

Responses from Workshop Day – May 2006

Organised by Carers Together in Hampshire

Session 1 - Response to consultation on Mental Capacity Act Code of Practice May 2006

Consultation held by Carers Together Hampshire – 22 May 2006

- The consultation session involved 60 carers, who sat at tables of between 7 and 9 people.
- Each table took one or two chapters and discussed them.
- The results are a mixture of comments and concerns.
- No attempt has been made to amend or change the comments - they have been recorded as written by the groups
- Some found (due to the extensive size of some of the chapters and trying to read them in context with the whole Act without detailed preparation) answering the questions difficult.
- However discussing general mental health issues was much easier.

Chapter 1

- Where to get code of practice?
- How to interpret?
- Where do carers get knowledge of the act, if not connected to any group, organisation, etc?

Chapter 2

- Section 2.3 Who will oversee/monitor to check people are receiving help and support making decisions?
- Section 2.5 Who is going to “police” this i.e. that care and treatment is in persons w/o capacity best interest.
- Will this legalise living wills?
- How would anyone know where to find your L.P.O.A forms before it is registered if you lose your capacity?
- Does this mean we all have to redo our existing P.O.A.s?
- Examples: seem sensible and clear.

Chapter 3

- Ongoing assessment of capacity – will fluctuate.
- Don't assume “downward” slope – sometimes will improve
- Holistic approach – emotional support as well as MH support
- Carers need to be involved in assessment – GP / S/S etc. not always know the “cared for”.
- CPA meeting.
Confidential issues – information not available if e.g. patient has seen psychiatrist.
Physical conditions – more exchange of info, less for MH.
- If unable to make one decision – do not assume they are unable to make another decision.
- Sometimes family also assume – likes & dislikes of cares for “piglet”.
- Emotional support unavailable for carers – sometimes e.g. CPN able to see carers DO need support.
- Carers need information/training at outset.
- Overlap of professionals/non paid staff to give a wider view

Examples:

- 1 Take more notice of his wife.
GP right decision – allowing for that “10” minutes in time.
- 2 Excellent If it does happen.
Knows patient, involving carer.
No more time involved – good understanding
- 3 Need a ‘good’ deputy!
How do you choose an independent one – interests of young man at heart.
Degrees of capacity?

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4 Distress – away from home – unknown.

Could treatment be administered at home, by, someone she knows.

More explanation of treatment as before.

Needs a link – someone she knows there.

Chapter 4 – not looked at

Chapter 5

Describe what mental incapacity is? At what point, and who decides has the authority.?

Scenario 1

Early stages of dementia.

Who makes the decision, daily care plans, helpful, carers 3 types of care:

Family – feeding

Nurse – dressing

Friend – walking

Scenario 2

Negligence during operation.

Consent correctly given but problems occurred later on. Very realistic, good example.

Necessary restraint

Scenario a typical example. Very realistic. However, what does minimum of force mean. Who decides what is acceptable?

Should some preparation be made for patients where certain behaviour is acceptable?

Chapter 6 - Lasting Power of Attorney

With EPA there are 2 levels

1. When the subject requests the action.
2. When the intellectual ability is thought not to be capable of appreciating the situation.

Reading under pressure of time reduces the ability of spotting all aspects (see 1st comment).

No guidance given on how to deal with grey areas (e.g.) when misleading answers & statements are given by patient to consultants etc, when carer knows otherwise.

We think this document is useful, but is lacking information on all aspects of decision making when making application.

Several attorneys

1. Health
2. Financial

Health attorney – good idea.

Clarifies situation. Dr. knows who to ask, who is responsible.

Chapter 7

7.3 How much is the fee to be?

7.39 The example doesn't say who has decided this young lady lacks the capacity. If never had the chance – may have the capacity with support to learn the skills.

7.39 How do those who are deemed lacking capacity get the chance to prove otherwise?
How do you give the opportunity, safely, without putting them at risk?

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Chapter 8

- 1 Re 8.15 – there should be an assessment of capacity, and a record of this.
- 2 Who decided who has mental incapacity.
- 3 Anyone with any mental illness should be allowed directives and these must be respected.
(This did NOT have full agreement all round the table).
- 4 A very emotive subject – differing points of view expressed.

Chapter 9

Independent Mental Capacity Advocate

Very small numbers:

They need to be “wise befriender”

Advocates must be independent.

Training for professionals on act to know when to call in mediation / IMCA.

How long take to call in mediation / IMCA

What mechanisms for “scrutiny/audit”?

In place/working to ensure people are “supported” to make decisions.

Chapter 10, 11, 12 not looked at

Chapter 13

13A

1. 13.6 Important to note that large organisations can abuse patients/service users,
e.g.
 - 1) Not telling people who lack capacity how much they have to pay for a service until after it is in plan.
 - 2) Decisions taken by hospital doctor that someone without capacity has to go into residential care – bullied into it
 - 3) Care homes putting people to bed at 6.00pm, to suit their own regimes.

CAN THE GOVT. BE CLEAR THAT RESTRAINT TO KEEP SOMEONE SAFE IS NOT NECESSARILY AN ABUSE?
2. 13.8 ROLE OF LPA.
LPAs should be checked not only for bankruptcy but also CRB checked, immigration checked, POVA list.
Also COP visitors should be checked as above.

13B Examples fine

Chapter 14

Mediation re disputes within family.

Need publicity to ensure “families” know of service.

Training for professionals on act to know when to call in mediation / IMCA.

How long take to call in mediation / IMCA

What mechanisms for “scrutiny/audit”?

In place/working to ensure people are “supported” to make decisions.

Chapter 15 not looked at

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Question 16

- Still assuming GP/Professional making decisions
- Need more involvement from carers/those who know the person.
- Carers having to fight for place on care team – not conforming.
- Son being bulldozed by system – now have 2 patients s mums is ill as well.
- Should not have to fight for help, being listened to.
- Help/support varies from area to area.
- Depends on the individual – some are hopeless, some very good.
- There is some consultation with carers support group – E.Hants help with leaflets etc.
- All services accessible to all – rival communities evening meetings if required.
- Local services.
- Memory tests done at home.

The Act

- 1 Simple, widely distributed information leaflet, on code – e.g. GP surgeries, CAB.
- 2 Publicity – media, T.V etc.
- 3 Communication at all levels, plain, simple, language, the right “attitude” towards carers.
- 4 IMCA and mediators must be “central government funded” – if via local government, must be “ring fenced”.
- 5 In principal “best interest” should not be governed by “resources” both human and money.

The Mental Capacity Act

- See more specific protection built in for the cared for.
- Aimed at paid carers. Paid carers do as they are told by professionals.
- We need a professional advocacy service – independent/impartial to hospital/paid carers/doctors, to interpret the Act. A proper title for non-paid carers.
- What is the aim of this act?
- To increase protection of cared for?
- To protect professionals in caring roles?
- Who is empowered by this act?
- Will family lose control over care?

e.g. When they become 18+, and/or into institutions.

Family may disagree with paid carers ideas about acceptable treatment and decisions made. Family members still want involvement in decision making –

i.e.: Restraint)	
Medication changes)	Patients interests
Force feeding)	
Any treatment)	

General Points

Human Rights Act legislation favours person without capacity but disregards carer’s Human Rights Act rights.

Institutions (social services) invade privacy, e.g.

- asking for proof of all family finance
- means testing is an abuse of privacy.