourselves in the lead up to full implementation the lower and more spread out the costs are likely to be. (For example, it costs less to be able to plan to revise material when existing stocks run low than to make the change hurriedly, shredding existing material.) These organisations will want to equip themselves sufficiently to advise people who have questions about the Bill, and take account of its provisions in the work that they do – they will already be advising people about mental incapacity issues. Once more, however, many of the concepts should be familiar since the Bill enshrines existing best practice. In many cases, the Bill will be translating into statute measures that the organisation has campaigned for many years to get. The resources they have expended on lobbying Government can thus be expended in the more satisfying task of helping the people for whom they speak. We have involved stakeholders extensively in preparing the Bill, and will continue to do so in preparing for implementation, so as to ensure that it genuinely delivers the benefits they and we envisage.

**Equity and fairness issues**

18. Fairness for some of the most vulnerable and disadvantaged members of society lies at the heart of this Bill. Unlike most of us, mentally incapacitated people can be denied the opportunity to take decisions for themselves. The decisions can be anything from what to wear or eat, to where to live, how they spend their money or whether they are happy with particular medical treatments. For the first time, the Bill will require people to start from the assumption that a person has capacity, rather than assuming that they cannot take any decisions for themselves. It also states that the test of capacity should be related to the decision to be taken, rather than being seen as an absolute test. All this should ensure that people who lack mental capacity are allowed to take as many decisions for themselves as they are capable of, and receive appropriate support for the decisions they cannot take on their own.

19. The Bill does not give any business an unfair advantage over another. As familiarity with using the Bill’s provisions increases amongst the relevant business sector and amongst the general public who use care homes, those most effective at using the best practice the Bill enshrines are likely to be most attractive to potential clients and
their families. This is a good thing, entirely consistent with the Government's wider policy of increasing protection for vulnerable adults, and driving up standards of care.

Benefits of each option

Option 1 – registration of EPAs

20. The only benefits of this option are that the amount of effort and resource devoted to it could be very clearly managed. Thousands or millions of pounds could be spent on it over a shorter or longer period. Since we do not know how many EPAs exist but are not registered it would be impossible to measure success or impact. In cases of abuse – which concern us most - these attorneys would be the most unlikely to register their EPAs voluntarily.

21. In terms of addressing identified risks and benefiting the vulnerable, this option has virtually no added benefits above the current position, and certainly none that is lasting. Some kind of awareness campaign might improve the rate of EPA registration in the short term. For example, there was an increase in registrations following an article in July 2002 from 779 that month to 1185 in August. But numbers fell to 976 in September. Any increase in EPAs on its own, however, does little to address the risks noted in paragraph 6 above. It addresses only the risk of financial abuse of adults (as current EPAs cover only finance, not health and welfare). But it would not do much to address even the risk of financial abuse, as Government could only encourage people to register, with no enforceable sanctions if this did not happen, and no means of tracking the use of EPAs that were not registered. It is also important to note that EPAs can only be taken out by people planning for a future loss of capacity, not by people who have, for example, had profound learning disabilities from birth. The Court of Protection has under its jurisdiction people who have assets of £16,000 or more – excluding the poorest, who are arguably the most vulnerable of all.

22. More widely, it would not improve decision making for the large group of vulnerable adults currently affected by the absence of clear law in this area, nor increase safeguards for them. Nor would this provide any protection for private individuals and professionals caring for people who lack mental capacity, or address the human and resource cost of protracted and confused decision making.

Option 2 – encouragement of voluntary codes of practice

23. Benefits would vary between sectors, depending on what codes of practice they had already. There is already a considerable amount of advice for medical professionals (e.g. British Medical Association (BMA) and General Medical Council (GMC)). And it is worth mentioning that these reputable bodies themselves are in favour of the Bill, accepting that professional codes are not sufficient in themselves, but that the law too needs to be clear. There is more of a gap in other sectors, such as voluntary carers or care homes, so a new voluntary code would have more of an impact. Over time, though, this would be likely to face the same problem as the medical codes, because of the underlying problems with the law itself. Homes providing poor standards of care are unlikely to respond to exhortations to adhere to voluntary guidance.
24. A key advantage of voluntary codes is that they are potentially flexible and easy to amend, and voluntary sector organisations themselves are well placed to understand their impact and adjust them accordingly. But this also constitutes a weakness and is not in itself without cost. Stakeholders feel a lack of certainty and legal protection in this area, which voluntary codes would do nothing to alleviate. And there could be no guarantee that voluntary codes would be introduced by all relevant organisations, thus leaving out some vulnerable adults, nor that they would be consistent with each other.

25. All this means that the main risks identified in this RIA would not be addressed by this option. There might be some improvements in some decision making in some sectors – but only where the sector was predisposed to the Bill’s positive approach anyway. But distress and confusion would undoubtedly continue, because of the voluntary, flexible nature of such codes. Indeed, in the worst case scenario, a plethora of codes could even make matters worse than at present. Their lack of statutory force would mean no real protection for vulnerable adults, and whilst a court could take them into account in deciding whether someone was e.g. acting in an incapacitated person’s best interests, they could not have the same force as statute.

26. The Codes would no doubt be based on the content and principles of the draft Bill, and would be seen to be instead of the Bill – though there would be no overarching quality control. As such, they could well have less impact than if they had been developed by the voluntary groups out of their own best practice. Sceptics might well say that if operating in this way was very important, Government would have used its Bill to enforce it in legislation, rather than leaving it to goodwill.

Option 3 – Government guidelines

27. Government guidance would have more force than voluntary codes of practice, and it would also avoid the problem of a plethora of potentially inconsistent guidance. As such, it could reduce the number of disputed decisions and clear up some of the confusion. It might also be effective, with appropriate publicity, in encouraging best practice in line with the principles now enshrined in the draft Bill, which would give more mentally incapacitated people a voice in decisions. But the guidance would be non-statutory and Government could not force people to act in accordance with it.

28. The fundamental problem, however, would be the same as option 2, in that it would do nothing to clear up the underlying uncertainty of the law; nor would it address or offer the prospect of remedies against those who wish to persist in bad practice. And perhaps even more than in option 2; people would question why, if the Government considered it so important, it did not legislate. The lack of real protection against abuse, and for carers, would continue.

Option 4 – the Mental Capacity Bill

29. This is the only option that addresses all of the risks inherent in the current situation, as listed in paragraph 6 above:

(a) the Bill addresses the problem of financial and other abuse of vulnerable adults through its requirements for registering new Lasting Powers of Attorney (LPAs), a
new Court of Protection and a new offence of ill treatment and wilful neglect of someone lacking capacity;

(b) vulnerable people will be given protection by the law. Given the ageing population and advances in medical treatments, the provisions of the Bill are particularly timely;

(c) the Bill clarifies some areas where there can be confusion, e.g. amongst the medical profession and family members, about the status of advance directives. The Bill is based on good practice, with the intention that this should become the norm;

(d) the Bill addresses the disempowerment and social exclusion that can be felt by people who lack capacity, by making the starting point an assumption that people have capacity to take their own decisions, and giving them maximum opportunity to participate in the decision making process;

(e) the Bill provides a defence against actions taken to care for a mentally incapacitated person, if it was demonstrably reasonable for the carer to have taken the action and he or she acted in the person’s “best interests”;

(f) the Bill addresses the difficulty of making health care decisions on behalf of someone who cannot give consent by allowing donees and court-appointed deputies to take decisions for the incapacitated person in health issues. This should save time, resources and distress, and lead to better and more timely decisions on behalf of the vulnerable adult involved;

(g) social care decisions will be made within a clear framework, since the Bill will set out how to involve the person in the decision and expect social workers or other carers to follow (and then be protected by) the best interests principle;

(h) the Bill addresses the problem of legal action against health and care professionals, who acted in good faith, via the general authority and “best interests” test. It also clarifies the legal status of advance decisions to refuse treatment, with safeguards against their abuse;

(i) the Bill gives people the ability to plan for the future by allowing them to appoint an attorney to take health and welfare decisions on their behalf if they lose capacity – this is currently only available for financial decisions.

30. The Joint Committee, which scrutinised the draft Bill, welcomed the creation of LPAs and the empowerment of allowing people with mental capacity to chose someone to make decisions about personal welfare, property and financial affairs should they become incapacitated.

31. The Committee also welcomed the clarity to be afforded by a unified Court of Protection and the greater accessibility brought by its regional presence.

32. Staff and owners of care homes would benefit from a clear best practice framework that could be used as a tool to drive up standards across the sector. The Bill would
also ensure that they were assured a role in the process when decisions had to be made on behalf of a client. The ‘best interests’ defence for staff acting under the general authority would reduce the risk of litigation and lead to reduced insurance premiums for care homes.

**Costs of each option**

**Current costs related to mental incapacity**

33. There is currently only a partial and unclear framework for decision making with people who lack capacity. This means many costs of making decisions are neither logged, nor counted separately from other care that the person may be receiving, as there is no obvious process or vehicle by which to do so. This does not mean, however, that bad decision making can be considered cost free, as the risks in paragraph 6 above illustrate.

34. There are, of course, costs for the Public Guardianship Office (PGO) and current Court of Protection, the Official Solicitor’s office (which represents people without capacity in court cases), and for legal aid. These annual costs are shown below:

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<thead>
<tr>
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<tbody>
<tr>
<td>PGO and Court of Protection</td>
<td>£13.2m (net cost after recovery of £10.4m via fees)</td>
</tr>
<tr>
<td>Official Solicitor</td>
<td>£415,000 (net cost after recovery of £75,000)</td>
</tr>
<tr>
<td>Legal assistance on matters relating to mental incapacity</td>
<td>£52,600</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£13,567,600</strong></td>
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The legal assistance figure excludes money currently spent on legal representation for mental incapacity cases heard in the High Court. Separate statistics are not kept on these cases since they form only a small category. The Official Solicitor does not keep separate figures on the cost of representing people in health and welfare cases. Therefore the figure given here includes the cost of representing people who lack capacity in other types of cases, such as adoption and divorce.

**Additional costs of option 1 – registration of EPAs**

35. Costs could be set according to the resources available in DCA/PGO/DH. The encouragement would be delivered through existing channels and, possibly, focused work by Press Offices to raise the profile of the issue in the media. There would be some costs to DCA of defending the decision not to introduce long-awaited legislation and dealing with correspondence from those committed to it. However, this would be met from within existing budgets. There might also be an increase in litigation over disputed EPAs. A hearing before a Master or Assistant Master, lasting four hours, would cost approximately £430 for judicial time and £50 for administrative time. However, these costs would usually be borne by the donor of the EPA.
Additional costs of option 2 – encouragement of voluntary codes of practice

36. The main cost would be to the voluntary organisations in developing, distributing, and monitoring new/additional codes of practice, including considering complaints. This might be done at cost if individuals had to buy a copy. (This is the situation with the guidance on incapacity jointly issued by the Law Society and BMA, which is sold at £19.95) There would be likely to be pressure on Government to contribute a portion of this if it was perceived to be instead of legislation and since the organisations who would have to do the work are likely to be less well resourced than e.g. the BMA or GMC.

37. The fact that voluntary codes of practice existed, but had no statutory basis, might result in a rise in disputed cases going to the High Court. The average cost of a case in the High Court is not less than £8,000 and a case can take between six and 18 months to resolve.

Additional costs of option 3 – Government guidelines

38. Many of the costs of this option would be similar to that for legislation, if the guidance was to have an impact. There would need to be training and information (costs mainly falling to PGO and DH), and some changes in PGO services. On the assumption that the exhortations to change behaviour worked, there would also be similar public sector costs to those caused by legislation arising from changes in processes by health and social care workers. Costs to the voluntary sector in producing their own codes to support centrally produced ones would also be the same as option 4. The costs that would not occur would be those arising from the “teeth” of legislation, i.e. the Court of Protection covering health and welfare issues, legal aid, judiciary etc, though increased awareness of the issues could well encourage more cases to come to existing courts, as in option 2 above, and the lack of clear law might make these cases more complex than was desirable either for the people involved or from the point of view of cost. There would also be no costs arising from new procedures for the PGO in administering LPAs. PGO costs would be for the development of codes, guidance and enhanced provision of advice. In operational terms, the costs would be for enhanced advice and guidance (probably through helplines). Based on the estimated costs of the Bill, the Government costs would be:

Set up costs

<table>
<thead>
<tr>
<th>Cost Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Producing Code of Practice</td>
<td>£1.9m</td>
</tr>
<tr>
<td>DH Training</td>
<td>£10.5m</td>
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<tr>
<td>Health and social care guidance in E &amp;W</td>
<td>£1.5m</td>
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<tr>
<td>PGO advice and guidance</td>
<td>£450,000</td>
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Running costs

<table>
<thead>
<tr>
<th>Cost Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>NHS and social care running costs</td>
<td>£8m</td>
</tr>
<tr>
<td>PGO additional running costs</td>
<td>£500,000</td>
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</tbody>
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Additional costs of option 4 – the MI Bill

39. Since to a considerable extent the Bill codifies what we know to be existing best practice in helping people with capacity problems to make decisions, it would not cause radical or wholesale change. We would plan to use the time preceding implementation to broadcast what the Bill was and was not about. It sets out an expectation that best practice in attitudes and behaviour should be the norm for everyone. The Bill does not give a new set of duties and responsibilities with obvious costs attached. The change in behaviour should be seen in everyone who cares for or supports someone who lacks mental capacity, but only in so far as they do not already act in accordance with best practice.

Costs to Government

40. These fall to DCA and DH.

41. For DCA, the costs lie in the changes to the functions of the PGO, which will become the Office of the Public Guardian (a new statutory figure created in the Bill) and the Court of Protection, plus costs of additional caseload for the Official Solicitor (who represents people without capacity) and legal aid. The additional costs of the Bill (i.e. over and above what DCA would spend on mental incapacity anyway) can be summarised as follows, covering set up costs and the first year of implementation (i.e. up to and including 2007-08 - our current working assumption is that the Bill would not be implemented sooner than April 2007):

DCA set-up and first year running costs

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>DCA direct costs: Code of Practice, awareness raising, evaluation etc.</td>
<td>£1.9m</td>
</tr>
<tr>
<td>Legal aid (this is lower than the £6m for subsequent years, assuming it will take some time for cases to move through the system and bills to be paid).</td>
<td>£4m</td>
</tr>
<tr>
<td>PGO and Court of Protection costs: including IT systems, developing new forms and information, judicial and staff training</td>
<td>£9.05m</td>
</tr>
<tr>
<td>Official Solicitor: representation work for additional caseload, and associated staff, training and other operational costs.</td>
<td>£0.9m</td>
</tr>
<tr>
<td><strong>TOTAL DCA COSTS</strong></td>
<td><strong>£15.85m</strong></td>
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DCA “steady state” running costs thereafter

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Code of practice, evaluation, awareness</td>
<td>£0.1m</td>
</tr>
<tr>
<td>PGO: new duties, such as processing applications for health ad welfare deputies</td>
<td>£2m</td>
</tr>
<tr>
<td>Official Solicitor: additional caseload</td>
<td>£0.6</td>
</tr>
<tr>
<td>Legal aid</td>
<td>£6m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£8.7m</strong></td>
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</tbody>
</table>
N.B. The PGO, Court of Protection and OS costs take into account fee recovery.

42. The cost to PGO is underpinned by these assumptions:

(a) they will explore the costs and benefits of using avenues other than the new OPG for providing information and advice to as wide a group of customers as possible (e.g. voluntary sector, other statutory agencies);

(b) all fee levels should be set at a level consistent with the Treasury policy of full cost recovery, but balanced with the commitment to maintain access to justice for this vulnerable group. There should be a fees exemption and remission policy for those who cannot pay. Deliberate cross subsidy should be avoided; and

(c) court fees should be paid upfront. People should pay their own court fees unless it would be inequitable for them to do so (e.g. if someone acts properly as a “whistle blower” in an incapacitated person’s best interests, the court fees should where possible be recovered from the incapacitated person’s assets).

43. The legal aid figure assumes:

(a) 200 health and welfare cases coming to the Court of Protection at the High Court level each year. The additional costs to the Official Solicitor also reflect this caseload. This yields a total cost of £420,000 for legal representation. Funding for this reflects our response to the Joint Committee that funding will be available for serious health and welfare issues dealt with by the High Court (for example, cases involving artificial nutrition and hydration and sterilisation); and

(b) that of the 1.2m total patient population (taken from DH figures used for workforce estimates – see paragraph 52 below) 1.5% will seek and receive legal help (this reflects the demand for legal help in 2002-03 and the eligibility level of the general population). DCA are working with the Legal Services Commission (LSC) on controlling access to legal help and representation to ensure mechanisms are in place to target it where it is most appropriate.

44. Our paramount principle in considering legal aid is the best interests of the mentally incapacitated person and the best means of resolving problems and disputes that arise. Research in family law suggests that disputes between separated parents are more likely to find a lasting resolution if the parents reach an agreement themselves without recourse to the courts and that court cases can sometimes exacerbate matters. The Joint Committee scrutinising the draft Bill recommended use of mediation as an alternative method of dispute resolution and the Codes of Practice accompanying the Bill will encourage this. Stakeholders have also told us that the best interests of mentally incapacitated people are rarely served by litigation. Therefore we, and many of its likely users, regard the Court of Protection as an important safeguard, but nonetheless a last resort. We plan to use and develop existing and planned health and social care structures to embrace complaints and disputes about mental incapacity and quality assure the processes that deal with these. Joint work with DH indicates that existing mechanisms in the NHS in England,

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8 Trinder, Beek and Connolly, ‘Children’s and Parents’ Experience of Contact after Divorce’ (York Publishing Services (2002), pp 42/43.
such as Patient Advice and Liaison Services (PALS) and Independent Complaints Advocacy Services (ICAS) are already doing at least some of this kind of work, so that the new resource requirement will be minimal. The Joint Committee recommended that decisions relating to the carrying out or continuation of life-sustaining treatment should always be referred to the Court of Protection when there is no LPA or advance decision. However, there will be occasions when it would be more appropriate for deputies to make these decisions, for example, to avoid the distress of going to court in the late stages of a degenerative illness. We shall want to ensure that when the court is used, the forms and procedures are as simple as possible, which should also reduce the need for legal representation in all but the more complex cases.

45. There could be an increase in the OS’s work on financial matters such as statutory wills, gifts etc. due to raised awareness. However, any increase would be met out of the patient’s estate. An increase in health and welfare cases is likely, partly because the Bill will raise awareness.

46. For DH, the costs arise from revising their own guidance, training of professionals in the approaches in the Bill and costs related to any necessary changes in procedures for the health and social care workforce. The costs can be summarised as follows:

**DH set-up costs**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training for social care workers (England)</td>
<td>£1.7m</td>
</tr>
<tr>
<td>Training for health care workers (England)</td>
<td>£8.2m</td>
</tr>
<tr>
<td>Revising existing guidance for the health and welfare sector (E &amp; W)</td>
<td>£1.5m</td>
</tr>
<tr>
<td><strong>Total DH set-up cost</strong></td>
<td>£11.4m</td>
</tr>
</tbody>
</table>

**DH running costs (England)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional costs to the health and social care workforce, due to changes in procedures etc.</td>
<td></td>
</tr>
<tr>
<td>Health care costs</td>
<td>£8.2m</td>
</tr>
<tr>
<td>Social care costs</td>
<td>£3.8m</td>
</tr>
<tr>
<td>Independent consultee costs</td>
<td>£6.5m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£18.5m</td>
</tr>
</tbody>
</table>

47. The training cost allows for care managers, consultants, GPs, psychologists, social workers and speech therapists to have half a day’s training, with locum costs where appropriate, incorporated into their continuing professional development. Other groups, such as care assistants, nurses, administrative staff, will receive general awareness raising via cascading in normal sessions with their managers.
48. The cost for revising guidance is based on a trawl of existing relevant guidance in DH and in the National Assembly for Wales. The actual cost may be slightly lower because some guidance would need to be updated in the normal course of events anyway so the Bill should not represent an extra task.

49. The Government has accepted the Committee’s recommendation that the Bill should contain provision to allow for strictly-controlled health and social care research to explore the causes and consequences of mental incapacity and to develop effective treatment for such conditions, but with rigorous safeguards. The UK is required to implement the EU Directive on Clinical Trials (2001/20/EC) by 1 May 2004. The Directive and the Regulations only relate to clinical trials but it will be desirable, as far as is practicable, for the measures in the Regulations relating to research with people with mental incapacity to be consistent with those in the Bill. There may be some additional costs for ethics committees in dealing with additional research proposals involving people with mental incapacity. However, these costs are likely to be small: around £10,000 per annum. At present there is no single system for social care ethics review. Proposals for a national system of social care ethics review are shortly to be published for consultation. This will be comparable to, but distinct from, the NHS ethics committees. Meanwhile independent review of the ethics of social care research is provided via a range of sources, including ethics committees in universities and the peer review systems of research sponsors.

50. The year on year operational cost to DH of operating the new regime is estimated at £18.5m in England. In relation to the workforce costs, it is worth noting that our consultations with stakeholders suggest that many will welcome the legal protection that the Bill will give them, and the fact that it will require everyone to act to the same standards. The level of workforce costs depends on the extent to which professionals do not already follow the best practice that the Bill will enshrine in law from 2007. We hope that our proposed approach of promoting the messages of the Bill before implementation to bring about a quiet revolution of spreading best practice, rather than sudden and radical change, will reduce the numbers who, in 2007, are not already doing what the Bill envisages. Those already using best practice will not need to make any changes in what they are doing, so the effect will be cost neutral. For others, where processes associated with decision making take more time, there will be an additional cost. In some cases, the clear legal framework will mean that decision making can be done more quickly than at present, thus representing a net saving of resources.

51. In order to be able to make an estimate of the net cost to the health and social care workers in the public sector, we have had to make some assumptions about behaviour now. In 2003 DH developed a workforce and costing model to assess the cost impacts. This used data gathered from a variety of sources including statistics relating to different conditions that can lead to mental incapacity, interviews with practitioners, workshops with representatives of stakeholders such as the Association of Directors of Social Services and NHS Federation, and discussions with relevant DH policy teams. In some cases, this yielded reliable data, and in others, it allowed for the development of reasonable estimates, which have been subject to additional testing by practitioners and service providers. It would only be possible to quantify the extent of best practice with a full-scale research study, at disproportionate cost. The modelling work done for DH alone cost £12,000.
52. This model allowed us to make some assumptions about the potential size of the population that might have mental incapacity as understood in the Bill. Out of around 53 million people in England and Wales, an estimated more than 1.2 million could have recourse to provisions relating to the Bill. The estimated cost is therefore based on this size of client population.

53. There was no evidence that day to day decision making or decision making in emergency situations would have a significant impact on staffing or other resources. The study did, however, identify certain key decision points or events where mental incapacity might be a serious issue. These were decisions affecting how the person was cared for, where they lived and significant medical treatments. Such key decisions would usually involve activities or processes in which care staff would be involved e.g. assessment, case conference, and patient discussion. It was then possible to estimate the likely frequency of such activities or processes for each decision point both before and after the Bill, which allowed us to estimate the annual staff cost in each case. Allowance was made both for where processes might be quicker and for where there might not be best practice at present.

54. DH currently funds the development of advocacy services (£1.3m for each of the last three years for the development of advocacy services for people with learning disabilities and 1.1m until March 2006) and other departments and agencies, such as the Lottery Community Fund, also provide funds to ensure that advocacy services are available. Many stakeholders would like provision for a statutory right to independent advocacy services for anyone affected by the Bill or, at least, when serious decisions are to be made. The cost of providing this has not been estimated, but we consider, given the number of people affected by the Bill, it would be unrealistic to expect that sufficient funding and trained people could be found.

55. Nevertheless, following the Joint Scrutiny Committee’s report, the Government considered how it could offer more reassurance to people who would like to see greater safeguards when serious decisions are taken and people are particularly vulnerable.

56. In addition, the published draft 2002 Mental Health Bill introduced new safeguards for adult patients who have a long-term incapacity to consent and who are in a hospital or care home receiving treatment for a serious mental disorder on an informal basis. As the legal basis of the treatment of these patients is the common law of necessity, which will be superseded by the Mental Capacity Bill, the Government has decided that it is more appropriate and consistent for safeguards for this group to be removed from the Mental Health Bill and integrated with the provisions of the Mental Capacity Bill.

57. The Government has therefore decided to provide an independent consultee to assist people who are unbefriended when particularly serious decisions are taken under the Bill (such as serious medical treatment decisions or permanent moves into care), when the person who lacks capacity has features that make him especially vulnerable. The consultee would provide an independent viewpoint in the decision-making process. The independent consultee would also be involved in an annual review of the original decision to move someone into long-term care to ensure that those arrangements were still in the person’s best interests. The Bill will also include a regulation making power to add other categories of people who the consultee
might help and other procedural safeguards for certain decisions for the most vulnerable. We would consult further and test the policies developed for these Regulations. The consultee will be used by NHS bodies, hospitals and care homes. The impact on the private and independent sector should be small as the duty to provide the independent consultee will fall on the NHS body or social services. Costs of these safeguards are estimated at £6.5m.

58. DCA has explored with the Office of the Deputy Prime Minister (ODPM) whether the Bill would have an impact in terms of the non social care functions of local authorities in so far as these require staff to become involved in decision making with people who lack mental incapacity. This largely happens when housing (or re-housing) people with mental health problems and learning disabilities who are not involved with social services. We have spoken to front-line housing staff and the Housing Corporation (which regulates Registered Social Landlords – mostly housing associations). They consider that staff already comply with the best practice principles when assessing people for housing and any support needs they may have. We therefore believe that the Bill will be cost neutral for them.

59. The Bill will cover England and Wales. DCA is responsible for England and Wales, so that their costs cover both. The Welsh Assembly have been involved in the work to estimate the health and social care costs, which are thus assumed (based on the Barnett formula) to be 6% of the DH costs (i.e. set up costs of £0.6m for training health and social care staff and running costs of £0.7m per annum plus £0.39m for the provision of independent consultees.

Costs outside central government

60. There will also be some costs to:

(a) private sector care homes and providers of domiciliary care in changes to procedures for their staff. Costs will arise when staff are involved in key decisions about how the incapacitated person is cared for and where they live. These costs are expected to be small, at around £80,000 per annum. The care home owners we have spoken to have said they already comply with the best practice in the Bill. They do have some concerns, however, about how the provision to call in an independent consultee will work in practice and whether this will involve them in extra bureaucracy. In general, care homes are already engaged in driving up standards: the Bill builds on the standards set out in the Care Standards Act for residential care homes and domiciliary care services. These include standards for training and qualifications and targets for 50% of residential care staff to be trained in the Level 2 Care NVQ by 2005 and 50% of domiciliary care staff to have a care NVQ by 2008. DH supports staff training to meet the standards via a grant of £15m, which is disbursed by Topss England. This grant is used mainly for NVQ training and assessment and is available to social care employers in all sectors. In addition, DH obtained funding in 2003 which was paid to local authorities to support the attainment of training and qualifications requirements in the national minimum standards. From April 2004 these funds are not ring-fenced and authorities can use the monies for any purpose they wish, but the need to meet the national minimum standards may encourage them to pass some of this money to contractors providing care services or set up joint training with them. Costs for training are therefore expected to be minimal;
(b) voluntary sector organisations that support and advise people with mental incapacity and/or the people who care for them. As noted above, these costs – for something that they see as a very welcome piece of legislation – are largely expected to be contained as part of the work these organisations already do. There may be an impact on the voluntary sector workforce and their ability to deliver other services to the NHS and social service departments if their involvement in representing people lacking capacity increases. But this may well be balanced by the saving of resources used at present in pressing for legislation.

Unintended consequences and indirect costs

61. None that we are aware of. The pre-legislative scrutiny has been very helpful in identifying some areas where the Bill as drafted might have been misconstrued, and we are continuing to work with stakeholders to ensure that it is properly understood.

Competition assessment

62. The new framework for making decisions with/on behalf of incapacitated people would be relevant to everyone concerned in the care of, or dealing with, those with impaired capacity. Whilst the majority of care and residential homes, and providers of care and support, are small businesses, it is unlikely that these changes will restrict or deter new entry into the sector. Indeed, clarity about the legal position could, on the one hand reassure those who are well intentioned and considering joining the sector; and on the other hand deter those whose intentions are less positive.

63. We consider that there will be no disproportionate effects in relation to compliance costs for businesses that deal with the care of those with impaired capacity. The scale of such costs is considered unlikely to be sufficient to have any significant effect on competition within the market.

Small firms’ impact test

64. We have talked through the possible impact of the Bill on small to medium businesses with care home managers. In addition, the Small Business Service has canvassed the views of care home owners’ trade associations via the Forum of Private Businesses. Those canvassed were generally in favour of the Bill and believe they are already following the best practice in it. For this particular group the Bill is unlikely to add any additional costs. However, some additional cost is likely to be incurred by those care home managers not currently following best practice, in terms of training and introducing changes to their current procedures. But the overall benefits of the Bill for care home owners are as set out in paragraph 32 above.

Enforcement arrangements

65. The legislation will create a new offence of ill-treatment and neglect of a mentally incapacitated person. We do not anticipate that this will create any significant additional burden for enforcement. The offences are largely created for deterrent purposes.
Monitoring and evaluating/reviewing

66. Once the implementation plan from our working assumption of 2007 onwards is clearer, we shall consider, with DH and PGO, what monitoring and evaluation would be most practical. We are already exploring what role existing or planned quality assurance bodies such as CHAI or CSCI might have. Our objective will be to ensure that the Bill is working as we expect it to, making a real difference in the lives of vulnerable adults, without imposing unnecessary additional bureaucratic burdens. The most important aspects of the Bill are quite difficult to measure. We shall want reassurance that the way in which people who lack capacity are helped to take decisions reflects the principles of the Bill, i.e. people are first assumed to have capacity, allowed to take their own decisions as far as possible, and that others act in their best interests. We shall also want to understand how the Bill has affected decision making in key situations – a clearer, easier, quicker process. Since the main and most widespread change we seek is a difference in how decisions are taken and delivering benefits to the wide group of vulnerable people, this is likely to involve qualitative research as well as reviewing feedback, e.g. MPs' letters and outcomes such as statistics on court cases, complaints, reports in the media. DCA is already considering these issues in the context of our PSA targets for SR 2004.

Consultation exercise results


Recommended preferred option

68. Option 4 – legislation.