



**Law  
Commission**  
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# Mental Capacity and Deprivation of Liberty A Consultation Paper

**50  
YEARS**

**Law Commission**

**Consultation Paper No 222**

**MENTAL CAPACITY AND DEPRIVATION  
OF LIBERTY**

**A Consultation Paper**



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**Topic of this consultation paper:** Mental capacity and deprivations of liberty.

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Please send your responses either:

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**THE LAW COMMISSION**

**MENTAL CAPACITY AND DEPRIVATION OF  
LIBERTY**

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# CHAPTER 1

## INTRODUCTION

1.1 This consultation paper considers how the law should regulate deprivations of liberty involving people who lack capacity to consent to their care and treatment arrangements. Article 5 of the European Convention on Human Rights guarantees the right to personal liberty and provides that no-one should be deprived of their liberty in an arbitrary fashion.<sup>1</sup>

1.2 In determining when a person is deprived of liberty, Lady Hale has confirmed the universal nature of human rights:

It is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else.<sup>2</sup>

1.3 The inevitable corollary is that what it means to be deprived of liberty must be the same for everyone, whether or not a person is disabled.

1.4 The consultation paper is not limited to article 5 matters. Any deprivation of liberty will also entail by its nature a limitation of article 8 rights to private and family life. A person who is deprived of liberty continues to enjoy “all the fundamental rights and freedoms guaranteed under the Convention save for the right to liberty” and moreover, “when a person’s personal autonomy is already restricted, greater scrutiny be given to measures which remove the little personal autonomy that is left”.<sup>3</sup>

### WHY THIS PROJECT?

1.5 The Law Commission’s 1995 report on mental incapacity formed the basis of the original Mental Capacity Act 2005 (“Mental Capacity Act”).<sup>4</sup> The deprivation of liberty safeguards (“DoLS”) were introduced separately at a later stage by amendment to the Mental Capacity Act by the Mental Health Act 2007. The DoLS establish an administrative process for authorising deprivations of liberty in a hospital or care home. In broad terms the DoLS provide for a professional assessment – conducted independently of the hospital or care home in question – of whether the person lacks capacity to decide whether to be accommodated in the hospital or care home for the purpose of care or treatment, and whether it is in their best interests to be deprived of liberty. The authorisation can be challenged through an administrative review procedure or in the Court of Protection. A more detailed summary of the DoLS can be found in chapter 2.

<sup>1</sup> The text of the Convention articles relevant to issues discussed in this consultation paper is set out in appendix C.

<sup>2</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [45].

<sup>3</sup> *Munjaz v United Kingdom* [2012] ECHR 1704 (App No 2913/06) at [79] to [80].

<sup>4</sup> *Mentally Incapacitated Adults*, Law Com No 231.

- 1.6 The DoLS have been subject to considerable criticism ever since their introduction. In March 2014 two events inflicted significant damage. First, the House of Lords post-legislative scrutiny committee on the Mental Capacity Act (the “House of Lords committee”) published a report which, amongst other matters, concluded that the DoLS were not “fit for purpose” and proposed their replacement.<sup>5</sup> A few days later, a Supreme Court judgment widened the definition of deprivation of liberty to a considerable extent.<sup>6</sup> The practical implications have been significant for the public image of the DoLS, and the regime has struggled to cope with the increased number of cases.

## **BACKGROUND TO THE PROJECT**

- 1.7 This project originated from a proposal from Mind for a review of the relationship between the DoLS and the Mental Health Act 1983 (the “Mental Health Act”). In the light of the House of Lords committee’s report and the *Cheshire West* decision, the Government originally asked the Law Commission to undertake a limited review of deprivations of liberty in supported living arrangements<sup>7</sup> and other community settings, and to consider the learning that could be applied to the DoLS.<sup>8</sup> The project was included as part of the Law Commission’s 12th programme of law reform published in 2014. Following subsequent engagement and discussion with stakeholders, Ministers agreed that it would be more appropriate for the Law Commission to consider the legislation underpinning DoLS in its entirety, in addition to its work on community settings (including supported living). This was formalised by a reference from the Department of Health to the Law Commission under Law Commissions Act 1965 section 3(1)(e).
- 1.8 Ongoing meetings have taken place since the start of the project with the Department of Health, as the sponsoring department for this project, to ensure that the Law Commission is aware of developing Government policy. The project is also supported by the Welsh Government, and meetings have taken place with officials in Cardiff. We are grateful for the input and expertise that officials have been able to provide.
- 1.9 The importance of a high degree of engagement with stakeholders was identified at the start of the project. We have benefited from a range of pre-consultation meetings with key stakeholders and other experts. These have included regional meetings with Best Interests Assessors and DoLS leads throughout England and Wales, and a series of visits to hospital, care home and supported living accommodation. Pre-consultation meetings have also taken place with a range of disability groups, carers organisations, professional groups, local authorities and NHS representatives, care providers, health and social care regulators, academics, legal experts and law firms.

<sup>5</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 32.

<sup>6</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896.

<sup>7</sup> Supported living is specialist or adapted accommodation or accommodation intended for occupation by people with care and support needs in which personal care is also available.

## **DEVOLUTION**

- 1.10 The project relates to mental capacity law in England and Wales. Legislative competence for mental health is devolved to Wales (subject to certain specific exemptions) under schedule 7 to the Government of Wales Act 2006. The law on mental capacity is part of general civil law and is not specifically devolved. The Mental Capacity Act, including the DoLS, applies to England and Wales. However, it is Welsh Ministers who make regulations in respect of Wales under the DoLS.
- 1.11 The remit of the review does not extend to Scotland or Northern Ireland.

## **WHAT IS DEPRIVATION OF LIBERTY?**

- 1.12 The European Court of Human Rights (“the Strasbourg court”) has confirmed that a deprivation of liberty for the purposes of article 5(1) has three elements:
- (1) the objective element of confinement in a restricted space for a non-negligible period of time;
  - (2) the subjective element that the person has not validly consented to that confinement; and
  - (3) the detention being imputable to the state.<sup>9</sup>
- 1.13 In most of the key cases it is common ground that consent is absent and the state has responsibility, and therefore most attention has been focused on the objective element.
- 1.14 The Strasbourg case law operates on the *Guzzardi* principle that the starting point in assessing whether there has been a deprivation of liberty is “the concrete situation” of the person and the consideration of “a whole range of criteria such as the type, duration, effects and manner of implementation of the [restrictive] measure in question”. The difference between deprivation of liberty and restriction upon liberty is “merely one of degree or intensity, and not one of nature or substance”.<sup>10</sup>

## **Cheshire West**

- 1.15 On 19 March 2014 the Supreme Court handed down its long-awaited judgment in the conjoined appeals of *P v Cheshire West and Chester Council* and *P and Q v Surrey County Council* (“*Cheshire West*”). The Surrey case concerned P and Q (otherwise known as MIG and MEG) who are sisters and have learning disabilities. MIG was placed with a foster mother to whom she was “devoted” and went to a further education unit daily. She never attempted to leave the foster

<sup>8</sup> HM Government, *Valuing Every Voice, Respecting Every Right: Making the Case for the Mental Capacity Act: The Government’s Response to the House of Lords Select Committee Report on the Mental Capacity Act 2005* (2014) Cm 8884, paras 7.27 and 7.29.

<sup>9</sup> *Storck v Germany* (2005) 43 EHRR 96 (App No 61603/00) paras 74 and 89.

<sup>10</sup> *Guzzardi v Italy* (1980) 3 EHRR 333 (App No 7367/76) paras 92 and 93.



home by herself but would have been restrained from doing so had she tried. MEG lived in a residential home for learning disabled adolescents with complex needs. She sometimes required physical restraint and received tranquillising medication. In 2009, the Court of Protection held that these living arrangements were in the sisters' best interests and did not amount to a deprivation of liberty. This finding was upheld by the Court of Appeal.

1.16 The Cheshire case concerned P who has cerebral palsy and Down's syndrome and requires 24 hour care. Until he was 37 he lived with his mother but, when her health deteriorated, the local authority obtained orders from the Court of Protection that it was in P's best interests to live in accommodation arranged by the authority. Since 2009 he has lived in a staffed bungalow with other residents near his home and has one to one support to enable him to leave the house frequently for activities and visits. Intervention is sometimes required when he exhibits challenging behaviour. The judge held that these arrangements did amount to a deprivation of liberty but it was P's best interests for them to continue. The Court of Appeal substituted a declaration that the arrangements did not involve a deprivation of liberty, after comparing P's circumstances with the life which another person with his disabilities might be leading.

1.17 In a decision by majority, the Supreme Court held that MIG, MEG and P had all been deprived of their liberty. Lady Hale, giving the leading judgment, held that human rights are the same for everyone:

If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person.<sup>11</sup>

1.18 The fact that the living arrangements were comfortable, and made life enjoyable, made no difference – “a gilded cage is still a cage.” For that reason, Lady Hale rejected the “relative normality” approach taken by the Court of Appeal in the case of P. Instead, the “acid test” revealed in a line of cases in the Strasbourg court, involves determining whether the person concerned was under continuous supervision and control, and not free to leave. Both conditions must be satisfied in order to amount to a deprivation of liberty.<sup>12</sup>

1.19 Lord Carnwath, Lord Hodge and Lord Clarke dissented in the case of MIG and MEG. They considered that the degree of intrusion was relevant to the concept of deprivation of liberty, and noted that the care regimes were no more intrusive or confining than required for the protection and well-being of the persons concerned. They were concerned that nobody using ordinary language would describe persons living happily in a domestic setting, like MIG and MEG, as being deprived of their liberty. It was also argued that the formulation of an “acid test” goes against the grain of Strasbourg case law which has always applied a case-

<sup>11</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [46] by Lady Hale.

<sup>12</sup> As above, at [46] to [49].

specific test applying a whole range of criteria.<sup>13</sup>

- 1.20 The decision has produced much debate and discussion. Some have questioned why people who lack capacity and are not free to leave their premises are not considered to be deprived of liberty – merely on the basis that they are not also under continuous supervision and control.<sup>14</sup> Some aspects of the acid test remain unclear. For example, Lord Neuberger stated that the “area and period of confinement” is also amongst the essential ingredients and that the acid test should be adopted “unless there is good reason not to do so”.<sup>15</sup> Lord Kerr suggested that the key factor in the case of MIG and MEG indicating a deprivation of liberty was that the restrictions were a “constant feature of their lives”.<sup>16</sup> There is ongoing debate over whether not being free to leave includes people who are physically unable to leave or have no alternative accommodation. In respect of people under the age of 18 the judgment also points towards an additional age and maturity comparator.
- 1.21 Most concerns have been raised over the practical implications of the judgment. Mr Justice Mostyn has pointed to the “significant resource implications” for local authorities and the state, as well as the “considerable expense to the public purse” that would result from the “tens if not hundreds of thousands” of court cases.<sup>17</sup> Allen has argued that “tens of millions of pounds are being diverted from health and social care budgets to enable such authorisations on an industrial scale”.<sup>18</sup>
- 1.22 We have a degree of sympathy with these concerns. However, the majority in *Cheshire West* were clear that disabled people have the same rights as anyone else. In our view, this must be the starting point. Our task is to find the best solution.

## **THE STRUCTURE OF THIS CONSULTATION PAPER**

- 1.23 This paper is divided into 15 chapters:
- (1) chapter 1 is the introduction;
  - (2) chapter 2 provides an analysis of the DoLS;
  - (3) chapter 3 sets out the principles that will inform the new scheme (known as “protective care”);
  - (4) chapter 4 discusses the scope of the new scheme;

<sup>13</sup> As above, at [105].

<sup>14</sup> J Landau, “Refilling the Bournemouth Gap after *Cheshire West*” [2014] 19(2) *Judicial Review* 128, 130.

<sup>15</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [61] and [63].

<sup>16</sup> As above, at [78].

<sup>17</sup> *Rochdale Metropolitan Council v KW* [2014] EWCOP 45 at [1] and *Tower Hamlets LB v TB* [2014] EWCOP 63 at [59] to [60].

<sup>18</sup> N Allen, “The (Not So?) Great Confinement”, (2015) 5 *Elder Law Journal* 1, 45.

- (5) chapter 5 provides a high-level summary of the new scheme;
  - (6) chapter 6 sets out our provisional proposals as to the part of the scheme that we have called “supportive care”;
  - (7) chapter 7 discusses the part of the scheme that we have called “protective care and treatment”;
  - (8) chapter 8 considers hospitals and palliative care;
  - (9) chapter 9 is concerned with rights to advocacy and the relevant person’s representative;
  - (10) chapter 10 discusses the interface with the Mental Health Act;
  - (11) chapter 11 considers rights of appeal;
  - (12) chapter 12 discuss the person’s wishes and feelings;
  - (13) chapter 13 is concerned with advance and supported decision making;
  - (14) chapter 14 looks at regulation and oversight; and
  - (15) chapter 15 looks at other issues.
- 1.24 In addition to these substantive chapters, we have set out all of the provisional proposals and questions included in this consultation paper in appendix A. Appendix B lists the meetings conducted as a part of our pre-consultation programme. Appendix C sets out some of the key legal provisions referred to in this consultation paper.

## **RESPONDING TO THIS CONSULTATION PAPER**

- 1.25 In this paper we make a number of provisional proposals for law reform. In doing so, we emphasise that these represent our initial view about how the law should be reformed and we will be reviewing these proposals on the basis of the responses to this consultation paper.
- 1.26 We will be undertaking a wide consultation process in order to gather as many different views and as much information as possible. We welcome responses from all interested parties. Details of how to respond can be found on the inside front page of this consultation paper.
- 1.27 An analysis of consultation responses will be published on our website. The next stage will be to produce and submit a report to the Lord Chancellor. Taking into account the responses we receive to this consultation paper, the report will contain our final recommendations and the reasons for them. A draft bill, giving effect to our final recommendations, will also be included.

## CHAPTER 2

# ANALYSIS OF THE DEPRIVATION OF LIBERTY SAFEGUARDS

- 2.1 This chapter provides a general overview of the DoLS, setting out the main features of the legislative procedures and safeguards. It also analyses the main criticisms that are commonly made of the DoLS. Much of this analysis is presented at a relatively high level, and many of the specific issues identified are explored in greater detail throughout this consultation paper.

### OVERVIEW OF THE DOLS

- 2.2 The DoLS are contained in schedules A1 and 1A to the Mental Capacity Act. They were not part of the original Act but were introduced as amendments by the Mental Health Act 2007.<sup>1</sup> The DoLS were a response to the case of *HL v United Kingdom* which concerned a 48 year old man (“HL”) who had suffered from autism since birth and lacked capacity to consent or object to medical treatment.<sup>2</sup> After 32 years in a psychiatric hospital he had been discharged to live with his paid carers, with whom he had lived for three years. But following an incident when he became agitated at a day-care centre, HL was taken back to hospital and, because he appeared fully compliant, he was admitted “informally” rather than under the formal detention powers of the Mental Health Act. This was common practice at the time. Once in hospital, HL’s contact with his carers was restricted, and clear instructions were given that he should be detained under the Mental Health Act if he tried to leave the hospital. HL never attempted to leave and so remained an informal patient. His care and treatment was justified on the basis of the common law doctrine of necessity. However, the European Court of Human Rights found that HL had been deprived of his liberty without the necessary procedural safeguards demanded by article 5 of the European Convention on Human Rights.
- 2.3 The DoLS were introduced in order to remedy these breaches of article 5. They aim to ensure that people who lack capacity to consent to being accommodated in a hospital or care home for the purpose of being given care and treatment are only deprived of liberty if it is considered necessary in their best interests. In simple terms, they do this by establishing an administrative process for authorising a deprivation of liberty and a means to challenge any such deprivation. The DoLS apply to all hospitals (including acute hospitals and psychiatric hospitals) and care homes. They do not extend to people living in supported living and shared lives accommodation, or to people living in family and other domestic settings.<sup>3</sup>
- 2.4 The DoLS provide that a hospital or care home (referred to in the legislation as the “managing authority”) must apply to a local authority (the “supervisory body”) for authorisation of a deprivation of liberty. The supervisory body must conduct six assessments by a minimum of two assessors – including a Best Interests

<sup>1</sup> They came into force in 2009.

<sup>2</sup> *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99).

<sup>3</sup> This issue is discussed further below, and in chapter 4.

Assessor and a Mental Health Assessor – to see if the following qualifying requirements are met:

- (1) the person is 18 or over (the age requirement);
  - (2) the person is suffering from a mental disorder within the meaning of the Mental Health Act (“any disorder or disability of the mind”) (the mental health requirement);
  - (3) the person lacks capacity to decide whether or not they should be accommodated in the hospital or care home for the purpose of being given the relevant care or treatment (the mental capacity requirement);
  - (4) it is in the person’s best interests to be deprived of liberty, and the deprivation of liberty is necessary to prevent harm to the person and a proportionate response to the likelihood and seriousness of that harm (the best interests requirement);
  - (5) the person is eligible for deprivation of liberty in the sense that they are not already detained or detainable, or subject to certain powers under the Mental Health Act (the eligibility requirement); and
  - (6) the deprivation of liberty does not conflict with a valid advance decision to refuse any part of the treatment to be provided, or the decision of a deputy appointed by the Court of Protection or donee of a lasting power of attorney (the no refusals requirement).<sup>4</sup>
- 2.5 If the assessments show that each of the six qualifying requirements are met, the supervisory body must grant a standard authorisation for the deprivation of liberty. If any of the qualifying requirements are not met, then the supervisory body may not grant any such authorisation.
- 2.6 The Best Interests Assessor may recommend that particular conditions be attached to the authorisation, and the supervisory body must have regard to these recommendations when deciding what conditions to impose on managing authorities.
- 2.7 In the absence of an application from the managing authority, anybody may request that the supervisory body decide whether or not there is an unauthorised deprivation of liberty, provided they have already requested that the managing authority make an application and the managing authority has not done so within a reasonable period of time. If what may be a deprivation of liberty is already occurring, or will occur imminently, the managing authority can grant itself an “urgent authorisation” for seven days, pending the supervisory body’s consideration of its application for a “standard authorisation”.
- 2.8 A “relevant person’s representative” must be appointed by the supervisory body if a standard authorisation is granted.<sup>5</sup> The role of the representative is to keep in

<sup>4</sup> See the further discussion of the Mental Health Act interface in chapter 10 below and of advance decision-making in chapter 13 below.

<sup>5</sup> The DoLS use the term “relevant person” to refer to the person who is the subject of a DoLS authorisation.

touch with the person to whom the authorisation relates and to represent them and support them in all matters relating to the authorisation. The representative is often a relative or friend of the person who is willing to act in this capacity. If there is no suitable person to perform this role, the supervisory body must appoint someone to perform this role in a professional capacity.<sup>6</sup>

- 2.9 A further key safeguard for people subject to a DoLS authorisation is the right to independent advocacy. In general terms, the supervisory body must instruct an Independent Mental Capacity Advocate (known as a section 39D advocate) where the person or their representative would otherwise be unable to exercise their rights. Section 39D advocates are given a number of specific functions, such as helping the person and representative to understand the authorisation, any conditions, the DoLS assessments and the relevant rights, and to take steps to exercise the right to apply to court and exercise the right of review.
- 2.10 The managing authority is under a duty to monitor each person's case so that it can request a review if circumstances change. The supervisory body can be asked to undertake a review by the managing authority, or by the relevant person or their representative, on the grounds that certain circumstances have changed. It must carry out a review if asked by any of these parties, and may do so at any other time. The relevant person and certain others (including their representative) can make an application to the Court of Protection as of right to challenge the authorisation. Any other person may apply to the Court for leave to appeal.
- 2.11 The Care Quality Commission has a statutory role to monitor and report on the use of the DoLS in England, but does not have explicit inspection or enforcement powers under the legislation. In Wales this function is carried out by the Care and Social Services Inspectorate Wales and the Healthcare Inspectorate Wales.

### **CRITICISMS OF THE DOLS**

- 2.12 The DoLS have been subject to heavy criticism since their inception. This culminated in the 2014 report by the House of Lords committee which concluded that:

The level and breadth of criticism of the DoLS, including from the judiciary, demonstrates that the legislation is not fit for purpose. Better implementation would not be sufficient to address the fundamental problems identified.<sup>7</sup>

- 2.13 The following summarises the main problems associated with the DoLS.

#### **The narrow focus on article 5**

- 2.14 A major criticism of the DoLS has been their fixation on article 5 of the European Convention. The DoLS were designed to address the specific issues that arose in *HL v United Kingdom*, and consequently they focus exclusively on identifying deprivations of liberty, and then supplying the necessary article 5 safeguards. But anchoring the safeguards to a definition of deprivation of liberty to be supplied

<sup>6</sup> See further discussion of representatives in chapter 9 below.

<sup>7</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 257.

ultimately by the courts is seen as a fundamental and enduring problem. First, it means that the trigger for the safeguards is based on case law which continues to be a moving target. In some cases, the case law has proved to be complex, controversial and on occasion contradictory.<sup>8</sup>

2.15 Secondly, the DoLS assume that nursing staff and care workers on the ground can identify and respond to deprivations of liberty. Yet this requires an assessment of a highly technical question of fact and law which is ultimately to be decided by the Strasbourg court. The concept of deprivation of liberty continues to cause disagreement amongst lawyers, academics and – as witnessed in *Cheshire West* – Supreme Court justices. The result is that “care providers, insofar as they think about DoLS at all, seem to perceive it as a technical legal solution to a technical legal problem” and not something that will benefit the relevant person in any tangible way.<sup>9</sup> Reports have shown that in care homes knowledge of, and confidence in, the DoLS is limited, and managers and staff are heavily reliant on their local authority to identify potential deprivations of liberty amongst residents.<sup>10</sup>

2.16 Thirdly, in focusing exclusively on article 5, the DoLS also have little to say about the person’s article 8 rights. Article 8 guarantees respect for private life, family life, home, and correspondence. This protection is qualified, and state interference is permitted if in accordance with law and necessary for certain listed purposes, including protecting health or the rights of others. In contrast to the Mental Health Act, the DoLS contain no specific procedures or safeguards governing the provision of care or treatment which might interfere with article 8 rights. Many article 8 issues – such as restrictions on a person’s contact with friends and family, and the removal of the person from their home in a situation where the state intends that their home be sold – will be of greater significance to the individual and their family than the technical question of deprivation of liberty.<sup>11</sup> In *London Borough of Hillingdon v Neary* – a case concerning a young disabled man unlawfully deprived of liberty – Mr Justice Jackson referred to the article 8 issues as “the nub of the matter” and went on to say:

By viewing the case primarily through the prism of article 5 one risks repeating a central fallacy and conflating the secondary question of whether a person is lawfully deprived of his liberty with the primary question of where he should be living.<sup>12</sup>

2.17 Finally, the focus on article 5 can also be seen as running counter to the policy of prevention. The DoLS come into play at a point in time when a person needs, or

<sup>8</sup> See, for example, A Ruck Keene, “Tying Ourselves into (Gordian) Knots? – Deprivation of Liberty and the MCA 2005”, 3 *Elder Law Review* 1 and N Allen, “The (Not So?) Great Confinement”, (2015) 5 *Elder Law Journal* 1.

<sup>9</sup> P Bartlett, “Reforming the Deprivation of Liberty Safeguards (DOLS): What Is It Exactly that We Want?” (2014) 20(3) *Web Journal of Current Legal Issues*, para 2.1.

<sup>10</sup> Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *A National Review of the use of the Deprivation of Liberty Safeguards (DoLS) in Wales* (2014) p 6.

<sup>11</sup> For example, see *Somerset CC v MK* [2014] EWCOP B25 and *Westminster CC v Sykes* [2014] EWCOP B9, (2014) 17 CCLR 139.

<sup>12</sup> *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [151] to [152].

may need, to be deprived of liberty; they do not address the underlying reasons that have led to this situation. They are not designed to prevent the person's needs deteriorating to the extent that deprivation of liberty is necessary. For many, the overall impression is that the DoLS exist to "set up paperwork processes to make restrictions on a person 'legal', rather than ... actual and real safeguards for people".<sup>13</sup>

### **Disconnect with the Mental Capacity Act**

- 2.18 The House of Lords committee referred to a "disconnect" between the wider Mental Capacity Act and the DoLS, in that they are regarded as separate legislation with different legal and philosophical histories. It heard evidence that the introduction of the DoLS had been led by the Department of Health which at the time had been dealing with the reform of the Mental Health Act, and found that the DoLS have a strong flavour of that legislation rather than the "elegant simplicity" and principles of autonomy and empowerment of the Mental Capacity Act.<sup>14</sup>
- 2.19 Whilst some suggested that the DoLS would work effectively if the principles of the Mental Capacity Act were applied properly, the House of Lords committee concluded that better implementation would not fix the fundamental problems identified with the DoLS. The Committee did, however, recommend that replacement legislative provisions be compatible in style and ethos with the Mental Capacity Act, which evidence showed was held in high regard.<sup>15</sup>
- 2.20 Others have also pointed to a disconnect between the DoLS and other legal provisions governing health and social care provision. For example, rights to advocacy under the DoLS overlaps significantly with rights to advocacy under the Care Act 2014 in England and, in some cases when a person is subject to the DoLS, the advocate will need to undertake dual roles.<sup>16</sup>

### **Local authority conflicts of interest**

- 2.21 There are long-standing concerns about potential conflicts of interest for local authorities acting as the supervisory body under the DoLS as well as undertaking their other statutory functions. For example, local authorities are often responsible for commissioning the care and support which deprives the person of liberty. No doubt the intention behind the DoLS is to encourage local authorities in the direction of less restrictive care provision. But the perception arises that local authorities are more likely to authorise deprivations of liberty, rather than alter care and support arrangements and possibly incur more cost as a result. Similarly, stakeholders have reported to us that where the Best Interests Assessor recommends that a standard DoLS authorisation should be made

<sup>13</sup> 3 Counties Independent Mental Capacity Advocate Service, cited in House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL Paper 139, para 273.

<sup>14</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL Paper 139, paras 254 and 258.

<sup>15</sup> As above, paras 273 to 274.

<sup>16</sup> Department of Health, *Care and Support Statutory Guidance* (2014) para 7.9.



subject to a condition, the local authority in its supervisory capacity is less likely to agree to the condition if it requires additional funding.

- 2.22 Conflicts of interest may also arise as a result of local authorities' safeguarding functions; for example the Care Act 2014 requires authorities in England to investigate cases of abuse and neglect.<sup>17</sup> The Care Quality Commission has pointed to a fundamental tension between safeguarding and the DoLS:

The approach taken by safeguarding teams tends to focus on protection from abuse, whether a person has capacity or not, whereas the DoLS are a measure specifically located within human rights law to protect the human rights of people lacking capacity. While human rights should be and often is an important dimension to safeguarding and protection, some court cases have shown that professionals can focus on protection to the detriment of autonomy and rights, and fail sometimes to work within the best interests framework of the Mental Capacity Act.<sup>18</sup>

- 2.23 In many authorities, the DoLS co-ordination/supervisory functions are hosted within safeguarding teams, reporting directly to the Safeguarding Adults Board.<sup>19</sup> This has led to the suggestion that the DoLS have been hijacked by safeguarding managers. Some have gone further and argued that the DoLS have been used as an "instrument of oppression, where local authorities acting as supervisory bodies have used DoLS to get their way".<sup>20</sup> Indeed, the courts have been highly critical of local authorities who have removed people from their homes – sometimes unlawfully and on the basis of unsubstantiated safeguarding alerts – and followed this with a DoLS authorisation in an attempt to legitimise the removal.<sup>21</sup>

- 2.24 This situation is not universal – and many local authorities have rigorous separation of functions to avoid such conflicts of interest. The Department of Health has advised local authority managers to review whether their internal office arrangements ensure that DoLS assessors and authorisers are independent from those involved in service delivery.<sup>22</sup> Similarly, Mr Justice Jackson in *London Borough of Hillingdon v Neary* warned that "where a local authority wears a number of hats, it should be clear about who is responsible for

<sup>17</sup> Care Act 2014, s 42. In Wales, similar functions are established under four primary sources including statutory guidance and public law requirements (see Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 12.5 to 12.22).

<sup>18</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2011/12* (2012) p 44.

<sup>19</sup> Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *A National Review of the use of the Deprivation of Liberty Safeguards (DoLS) in Wales* (2014) p 13.

<sup>20</sup> Professor Richard Jones, oral evidence to the House of Lords post-legislative scrutiny committee on the Mental Capacity Act, see House of Lords Mental Capacity Act 2005 Select Committee, *Oral and Written Evidence - Volume 2 (L-W)* (2014) Q25.

<sup>21</sup> See, for example, *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584, *Somerset CC v MK* [2014] EWCOP B25 and *Essex CC v RF* [2015] EWCOP 1.

<sup>22</sup> Department of Health, *Deprivation of Liberty Safeguards (DoLS): Funding Fact Sheet for 2013/14* (2012) pp 5 and 7.

its direction”.<sup>23</sup> However, this may be easier to achieve in a large authority than in a small one, where inevitably managers have to wear multiple hats.

### Limited scope

- 2.25 The DoLS apply only to hospitals and care homes, and not to other care settings such as supported living and shared lives accommodation<sup>24</sup>. Yet it is argued that those in supported living are:

[no] less vulnerable to inadequate or abusive care, or to being deprived of their liberty, than are people in registered care homes. Indeed, they may be more vulnerable, since the actual living arrangements are not currently inspectable by the Care Quality Commission and are therefore effectively unregulated.<sup>25</sup>

- 2.26 This issue has become more important in recent years as a result of a policy shift away from care homes to community-based accommodation. The House of Lords committee recommended that the replacement for the DoLS should extend to those accommodated under supported living arrangements.<sup>26</sup> The extension of the safeguards outside hospitals and care homes has also received some support from Lady Hale in *Cheshire West*.<sup>27</sup>

- 2.27 As part of our pre-consultation programme, members of the project team have visited a range of housing schemes.<sup>28</sup> In all cases, the purpose of these schemes was clearly directed towards promoting independent living for a wide range of older and disabled people, including those with high levels of need. Sometimes independent living was achieved through the use of a variety of alarm or monitoring systems, and other assistive technologies, including wireless door sensors and GPS-based tracking devices. There was also a range of diversionary techniques aimed at ensuring that certain residents did not leave the property or grounds unaccompanied.

- 2.28 In certain cases it is possible that these arrangements will constitute restrictions of the person’s liberty and may tip over into deprivation of liberty.<sup>29</sup> Outside hospitals and care homes, deprivations of liberty must be authorised directly by the Court of Protection. However the House of Lords committee concluded that barriers to accessing the Court, and evidence of the failure of local authorities to

<sup>23</sup> *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [33].

<sup>24</sup> Shared lives, formerly known as adult placements, is a service that normally involves placements of people in family homes where they receive care and support from a shared lives carer and have the opportunity to be part of the carer’s family and support networks.

<sup>25</sup> Mental Health Alliance, written evidence to the House of Lords post-legislative scrutiny committee on the Mental Capacity Act, see House of Lords Mental Capacity Act 2005 Select Committee, *Oral and Written Evidence - Volume 2 (L-W)* (2014) p 1118.

<sup>26</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 297.

<sup>27</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [57].

<sup>28</sup> See appendix B for full details.

<sup>29</sup> See the discussion of *Guzzardi v Italy* (1980) 3 EHRR 333 (App No 7367/76) in chapter 1.

bring cases to court when necessary, suggested that this was unlikely to provide the safeguards intended.<sup>30</sup>

### **A one-size-fits-all approach**

- 2.29 The DoLS impose a single approach irrespective of setting. Thus, deprivations of liberty in an intensive care hospital ward are dealt with in the same way administratively as they would in a long-stay care home. Bartlett has argued that:

It may well be appropriate to restrain to the point of depriving of liberty a person incapacitated by the after-effects of an anaesthetic administered as part of an operation. That person may well have recovered capacity and been discharged home before any DoLS assessors would arrive to implement the present safeguards, however. What exactly is the point of requiring an application for a DoLS authorisation in these circumstances?<sup>31</sup>

- 2.30 Similar concerns arise in settings where care is not planned in advance, and where a deprivation of liberty may last for a matter of hours rather than days, such as in accident and emergency departments. There are other settings or circumstances for which the DoLS seem ill-suited. For instance, applying the DoLS procedures to hospices and end of life care may have no tangible benefit for the person, and the added formalities at such a sensitive time can cause additional distress to families. Moreover, the person's stay in a hospice may well be for less than seven days, making a standard authorisation irrelevant.
- 2.31 Hargreaves has argued that the DoLS were designed with the hospital sector in mind (particularly psychiatric hospitals). This was the sector in which the *HL v United Kingdom* case arose, and with which the Department of Health deals directly. The sector also has a long established multi-agency care planning system, plus large numbers of professionally qualified and legally literate staff. In contrast, the care home sector is made up of small independent organisations with fewer qualified staff, minimal knowledge of mental health and capacity law, and little access to legal advice.<sup>32</sup> If this is correct, then the nature of the scheme is unsuited to the sector in which the majority of DoLS cases arise. It is estimated that the care home sector, in terms of bed numbers, is three times the size of the National Health Service bed complement in England.<sup>33</sup>

### **Lack of oversight and effective safeguards**

- 2.32 The DoLS have been criticised for lacking an effective system of oversight and monitoring. Particular difficulties arise in monitoring compliance with any condition attached to a standard authorisation. The DoLS do not require any

<sup>30</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 296.

<sup>31</sup> P Bartlett, "Reforming the Deprivation of Liberty Safeguards (DOLS): What Is It Exactly that We Want?" (2014) 20(3) *Web Journal of Current Legal Issues*, para 3.1.

<sup>32</sup> R Hargreaves "The Deprivation of Liberty Safeguards – Essential Protection or Bureaucratic Monster?" (2009) 19 *Journal of Mental Health Law* 117, 120.

<sup>33</sup> See, for example, S Liffé and others, "Provision of NHS Generalist and Specialist Services to Care Homes in England: Review of Surveys" (2015) *Primary Health Care Research and Development* Doi:10.1017/S1463423615000250.

specific person to undertake this role. In practice it is often left to the Best Interests Assessor when reviewing the authorisation. Indeed we have been made aware of examples where Best Interests Assessors have recommended short authorisations in order to monitor the implementation of conditions. Monitoring may also be undertaken in practice by any allocated health or social care professional, the representative and the Independent Mental Capacity Advocate.<sup>34</sup> We are aware that some supervisory bodies have internal processes to monitor compliance but that this is not commonplace.

- 2.33 It is further argued that the safeguards available to the person under the DoLS are inadequate and ineffective. The person faces many practical obstacles in challenging decision-makers and will often be reliant on others to do so. The DoLS attempt to protect the person's rights through a complicated interaction between the respective roles of the section 39A Independent Mental Capacity Advocate and the representative, and, as a last resort, the local authority bringing proceedings before the Court of Protection.<sup>35</sup> However, there is no system of automatic referral to the Court. Difficulties can arise when one or more of these persons support the deprivation of liberty and fail to initiate proceedings.<sup>36</sup> Evidence suggests that few advocates and representatives give the person support to appeal against their deprivation of liberty, and authorities rarely refer cases to the Court.<sup>37</sup>

#### **Length and complexity**

- 2.34 It is widely recognised that the statutory provisions contained in schedules A1 and 1A to the Mental Capacity Act are "tortuous and complex".<sup>38</sup> Certainly, they are extensive and densely drafted. The provisions only contain a single authorisation regime, but they run to a total of 205 paragraphs and are accompanied by regulations made by the Secretary of State and Welsh Ministers which also run to over 77 paragraphs. This is more than is devoted to the two complete detention regimes (consisting of several different detention powers, for civil patients and mentally disordered offenders) under the Mental Health Act.<sup>39</sup>
- 2.35 The Joint Committee on Human Rights warned that the DoLS were overly detailed and complex, and questioned "whether they will be readily understood by proprietors of residential care homes, even with the benefit of professional

<sup>34</sup> See chapter 9 below on representatives and Independent Mental Capacity Advocates.

<sup>35</sup> Under section 39A, an Independent Mental Capacity Advocate must be appointed where a person becomes subject to the DoLS and there is no person (other than a professional or paid carer) to consult in determining the person's best interests. See chapter 9 for a discussion of the Independent Mental Capacity Advocate.

<sup>36</sup> See, for example, *AJ v A Local Authority* [2015] EWCOP 5.

<sup>37</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13* (2014) pp 28 and 29, Department of Health, *The Sixth Year of the Independent Mental Capacity Advocacy (IMCA) Service: 2012-2013* (2014) pp 33 and 59 to 62, and House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 234 to 235.

<sup>38</sup> *AJ v A Local Authority* [2015] EWCOP 5 at [27].

<sup>39</sup> Civil patients are those detained under the civil law provisions in part 2 of the Mental Health Act – in contrast to patients detained under the part 3 criminal law provisions.

advice”.<sup>40</sup> Hargreaves has pointed to their “obscure language”, “relentless over-specification of detail” and tendency to lead practitioners into “legal cul-de-sacs”.<sup>41</sup> Jones has described the DoLS as “complex, voluminous, overly bureaucratic and difficult to understand”.<sup>42</sup> Paul Bowen QC – who represented HL – referred to the DoLS as “the new triumph of legalism” and “so labyrinthine and bureaucratic that those responsible for administering them are likely to take every opportunity to avoid using them”.<sup>43</sup>

- 2.36 These views have received judicial support. Lady Hale has referred to the DoLS’ “bewildering complexity”.<sup>44</sup> Mr Justice Charles, Vice President of the Court of Protection, described the experience of writing a judgment in a case involving the DoLS as feeling “as if you have been in a washing machine and spin dryer”.<sup>45</sup> In *C v Blackburn with Darwen Borough Council* Mr Justice Jackson stated:

It is a truly unhappy state of affairs that the law governing the fundamental rights and welfare of incapacitated people should be so complex. As this case shows, its intricacies challenge the understanding of professionals working in the field and are completely inaccessible to those for whose benefit the legislation has been devised, including those with a relatively high level of understanding, such as Mr C.<sup>46</sup>

### **Ill-suited and inadequate terminology**

- 2.37 During our pre-consultation exercise, people have consistently criticised the terminology used in schedules A1 and 1A. Terms such as “standard authorisations”, “managing authority” and “supervisory body” have been described variously as cumbersome, Orwellian, and failing to reflect modern health and social care functions. Particular criticism has been directed at the label “Deprivation of Liberty Safeguards”. It is suggested that care providers are put off by the label, and do not want to acknowledge that they are depriving people of their liberty because they see themselves as helping and protecting people. Carers have described to us the distress caused when informed that their loved one needs to be made subject to the “Deprivation of Liberty Safeguards” – especially where nobody is dissatisfied with the care and support arrangements.

<sup>40</sup> The Joint Committee on Human Rights is appointed by the House of Lords and the House of Commons to consider matters relating to human rights in the United Kingdom (but excluding consideration of individual cases). House of Lords, House of Commons Joint Committee on Human Rights: Legislative Scrutiny: Mental Health Bill: Fourth Report of the Session 2006-07 (2007) HL Paper 40, HC 288, para 90.

<sup>41</sup> R Hargreaves “The Deprivation of Liberty Safeguards – Essential Protection or Bureaucratic Monster?” (2007) 19 *Journal of Mental Health Law* 117, 124.

<sup>42</sup> R Jones, *Mental Capacity Act Manual* (3rd ed 2008) p v.

<sup>43</sup> P Bowen, *Blackstone’s Guide to the Mental Health Act 2007* (2007) p ix.

<sup>44</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [9].

<sup>45</sup> House of Lords Mental Capacity Act 2005 Select Committee, *Oral and Written Evidence - Volume 1 (A-K)* (2014) Q293.

<sup>46</sup> *C v Blackburn with Darwen BC* [2011] EWHC 3321 (COP), (2012) 15 CCLR 251 at [24].

- 2.38 The Department of Health has argued that too often people concentrate on the “deprivation of liberty” element, when the focus should be on the word “safeguards”. But it is acknowledged that the label has distracted from the purpose of ensuring “that people who in their best interest have some restrictions on their liberty ... have adequate recourse and protection within the law and within the system”.<sup>47</sup>

### **Scale of the problem**

- 2.39 The Government’s original impact assessment considered that very few people who lack capacity would need to be deprived of liberty: on a worst case scenario only 21,000 people in England and Wales were expected to be subject to a DoLS assessment and authorisations were expected to range from 5,000 in the first year to 1,700 in the following years.<sup>48</sup> In fact, the number of applications was initially low, with only 7,157 in 2009/10, rising to 11,887 in 2012/13, just over half of which received authorisation.<sup>49</sup> However, since the *Cheshire West* judgment there has been a significant increase in DoLS applications. In a 12 month period in 2013-14 the total number of applications in England was 11,300 of which 56 per cent (6,400) were granted, 41 per cent (4,600) were not granted and 3 per cent (300) were not yet processed by the Supervisory Body or were withdrawn. In the subsequent 12 month period in 2014-15 there were 113,300 DoLS applications, of which 36 per cent were granted (40,800), 10 per cent not granted (11,300) and 54 per cent were not yet signed off by the Supervisory Body or were withdrawn (61,200).<sup>50</sup>
- 2.40 The implication is that the DoLS were designed to provide a comprehensive set of safeguards for a relatively small number of cases. They were not intended to deal with the numbers of cases that have been apparent post *Cheshire West*. It is also possible that these figures are only the tip of the iceberg. It has been reported to us by stakeholders that local authorities are not currently prioritising cases of alleged deprivation of liberty in supported living and community settings. If local authorities are not applying to the Court of Protection for authorisation when they should be, there may be many more unauthorised deprivations.

### **PROVISIONAL VIEW**

- 2.41 Our provisional view is that there is a compelling case for replacing the DoLS. We consider that many – although by no means all – of the criticisms of the DoLS are convincing. The cumulative effect is that the DoLS are perceived to be overly technical and legalised and that, more significantly, they are not meaningful for disabled people and their families or carers, and fail to secure buy-in from health

<sup>47</sup> House of Lords Mental Capacity Act 2005 Select Committee, *Oral and Written Evidence - Volume 2 (L-W)* (2014) Q14.

<sup>48</sup> Department of Health and Ministry of Justice, *Impact Assessment of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards to Accompany The Code of Practice and Regulations* (2008) paras 30 and 32.

<sup>49</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards Assessments (England): Third report on annual data, 2011/12* (2012) p 4, and Health and Social Care Information Centre, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards Assessments (England): Annual report 2012/13* (2014) p 5.

<sup>50</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England) Quarter 4 Return, 2014-15* (2015) p 5.

and social care practitioners. Perhaps the most important consequence is likely to be that the rights of people who are deprived of liberty and those supporting them are difficult to discern.

- 2.42 A minority of stakeholders have reported to us that they consider the flaws in the DoLS to have been exaggerated. Whilst the drafting may be confusing, the basic structure is seen as sound. We do not agree. Our provisional view is that the DoLS are deeply flawed for the various reasons explained above and that this cannot be addressed simply by, for example, redrafting the legislative provisions or fostering greater awareness of the principles of the Mental Capacity Act. Moreover, given the scale of the challenges faced post *Cheshire West*, any notion that the existing system can cope with the expansion in numbers, in our view, is just not sustainable.
- 2.43 In establishing a new scheme, we consider that it will be essential for the legislation to be accompanied by a code of practice. This could be provided in a separate code (as is currently the case under the DoLS), or by revising the main *Mental Capacity Act Code of Practice*. In any event, we think that the introduction of new legislation would be an opportunity to review the main *Mental Capacity Act Code of Practice* more generally.
- 2.44 This is an area where terminology is of some importance. The term “deprivation of liberty safeguards” is not a legal term; it does not appear in the Mental Capacity Act or the schedules. But it has been adopted in the *DoLS Code of Practice* and is now a widely-used policy shorthand. Strictly speaking, our new scheme does not need to be given a name in legislation. We are conscious that Parliamentary Counsel will choose the appropriate language to be used in the legislation, but in this area the implications of certain terms carry important messages for the public and practitioners. Our consultation offers an important opportunity to seek further views on the relevant nomenclature.
- 2.45 The term “deprivation of liberty” is seen as unhelpful, but it is not possible to eliminate its use altogether given that it derives from article 5 of the European Convention. Indeed, it might be argued that the label does at least keep people’s minds attuned to the issues of liberty that are at stake here. Nevertheless it is accepted that new terminology would provide benefits. Many have advocated the term “protective care”. Initially, this was the name given to the DoLS, and some have suggested that it would be a more appropriate label now.<sup>51</sup> We have therefore opted for this term to describe our new scheme. However, we welcome views on the terminology and any suggestions on alternative labels.
- 2.46 **Provisional proposal 2-1: the Deprivation of Liberty Safeguards should be replaced by a new system called “protective care”.**
- 2.47 **Provisional proposal 2-2: the introduction of protective care should be accompanied by a code of practice, and the UK and Welsh Governments should also review the existing *Mental Capacity Act Code of Practice*.**

<sup>51</sup> Department of Health, “*Bournewood*” Consultation: *The approach to be taken in response to the judgement of the European Court of Human Rights in the “Bournewood” case* (2005).

## **CHAPTER 3**

# **PRINCIPLES OF PROTECTIVE CARE**

- 3.1 The previous chapter of this consultation paper set out the main criticisms of the DoLS. Underlying many of the criticisms are a number of important principles that we provisionally consider should inform the new scheme (known as protective care). These are listed and discussed below. We would welcome views on whether these are the correct principles, and if there are others that should inform our thinking.

### **A SCHEME THAT DELIVERS IMPROVED OUTCOMES**

- 3.2 We consider that it is vital that the new protective care scheme should secure the support of disabled people, their family or carers, and those responsible for administering the scheme (most obviously health and social care practitioners). The evidence presented in chapter 2 suggests that the DoLS are seen as a bureaucratic and legal process that offers little benefit to the relevant person. The House of Lords committee noted that the term itself is alienating, and others have claimed that to service providers “deprivation of liberty” sounds too much like offering bad care and that, as a result, they want little to do with it.<sup>1</sup> The new scheme therefore needs to secure “buy-in” from all concerned.
- 3.3 To do this, the new scheme needs to deliver – and be seen to deliver – tangible benefits and improved outcomes. Primarily this means providing meaningful safeguards for those whose care and treatment arrangements are becoming sufficiently restrictive or intrusive to warrant such safeguards. This should not only be determined by the concept of a deprivation of liberty, but also by acknowledging that in many cases, a person’s article 8 rights will be engaged. Indeed, issues such as removal from the family home and limits on social contacts will often be much more important for the person than detention-related issues.
- 3.4 We also think that the scheme needs to offer prevention measures, and to recognise that if relatively low-level support is delivered at an early stage, the need for deprivations of liberty will be reduced. In other words, it is hoped that early interventions (such as support from an advocate or the provision of supported decision-making) will prevent or defer the need for more costly restrictive care and treatment. The scheme should also be perceived as a straightforward scheme which not only makes sense to practitioners but is also easier to explain to the relevant person and their family or carers.

### **A MENTAL CAPACITY ACT-BASED SCHEME**

- 3.5 The House of Lords committee concluded that the replacement scheme for the DoLS should be grounded in the Mental Capacity Act. It heard evidence that the DoLS were not working in practice primarily because of a lack of understanding

<sup>1</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL Paper 139, paras 284 to 285 and P Bartlett, “Reforming the Deprivation of Liberty Safeguards (DOLS): What Is It Exactly that We Want?” (2014) 20(3) *Web Journal of Current Legal Issues*, para 2.1.



of the Act. For instance, the Care Quality Commission reported that the safeguards would be adequate if the principles of the Act and the concepts of capacity and best interests were properly understood by those working at all levels of the health and social care system. Significant criticisms were also made of the failure to apply the “less restrictive option” principle in section 1(6) of the Mental Capacity Act.<sup>2</sup> The House of Lords committee therefore recommended that the DoLS replacement legislation must “make a clear link to the principles of the Mental Capacity Act to ensure consistency with the empowering ethos of the Act as a whole”.<sup>3</sup> This is also the approach favoured by the UK Government.<sup>4</sup>

- 3.6 Some commentators have put forward solutions based on the Mental Health Act. For example, an amended form of guardianship has been proposed as a possible alternative to the DoLS.<sup>5</sup> This option was put forward by the Department of Health when it consulted originally on how to respond to the *HL v United Kingdom* case. However, the extension of guardianship was rejected on the basis that it is a community-based provision that was not intended for hospital settings, and to amend it would alter its nature by turning it into a “detaining section”.<sup>6</sup>
- 3.7 Our proposed protective care scheme is firmly rooted in the Mental Capacity Act. We consider that the principles set out in section 1 of the Mental Capacity Act (such as maximising decision making capacity and the consideration of less restrictive interferences) provide a sound and comprehensible basis for the new scheme. As Lady Hale has argued, these values are less obviously reflected in the Mental Health Act, which has always been concerned to protect the public as well as the patient.<sup>7</sup>
- 3.8 We are aware that elements of the Mental Capacity Act have been the subject of criticism in recent years. In particular, many have questioned whether there is sufficient adherence to and awareness of the Act, and whether the concept of best interests gives sufficient priority to the person’s wishes and feelings. These criticisms are discussed throughout this report, and in some places we have made provisional proposals which are aimed at addressing them. But this does not affect our conclusion that the fundamental structure and principles of the Mental Capacity Act are sound, and that the new scheme should be in keeping with the approach, language and ethos of the Mental Capacity Act.

<sup>2</sup> Section 1 of the Mental Capacity Act 2005 is reproduced in appendix C.

<sup>3</sup> As above, paras 273 to 274.

<sup>4</sup> HM Government, *Valuing Every Voice, Respecting Every Right: Making the Case for the Mental Capacity Act: The Government’s Response to the House of Lords Select Committee Report on the Mental Capacity Act 2005* (2014) Cm 8884, para 7.27.

<sup>5</sup> See, for example, R Robinson and L Scott-Moncrieff “Making Sense of Bournemouth” (2005) 12 *Journal of Mental Health Law* 17, 21.

<sup>6</sup> Department of Health, *Protecting the Vulnerable: The “Bournemouth” Consultation: Report of the public consultation on the Government’s proposed response to the “Bournemouth” case (the judgment of the European Court of Human Rights in the case of HL v the UK)* (2006) paras 71 and 73.

<sup>7</sup> Lady Hale, *The Other Side of the Table: Mental Health Tribunals Members’ Association: 17 October 2014*, p 21, see: <https://www.supremecourt.uk/docs/speech-141017.pdf> (last visited 22 June 2015).

## **A NON-ELABORATE SCHEME**

- 3.9 As noted previously, the DoLS have been criticised widely for being complex and overly-bureaucratic. Their level of formality is almost certainly unnecessary. For instance, Lady Hale in *Cheshire West* observed that people deprived of liberty needed a:

periodic independent check on whether the arrangements made for them are in their best interests. Such checks need not be as elaborate as those currently provided for in the Court of Protection or in the Deprivation of Liberty safeguards (which could in due course be simplified and extended to placements outside hospitals and care homes).<sup>8</sup>

- 3.10 This also appears to have been the view of the Strasbourg court in *HL v United Kingdom*. Whilst the court noted “the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted”, it also expressly acknowledged the UK Government’s concern to avoid the “full, formal and inflexible impact of the [Mental Health Act]”. It went on to refer favourably to the Mental Capacity Act as potentially a means of achieving such an approach.<sup>9</sup> The underlying message would seem to be that a relatively informal and minimal response would be appropriate.
- 3.11 Our provisional proposals therefore seek to remove the unnecessary bureaucracy and over-elaborate procedures that are apparent in the DoLS. These include the requirement for six assessments in each case and the need for supervisory bodies to develop layers of bureaucracy to sign off DoLS decisions. The aim is to create a relatively efficient and straightforward set of safeguards. However, this does not mean that the new scheme should be “light-touch” when it comes to protecting people’s fundamental rights and freedoms. We think it is possible to design a new system which is both simple and straightforward, and seeks to protect the legal rights of, and provide meaningful procedural safeguards for, those who may lack capacity.

## **A CONVENTION COMPLIANT SCHEME**

- 3.12 The European Convention on Human Rights, and its incorporation into domestic law through the Human Rights Act 1998, has had a substantial impact on the development of mental health law. Mental health has proved to be one of the most fruitful areas of challenge under the Human Rights Act, and was the subject of the first remedial legislation to be introduced under the Act.<sup>10</sup> Moreover, the Convention has produced a significant body of case law in this field. The main focus of the case law, and of the evidence we received from stakeholders, has been on articles 5 and 8 of the Convention, as well as on article 3 (which prohibits torture and inhuman or degrading treatment or punishment) and article 14 (which proscribes discrimination in relation to any of the substantive rights

<sup>8</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [57].

<sup>9</sup> *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99) at [120] and [122].

<sup>10</sup> Mental Health Act 1983 (Remedial) Order 2001, SI 2001 No 3712.

conveyed by the Convention). It is of course a basic tenet of our review that the new protective care scheme must be fully compatible with the Convention.

- 3.13 But how compliance is achieved is not a straightforward matter. The state is granted a margin of discretion in securing compliance, which may be achieved in a number of different ways. Moreover, the ethos of the Convention does clash in places with that of the Mental Capacity Act. As Bartlett has argued:

The Mental Capacity Act is designed to create a supportive framework in which decisions are taken for the benefit of people lacking capacity. Procedure is kept to a minimum, and criteria are intended to be flexible enough to meet a wide variety of needs ... The [European Convention on Human Rights] by comparison is designed to protect the individual against human rights violations. It therefore tends to favour procedural safeguards and clear criteria.<sup>11</sup>

- 3.14 It is axiomatic that our scheme should achieve compliance with the European Convention. But we think this is possible to achieve in a way that reflects the supportive framework and relative flexibility of the Mental Capacity Act.

- 3.15 As noted in chapter 2, one of the most significant criticisms of the DoLs has been its fixation on article 5 matters. We also intend that the new scheme should address article 8 rights. The right to family and private life guarantees “respect for” private life, family life, home and correspondence. Article 8 prohibits the state from unjustifiably interfering with these often overlapping rights. It also imposes positive obligations on the state to adopt policies which are designed to secure these rights positively. These positive obligations may require the state to take action to stop interferences with the right caused by its own inaction, or to stop interferences caused by the actions of other private individuals.<sup>12</sup> Our new scheme is designed to recognise these obligations.

- 3.16 We have noted the announcement in the Queen’s Speech that the UK Government will “bring forward proposals for a British Bill of Rights to replace the Human Rights Act”.<sup>13</sup> The precise details of the proposals and the timetable for publication have not been announced. We are assuming that if this policy were implemented, rights to respect for private and family life and to liberty would continue to attract a similar level of protection to that presently afforded. In any event, rights to liberty enjoy a longstanding history within the common law, which would continue to offer a level of domestic protection in various ways.<sup>14</sup> In these circumstances, we consider it appropriate that our scheme be designed to satisfy the requirements of the European Convention, including articles 5 and 8 as presently applied by the Supreme Court and by the Strasbourg court.

<sup>11</sup> P Bartlett, *Blackstone’s Guide to the Mental Capacity Act 2005* (2nd ed, 2008) para 5.31.

<sup>12</sup> *X v Netherlands* (1986) 8 EHRR 235 (App No 8978/80) at [23] and *Moldovan v Romania (No 2)* (2007) 44 EHRR 16 (App Nos 41138/98 and 64320/01) at [93].

<sup>13</sup> Cabinet Office and Prime Minister’s Office, *Queen’s Speech 2015: Background Briefing Notes* (2015) p 6.

<sup>14</sup> *R v Governor of Brockhill Prison ex parte Evans (No 2)* [1999] QB 1043, 1060 and *R (Osborn) v Parole Board* [2013] UKSC 61, [2014] AC 1115 at [54] to [63].

## **A SCHEME THAT IS SUPPORTIVE OF THE UN DISABILITY CONVENTION**

- 3.17 The United Nations Convention on the Rights of Persons with Disabilities (“UN Disability Convention”) was ratified by the Government in 2009. The UN Disability Convention’s purpose is to protect the rights of people who have long-term physical, mental, intellectual or sensory impairments. Although not directly incorporated into our domestic law, it is recognised and applied by the Strasbourg court<sup>15</sup> and the domestic courts are required by the Human Rights Act 1998 to take account of this jurisprudence.
- 3.18 The UN Disability Convention has been lauded as a new paradigm and a revolution in human rights law for disabled people.<sup>16</sup> Its stated purpose is to:
- promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.<sup>17</sup>
- 3.19 It has a wide field of application and encompasses civil and political rights, as well as economic, social and cultural ones. These rights are extensive and cover matters such as the right to life, access to justice, independent living, education, work and cultural life.
- 3.20 We are keen to ensure as far as possible that our system is not only compatible with the UN Disability Convention, but is supportive of its aims and aspirations. However, we are aware that some have pointed to discrepancies between the UN Disability Convention and the Mental Capacity Act. For example, article 12 sets out the right to legal capacity on an equal basis with others. The Committee on the Rights of Persons with Disabilities (which is responsible for monitoring the implementation of the UN Disability Convention) has clearly stated that systems of substituted decision-making deny legal capacity and are incompatible with article 12, and therefore must be replaced with systems of supported decision-making.<sup>18</sup> Supported decision-making is a process of providing support to people whose decision-making ability is impaired to enable them to make their own decisions, whereas substituted decision-making involves someone making decisions on behalf of someone else on the basis of some objective standard such as best interests. If the Committee is correct, then the Mental Capacity Act clearly falls short: it provides for a substituted decision-making regime where decisions are made on behalf of the person in their best interests (for instance, by a court appointed deputy). The wishes and feelings of the person are just one

<sup>15</sup> See, for example: *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision).

<sup>16</sup> See, for example: E Flynn and A Arstein-Kerslake, “Legislating Personhood: Realising the right to Support in Exercising Legal Capacity” (2014) *International Journal of the Law in Context* 81.

<sup>17</sup> Convention on the Rights of Persons with Disabilities, adopted by the United Nations General Assembly on 13 December 2006 (Resolution A/RES/61/106) art 1.

<sup>18</sup> See, for example, United Nations Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12: Equal Recognition before the Law* (2014) paras 26 to 29.

factor to be considered alongside others, and are not attributed any “a priori weight or importance”.<sup>19</sup>

- 3.21 Article 14 of the UN Disability Convention states that “the existence of a disability shall in no case justify a deprivation of liberty”. According to the UN High Commissioner for Human Rights this means that the legal grounds for a detention must be “de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis”.<sup>20</sup> Insofar as this is correct, it is difficult to see that the Mental Capacity Act (or indeed all mental health and capacity law in the United Kingdom) is remotely compliant. As Fennell and Khaliq point out, this also gives rise to a conflict between the UN Disability Convention and article 5 of the European Convention on Human Rights under which “unsoundness of mind” forms one permitted justification for deprivation of liberty.<sup>21</sup>
- 3.22 The UN Disability Convention challenges existing understandings and categorisations of disability rights. There is much in its terms to be enthusiastic about. Its full implications are still being grappled with by governments across the world. In our new scheme we have attempted to avoid unduly rigid reading of the UN Disability Convention. All appropriate efforts have been made to give effect to the will and preference of the person, and in places we have provisionally proposed amendments to the Mental Capacity Act in order to achieve this. However, aspirations such as the complete removal of substituted decision-making and of differentiation in law attributable to mental disability would require a greater process of change over a much longer timescale. They would also require policy decisions and resources from Government. These are matters beyond our powers. In the meantime, our new scheme aims to support the principles of the UN Disability Convention, whilst creating an appropriate balance with the existing regime of the Mental Capacity Act and ensuring compatibility with the European Convention on Human Rights.

### **A TAILORED SCHEME**

- 3.23 As noted in chapter 2, a significant criticism of the DoLS has been that it imposes a one-size-fits-all scheme. We consider that the new scheme should be flexible and establish different approaches in particular settings. Lady Hale in *Cheshire West* accepted that different levels of safeguards could be provided in different settings.<sup>22</sup> Therefore we have designed different protective care schemes for certain settings, such as care homes and community settings (see chapters 6 and 7), domestic and family homes (see chapter 7), hospitals and palliative care (see chapter 8) and psychiatric hospitals (see chapter 8).

<sup>19</sup> *ITW v Z* [2009] EWHC 2525 (Fam), [2011] 1 WLR 344 at [35].

<sup>20</sup> United Nations High Commissioner for Human Rights, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities* (2009) A/HRC/10/48, para 49.

<sup>21</sup> P Fennell and U Khaliq, “Conflicting or Complementary Obligations? The UN Disability Rights Convention on Human Rights and English Law” (2011) 6 *European Human Rights Law Review* 662.

<sup>22</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [57].

**3.24 Question 3-1: have we identified the correct principles to underpin protective care, namely that the scheme should deliver improved outcomes, and be based in the Mental Capacity Act, non-elaborate, compliant with the European Convention on Human Rights, supportive of the UN Disability Convention, and tailored according to setting?**

## CHAPTER 4

# THE SCOPE OF THE NEW SCHEME

- 4.1 This chapter considers how far our new scheme should extend. Currently the DoLS only apply to hospitals and care homes. In part, the required scope depends on an analysis of the scope of article 5 of the European Convention on Human Rights and, in particular, when the state becomes responsible for a deprivation of liberty.

### IMPUTABILITY TO THE STATE

- 4.2 As discussed in chapter 1, a deprivation of liberty must be imputable to the state in order to engage article 5. According to the Strasbourg court this may happen as a result of the “direct involvement” of public authorities in the person’s detention, or where the state fails in its positive obligations to protect the person against interferences with their liberty carried out by private persons.<sup>1</sup> These are considered in turn below.

#### The direct involvement of the state

- 4.3 It is straightforwardly the case that if the deprivation of liberty takes place in a hospital or care home that is run by a public authority, the state will be directly involved. Therefore, detentions under the Mental Health Act or DoLS in NHS hospitals are recognisably imputable to the state, whether or not the state was involved in the original admission to the institution.<sup>2</sup>
- 4.4 However, most long-term care is now delivered by the independent sector, consisting of both for-profit and not-for-profit organisations. For instance, there are around 17,000 care homes in England<sup>3</sup> that accommodate around 376,250 people<sup>4</sup>, and over 90% of them are independently owned<sup>5</sup>. In such cases the state may still be directly involved in any deprivation of liberty. For example, if the NHS or a local authority place the person in a private hospital or care home or fund their care and treatment there, and those arrangements amount to a deprivation of liberty, the state will be directly involved. Moreover, section 73 of the Care Act 2014 establishes that independent care providers in such cases will normally be exercising a function of a public nature for the purposes of section 6

<sup>1</sup> *Storck v Germany* (2006) 43 EHRR 6 (App No 61603/00) at [89]. In addition the court held that the state could be responsible if the courts failed to interpret the law governing any claim for compensation for unlawful deprivation of liberty in the spirit of article 5. This is not relevant for the purposes of the present discussion.

<sup>2</sup> *Shtukaturov v Russia* (2012) 54 EHRR 27 (App No 44009/05).

<sup>3</sup> Care Quality Commission, *Annual report and accounts 2013/14* (2014) p 27.

<sup>4</sup> Care Quality Commission, *The Adult Social Care Market and the Quality of Services* (2010), Figure 7: Places in homes for older people by population aged 65 and over, 7.

<sup>5</sup> J Forder and S Allen, *Competition in the Care Homes Market: A report for the OHE Commission on Competition in the NHS* (2011).

of the Human Rights Act 1998.<sup>6</sup> Section 6 makes it unlawful for all public authorities (defined to include any body with public functions) to act in a way which is incompatible with the Convention.

- 4.5 Many individuals live in a private care home where the state has not been responsible for the initial placement or funding of their care arrangements. It is estimated that two-fifths of care home provision is bought privately by self-paying individuals.<sup>7</sup> In these circumstances it is less straightforward whether the state is directly involved in any deprivation of liberty, but not impossible that it is. For instance, the state's direct involvement may arise if the police are involved in forcibly returning the person to the premises from which they have fled.<sup>8</sup>
- 4.6 Whilst the relevant Strasbourg case law relates to hospitals and care homes, there is nothing to prevent the same principles regarding the responsibility of the state applying to "domestic settings" (although see the discussion below of the potential relevance of the setting to the test for a deprivation of liberty). Domestic settings include being cared for at home by family members or carers, and placements in "a small group or domestic setting which is as close as possible to 'normal' home life".<sup>9</sup> This includes care provided by paid non-family carers in shared lives arrangements or foster care.<sup>10</sup> Where a person has been "placed" in a particular domestic setting, the direct involvement of the state in any deprivation of liberty is more likely. The case of MIG in *Cheshire West* is particularly relevant in this context. In the Supreme Court, the majority held that the state was responsible for MIG's deprivation of liberty, even though she was living with a paid carer in an ordinary home.<sup>11</sup> Although the question of attribution of responsibility was not argued before the Supreme Court, the Court of Appeal and the Court of Protection had previously both also found that the state was responsible for her care arrangements.<sup>12</sup> In so finding, these courts noted in particular that she had originally been placed there by a local authority pursuant to a court order under the Children Act 1989, and that the court and local authority had restricted her contacts with others (primarily with members of her family).<sup>13</sup>

<sup>6</sup> Section 73 of the Care Act 2014 provides that all registered care providers are exercising a function of a public nature if they are providing personal care in the person's home or residential accommodation with nursing or personal care, and the care has been arranged or funded by a local authority, health and social care trust or authority within the meaning of the Carers and Direct Payments Act (Northern Ireland) 2002.

<sup>7</sup> J Forder and S Allen, *Competition in the Care Homes Market: A report for the OHE Commission on Competition in the NHS* (2011).

<sup>8</sup> *Storck v Germany* (2006) 43 EHRR 6 (App No 61603/00) at [90] to [91].

<sup>9</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [32] by Lady Hale.

<sup>10</sup> As above, at [90] by Lord Carnwath and Lord Hodge.

<sup>11</sup> As above, at [54] by Lady Hale.

<sup>12</sup> Albeit that both of these courts found that these arrangements did not amount to a deprivation of liberty.

<sup>13</sup> See *Surrey CC v CA* [2011] EWCA Civ 190, [2012] Fam 170 and *Surrey CC v CA* [2010] EWHC 785 (Fam), [2011] MHLR 108.



- 4.7 In contrast, the case of *A Local Authority v A* concerned two disabled people being locked in their bedroom at night for their own safety by their parents, and in circumstances in which they had not been placed in their home by the state. In both cases the local authority provided care and support services (but not for the period when they were locked in their rooms) and were aware of the night-time arrangements. Sir James Munby President of the Court of Protection held that the provision of care and support by the state to someone in a domestic setting will not, of itself, trigger direct state responsibility for a deprivation of liberty and that, similarly, “mere knowledge” of the home arrangements which led to the detention will also not be sufficient.<sup>14</sup> This may, however, engage the state’s positive obligation, as is discussed below.

### **Positive obligations**

- 4.8 The Strasbourg jurisprudence establishes a positive obligation on the state to protect all of its citizens against interferences with their liberty, whether by state agents or by private individuals. Public authorities are therefore obliged to take measures providing “effective protection of vulnerable persons”, including “reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge”.<sup>15</sup>
- 4.9 In *A Local Authority v A* it was held that where the state (in this case a local authority) “knows or ought to know” that a person is subject to restrictions of their liberty imposed by a private individual that arguably give rise to a deprivation of liberty, then its positive obligations under article 5 will be triggered. These obligations include the duty to investigate, in order to determine whether there is, in fact, a deprivation of liberty. If the state is satisfied that there is no deprivation of liberty, it will have discharged its immediate obligations. However, its positive obligations may in certain cases require ongoing monitoring of the situation.<sup>16</sup>
- 4.10 If, however, the state concludes that there is or may be a deprivation of liberty, it will be under a positive obligation (both under article 5 alone and taken together with article 14<sup>17</sup>) to take “reasonable and proportionate measures to bring that state of affairs to an end”. What is reasonable and proportionate in the circumstances will be context-specific, but it might require the provision of support services for the carers. If there are no reasonable measures that the state can take to bring the deprivation of liberty to an end or, if the proposed measures are objected to by the individual or the family, then it may be necessary to seek the assistance of the court in determining whether there is, in fact, a deprivation of liberty and, if there is, “obtaining authorisation for its continuance”.<sup>18</sup>

<sup>14</sup> *A Local Authority v A* [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [109].

<sup>15</sup> *Storck v Germany* (2006) 43 EHRR 6 (App No 61603/00) at [102].

<sup>16</sup> *A Local Authority v A* [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [95].

<sup>17</sup> Under article 14, the state may have a positive obligation to remedy a situation where a measure – or a failure to adopt a measure – has disproportionately prejudicial effects on a particular group with a protected status (see *Adami v Malta [GC]* (2007) 44 EHRR 3 at para [80]).

<sup>18</sup> *A Local Authority v A* [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [95].

## DEPRIVATION OF LIBERTY IN DOMESTIC SETTINGS

- 4.11 Some domestic case-law has suggested that the occurrence of a deprivation of liberty (irrespective of state responsibility) is far less likely in a domestic setting. While making no ruling on the matter, Mr Justice Baker has observed that:

Common sense suggests that when considering deprivation of liberty there is a clear distinction between a placement at home, with family or an adult carer, and in a residential establishment ... In most cases the circumstances are more likely to fall into the category of a restriction, rather than a deprivation, of liberty.<sup>19</sup>

- 4.12 These comments were made before the Supreme Court decision in *Cheshire West*, and it is possible that the introduction of the “acid test” may mean that the care and support arrangements likely to amount to deprivation of liberty in domestic settings have expanded beyond those envisaged by Mr Justice Baker. Moreover, Lady Hale in *Cheshire West* stated that the “home-like” quality of MIG and MEG’s lives “does not answer the question of whether in other respects they involved a deprivation of liberty for which the state was responsible”.<sup>20</sup>
- 4.13 However, the judgment in *HL v United Kingdom* suggests that domestic settings can be distinguished from institutions for the purposes of deprivation of liberty. Robinson and Scott-Moncreiff, who were solicitors in this case, point out that because of the nature of his disabilities, HL is likely to require constant supervision and control, and not to be able to leave, wherever he lives. This was the case when he was admitted to the hospital and equally when he was at home with his paid foster carers. But the clear implication of the judgment is that when moved from home to the hospital, HL lost his liberty. The authors conclude that the specific situation of HL in hospital can only be distinguished from his situation at home, so that the former, but not the latter, amounts to deprivation of liberty, by “asserting the primacy of home and family life over institutional care”.<sup>21</sup>
- 4.14 In *Cheshire West*, some concern was expressed by the dissenting judges that the “acid test” for a deprivation of liberty set out by Lady Hale would have led in the case of *HL v United Kingdom* to the result that HL would still be considered to be deprived of his liberty after his return from hospital to live in a family home with his paid foster carers.<sup>22</sup> However, Lady Hale pointed out that the court in *HL v United Kingdom* was not called upon to reach a conclusion on that aspect of the situation.<sup>23</sup>
- 4.15 Recently, Mr Justice Bodey – in a case concerning an older person with dementia living in her home – has stated that “the ‘own home’ consideration must be a relevant factor in the mix” when deciding the question of deprivation of liberty.

<sup>19</sup> *G v E* [2010] EWHC 621 (Fam), [2010] MHLR 364 at [117].

<sup>20</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [47].

<sup>21</sup> R Robinson and L Scott-Moncreiff (2005), “Making Sense of Bournemouth”, 12 *Journal of Mental Health Law* 17, 23.

<sup>22</sup> *P v Cheshire West and Chester Council and, P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [100].

<sup>23</sup> As above, at [53].

Whilst on the facts there was no deprivation of liberty, even if there had been a deprivation of the person's liberty this could not be imputed to the state because of the "strong role" which the family played in the relevant care arrangements.<sup>24</sup>

### **PROVISIONAL VIEW**

- 4.16 The reach of article 5 is potentially broad. It will extend to cases far removed from the paradigm example of imprisonment to include, in some circumstances, deprivation of liberty in domestic settings. If article 5 is engaged, appropriate safeguards must be made available. The DoLS currently provide such safeguards to those deprived of liberty in hospitals and care homes. Where individuals are subject to restrictions that might give rise to a deprivation of liberty in other settings, article 5 safeguards currently include an investigation by the state and authorisation of any deprivation of liberty by the Court of Protection.<sup>25</sup>
- 4.17 But the scope of article 5 does not necessarily answer the question of how broad protective care should be. It may be appropriate for the scheme to deliver safeguards to some, but not all, of those deprived of liberty; article 5 safeguards for those who fall outside the new scheme could be secured by the direct authorisation of the Court of Protection. An all-encompassing scheme would be very costly, and may be perceived as overly intrusive and unnecessary, particularly if deprivation of liberty is unlikely in certain settings. The position of those in domestic settings is particularly difficult in this respect. It is therefore necessary to consider whether a circumscribed scheme is appropriate.
- 4.18 It is relatively straightforward that our scheme should apply to hospitals and care homes, albeit that the nature of the safeguards provided should differ according to the setting – see chapter 3. Hospitals and care homes are already covered by the DoLS and are the settings in which deprivation of liberty within the meaning of article 5 is most likely to be necessary in a person's best interests. We also provisionally consider that our scheme should include other forms of accommodation which are intended for those with health and care needs, namely supported living and shared lives accommodation. As explained in chapter 3, those living in such settings can be just as vulnerable to being deprived of liberty as those in care homes. Whilst we are not aware of any statistics which establish the likely number of deprivations in such settings, it is possible that there will be a relatively large number of cases – especially in settings which are similar to care homes and provide an extensive level of care and support. We would welcome further evidence on this point.
- 4.19 We are aware of some concerns over the legal definition of supported living in England. Regulations under the Care Act provide that supported living means:
- (1) accommodation in premises which are specifically designed or adapted for occupation by adults with needs for care and support to enable them to live as independently as possible; and

<sup>24</sup> *W City Council v Mrs L* [2015] EWCOP 20 at [22] and [27].

<sup>25</sup> *A Local Authority v A* [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [95] and Mental Capacity Act 2005, s16(2)(a).

- (2) accommodation which is provided in premises which are intended for occupation by adults with needs for care and support (whether or not the premises are specifically designed or adapted for that purpose), and in circumstances in which personal care is available if required; however, this does not include adapted premises where the adult had occupied those premises as their home before the adaptations were made.<sup>26</sup>
- 4.20 The primary concern is that the definition would appear to exclude disabled people living in accommodation which is not intended for occupation by those with care and support needs (including non-designated or non-adapted accommodation). In particular, Series has argued that the definition undermines the philosophy behind supported living, being that disabled people should be able to choose where they live and be provided with the appropriate support.<sup>27</sup> On the other hand – for our limited purposes – this definition may be a useful way of distinguishing supported living from other forms of domestic settings. We would welcome further views on the suitability of the above definition.
- 4.21 We have also considered whether our new scheme should extend into family and other domestic settings. It is acknowledged that this could be viewed as contentious. Indeed Lord Neuberger in *Cheshire West* suggested that some people may be surprised to learn that those living in a domestic setting could complain of a deprivation of liberty under article 5.<sup>28</sup> Nevertheless, the right to personal liberty and to article 5 safeguards are too important to be disregarded on the basis of the home-like quality of the setting. Our concern here is to determine how (and not whether) safeguards are provided: through our scheme or by some other mechanism.
- 4.22 On balance we provisionally consider that protective care should extend to family and other domestic settings (albeit that the nature of the safeguards provided would be different – see chapter 3). We do not think it would be acceptable to require that every case of deprivation of liberty in a domestic setting be taken to a court. This would be unnecessarily onerous and expensive for public authorities, and potentially distressing for the individual and family concerned. As a result, we consider that, where a deprivation of liberty is proposed as a part of care or treatment offered in a domestic setting, the safeguards set out in chapter 7 should apply. However, it is also important to consider how this is implemented in private homes and family cases without causing distress and possibly engaging article 8. We would welcome views on this point.
- 4.23 Finally, we have considered the position in relation to day centres. There is currently no case law on this point, but it is at least possible that a deprivation of liberty could arise where, for instance, the day centre needs to lock its doors to

<sup>26</sup> See, for example, Care and Support and After-care (Choice of Accommodation) Regulations 2014, SI 2014 No 2670, reg 8.

<sup>27</sup> L Series, *A Stupid Question about Supported Living* (February 2005), see: <https://thesmallplaces.wordpress.com/2015/02/18/a-stupid-question-about-supported-living/> (last visited 22 June 2015).

<sup>28</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [71].

ensure safety, and people have been persuaded to go there against their wishes. On the other hand attendance at a day centre is more time limited than the setting in which a person lives. And in broad terms, day centres are intended to increase the liberty of a person.

- 4.24 It seems to us almost inconceivable that a person who was deprived of liberty in the course of their visits to a day centre would not also be being deprived of liberty in their place of residence; such people would fall under our proposed scheme in any event by virtue of the arrangements about their residence. It there seems to us to be unnecessary to create additional work for day centre managers by applying our scheme to day centres as such. We would welcome views on this.
- 4.25 **Provisional proposal 4-1: the scope of protective care should include hospital, care home, supported living, shared lives and domestic accommodation.**
- 4.26 **Question 4-2: is the definition of supported living provided under the Care Act 2015 appropriate for our scheme?**

## **CHAPTER 5**

### **OVERVIEW OF PROTECTIVE CARE**

- 5.1 This chapter provides an overview of our provisional proposals for the new scheme of protective care. This new scheme is firmly rooted in the Mental Capacity Act, and therefore in broad terms would only apply when the person lacks the relevant decision-making capacity.

#### **OUR GENERAL APPROACH TO PROTECTIVE CARE**

- 5.2 As noted in chapter 4, our provisional proposal is that protective care will apply to hospital, care home, supported living, shared lives and domestic accommodation. However, the nature of the safeguards will vary according to the particular setting.
- 5.3 We provisionally propose that people who lack capacity and are living in care homes, supported living and shared lives accommodation be provided with a set of safeguards, provisionally called “supportive care”. This is intended to ensure that prevention measures are in place and existing legal rights are being given effect to. There will also be additional safeguards (which we have called the “restrictive care and treatment” scheme) which would apply if a person in such settings requires more restrictive or intrusive forms of care or treatment. This will include individuals deprived of liberty, but also some whose arrangements fall short of this.
- 5.4 A separate scheme would apply to hospital settings and palliative care where, in contrast to long-term care, admissions ordinarily involve shorter stays and an assumption that the person will return home as soon as possible. This is a more streamlined scheme and based around the concept of deprivation of liberty.
- 5.5 Our proposed protective care scheme will not be capable of being used to authorise the detention in hospital of incapacitated people who require treatment for a mental disorder. Instead, the Mental Health Act would be amended to establish a formal process and safeguards for such people.
- 5.6 Finally, the new scheme would allow for the authorisation of a deprivation of liberty of a person living in family or other domestic settings. This would be an administrative form of authorisation, and it would no longer be necessary to seek court authorisation in all such cases.
- 5.7 In summary, the protective care scheme would consist of:
- (1) supportive care – which would apply to people in care home, supported living and shared lives accommodation;
  - (2) a restrictive care and treatment scheme – which would apply to people receiving restrictive care and treatment in care home, supported living

and shared lives accommodation (and to deprivations of liberty involving people living in family and other domestic settings);<sup>1</sup> and

- (3) a hospital scheme – which would also cover, in some cases, palliative care.

5.8 In addition, people who lack capacity and need treatment for their mental disorder would fall within a separate scheme provided under the Mental Health Act.

### **SUPPORTIVE CARE**

- 5.9 Supportive care offers a protective outer layer for the scheme. It consists of prevention measures, but also recognises the importance of minimising regulatory burdens and resource implications. Therefore, the focus is on reinforcing existing support mechanisms, more than creating new legal machinery.
- 5.10 The safeguards would apply to people living in, or moving into, care home, supported living or shared lives accommodation, and who may lack capacity to consent to their living arrangements. In such cases, the local authority would be required to arrange an assessment regarding the person’s capacity to decide where they should be accommodated, or ensure that an appropriate assessment has taken place. There would be no requirement for an “independent assessment” in the DoLS sense. The assessment could be undertaken by anyone that the local authority thinks is appropriate, including social workers or nurses already working with the person.
- 5.11 In the vast majority of cases (where a local authority or the NHS is involved in the person’s care) this assessment should have already taken place when the person was admitted to the accommodation or where they lose capacity while in situ. For example the assessment might have been carried out under the Care Act 2014 in England or the National Health Service and Community Care Act 1990 in Wales. So it should be just a matter of making sure these considerations form part of the existing assessment.
- 5.12 People who fall within the supportive care part of our new scheme will benefit from a number of safeguards, including the appointment of an independent advocate or an appropriate person. Amongst other matters, advocates and appropriate persons would be tasked with ensuring that the person has access to the relevant review or appeals process (for example the appeals mechanism under the Care Act, the social care complaints system in Wales, or the Court of Protection under the Mental Capacity Act). Supportive care would also require local authorities to:
- (1) keep under review the person’s health and care arrangements and whether a referral to the “restrictive care and treatment” scheme is needed; and

<sup>1</sup> We provisionally propose that there should be a list of circumstances in which a person will be regarded as receiving restrictive care or treatment, see chapter 7.

- (2) ensure that the person's care plan includes a record of capacity and best interests assessments, sets out any restrictions being placed on the person, and confirms the legal arrangements under which the accommodation is being provided.
- 5.13 In most cases, assessments and ongoing reviews will already be happening, for instance through the Care Act in England, the community care process in Wales, and the requirements of best interests decision-making under the Mental Capacity Act. In such cases it would simply be a matter of the local authority linking with existing reviews to discharge this responsibility.
- 5.14 Importantly, our proposed scheme will come into operation at the stage where it is proposed that a person should move into one of the forms of accommodation mentioned above and the person may lack capacity to consent to making the move. This is intended to contribute to ensuring that the person makes a supported decision whenever they have capacity to do so, as is required by section 1(3) of the Mental Capacity Act and that, if the decision has to be made by others, it is a decision that is truly in the person's best interests.<sup>2</sup>

#### **THE RESTRICTIVE CARE AND TREATMENT SCHEME**

- 5.15 The restrictive care and treatment scheme provides the direct replacement for the DoLS. But, importantly, it is not organised around deprivation of liberty. Instead it looks at whether care and treatment arrangements are becoming sufficiently intrusive or restrictive to justify enhanced formal safeguards. This will include those deprived of liberty, but will also include some whose arrangements fall short of this.
- 5.16 A person would be eligible if:
  - (1) they are moving into, or living in, care home, supported living or shared lives accommodation;
  - (2) some form of "restrictive care or treatment" is being proposed; and
  - (3) the person lacks capacity to consent to the provision of the "restrictive care or treatment".
- 5.17 The meaning of restrictive care and treatment would be determined by reference to an illustrative list. The list would include care and treatment where the person is subject to continuous supervision and control *or* is not free to leave. It would also cover instances where the person either is not allowed, unaccompanied, to leave the premises, or is unable, by reason of physical impairment, to leave those premises unassisted. It also refers to cases where barriers are being used, the person's actions are controlled, the person objects, or significant restrictions are being placed on diet, clothing or contact.

<sup>2</sup> Supported decision-making, and taking account of the person's wishes and feelings, are both discussed in chapter 12.



- 5.18 The restrictive care and treatment scheme would be based around a revised role for the Best Interests Assessor (known as the Approved Mental Capacity Professional under our proposals). The local authority would be required to refer cases to an Approved Mental Capacity Professional. The Approved Mental Capacity Professional would be required either to undertake an assessment themselves or to arrange for such an assessment to be undertaken by a person already involved in the person's care (for example, their social worker or nurse).
- 5.19 If the person met the criteria, an Approved Mental Capacity Professional would be required to ensure that:
- (1) the decision-making processes and care arrangements continue to comply with the Care Act, Mental Capacity Act and continuing health care regulations;
  - (2) regular review meetings take place (involving the family); and
  - (3) an advocate and appropriate person have been appointed and are involved in the person's care.
- 5.20 As with supportive care, the scheme would come into operation either where a move into one of these forms of accommodation, accompanied by one or more forms of restrictive care or treatment, was being proposed for a person who may lack capacity to consent to this, or where the introduction of forms of restrictive care or treatment were being proposed in the accommodation where such a person was already living.
- 5.21 There would be no parallel processes or documentation as everything would be contained within the overall Care Act, Mental Capacity Act or NHS continuing health care processes.
- 5.22 The Approved Mental Capacity Professional would have the power to recommend that conditions should be included in the care plan. Within this scheme there would be a right for the person (as well as the Approved Mental Capacity Professional, family members, advocates and appropriate persons) to seek reviews of the care plan and apply to the First-tier Tribunal. There would be a right to appeal the decisions of the tribunal to the Upper Tribunal or the Court of Protection.

### **Deprivations of liberty**

- 5.23 Restrictive care and treatment would include the deprivation of liberty of a person who lacks capacity in their best interests. Any such deprivation of liberty should first be authorised expressly by the care plan. The Approved Mental Capacity Professional would need to confirm that objective medical evidence had been secured. The care plan would therefore become sufficient authority for the care provider named in the plan to deprive the person of liberty if necessary, in accordance with the terms of the plan. The duration of the authority would be set by the review date (with a limit of 12 months) and there would be a right of appeal to the tribunal.

- 5.24 The scheme could authorise a deprivation of liberty in family and other domestic settings, as well as those living in care home, supported living or shared lives accommodation.

### **HOSPITAL SETTINGS**

- 5.25 A separate scheme would apply to authorise deprivation of liberty in hospital and palliative care settings. Under it, we propose that a person may be deprived of liberty for up to 28 days in a hospital setting based on the report of a doctor. A responsible clinician must be appointed for any such patient, as well as an advocate and appropriate person. Further authorisations for a deprivation of liberty would require the agreement of an Approved Mental Capacity Professional. The person and anyone else on their behalf may apply to the judicial body for review of the decision to deprive the person of liberty.

### **MENTAL HEALTH CARE AND TREATMENT**

- 5.26 There would be a new mechanism under the Mental Health Act to enable the admission to hospital of people who lack capacity and who are not objecting to their care and treatment. The safeguards provided would include an independent advocate, a requirement for a second medical opinion for certain treatments and rights to appeal to the mental health tribunal. The Mental Capacity Act (and our new scheme) could not be used to authorise the hospital admission of incapacitated people who require treatment for mental disorder.

## CHAPTER 6

# SUPPORTIVE CARE

- 6.1 Our proposed scheme of supportive care would provide safeguards for people who lack capacity and are living in care homes, supported living and shared lives accommodation. The main elements of supportive care are set out below.

### WHEN SHOULD SUPPORTIVE CARE APPLY?

- 6.2 Supportive care is intended to provide suitable protection for people who are in a vulnerable position, but not yet subject to restrictive forms of care and treatment (including deprivation of liberty). In other words, it is intended to establish a preventive set of safeguards that reduce the need for intrusive interventions in the longer term. We have identified people who lack capacity and are living in or moving into care home, supported living or shared lives accommodation as particularly vulnerable in this respect (see chapter 4). Supportive care would also apply to someone who has moved into the accommodation but subsequently loses mental capacity.
- 6.3 However, it is important to emphasise that supportive care is not intended to provide the legal authorisation for moving someone into the accommodation. Section 5 of the Mental Capacity Act would continue to offer protection against civil and criminal liability for certain acts done in connection with the care and treatment of a person who lacks capacity. This might include moving the person from their home into a care home. Supportive care would not alter this position, but it would offer additional safeguards for the person.
- 6.4 Supportive care would not apply to people living in family settings or in other domestic settings.<sup>1</sup> This is because supportive care is by definition aimed at people who are not being deprived of their liberty; we provisionally consider that it would be over-intrusive and an inappropriate use of public resources to require additional assessments or the formal appointment of an advocate or appropriate person in these circumstances.<sup>2</sup> However we would welcome consultees' views on this issue.
- 6.5 **Provisional proposal 6-1: supportive care should apply where a person is living in care home, supported living or shared lives accommodation, or if a move into such accommodation is being considered.**

### WHO IS COVERED BY SUPPORTIVE CARE?

- 6.6 Currently, the DoLS apply to people who suffer from a "mental disorder" within the meaning of the Mental Health Act, and lack capacity in relation to the question whether or not they should be accommodated at the relevant hospital or

<sup>1</sup> Unless the domestic setting is supported living or shared lives accommodation.

<sup>2</sup> By contrast, we provisionally propose in chapter 7 that the restrictive care or treatment scheme should apply where someone in any domestic or family setting is deprived of liberty.

care home for the purpose of being given the relevant care or treatment.<sup>3</sup>

- 6.7 Taking these two criteria in turn, the Mental Health Act defines a mental disorder as “any disorder or disability of mind”, apart from dependence on alcohol and drugs.<sup>4</sup> The distinction in the Mental Health Act between learning disabilities depending on whether or not they are associated with abnormally aggressive or seriously irresponsible behaviour is not relevant for the purposes of the DoLS. Therefore the DoLS definition includes all learning disabilities.<sup>5</sup>
- 6.8 The definition of a mental disorder includes mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression, as well as personality disorders, autistic spectrum disorders and learning disabilities. But it does not include disorders or disabilities of the brain. Those with brain disorders include people in a persistent vegetative state or minimally conscious state caused by a concussion or brain injury, or someone suffering from a stroke or locked in syndrome (a condition describing someone who is conscious but cannot move or communicate verbally). However, someone suffering from a disorder of the brain which gives rise to a mental disorder would be within the remit of the DoLS.
- 6.9 In contrast, the wider provisions of the Mental Capacity Act apply to people who lack decision-making capacity as a result of “an impairment of, or a disturbance in the functioning of, the mind or brain”.<sup>6</sup> This covers a broader range of conditions than the Mental Health Act definition, most notably “pure” brain disorders or disabilities, and the symptoms of alcohol and drug use.
- 6.10 The mental capacity requirement for the purposes of the DoLS requires that the person must lack capacity to decide where they should live for the purpose of being given the relevant care or treatment. The wider provisions of the Mental Capacity Act are relevant to the assessment of capacity. These import a diagnostic test and a functional test, and the principles of the Act, into the DoLS determination.<sup>7</sup> In *A Local Authority v FG* Mr Justice Hedley provided the following advice on the DoLS mental capacity requirement where the choice is between family and local authority provision:

[Capacity] involves an ability to understand what the issues are that determine family or local authority provision, what the consequences of any such decision are, and how they are likely to impact on the person’s emotional, physical and educational welfare. That is a relatively sophisticated process, and in the context of this case is, it seems to me, a difficult one.<sup>8</sup>

- 6.11 This sets a high bar for the test of capacity. The person must not only be capable of deciding where they would like to live, but also consider the impact on their health and care needs of the accommodation. This would include being able to

<sup>3</sup> Mental Capacity Act 2005, sch A1, paras 14 and 15.

<sup>4</sup> Mental Health Act 1983, s 1(2) and (3).

<sup>5</sup> Mental Capacity Act 2005, sch A1, para 14.

<sup>6</sup> As above, s 2(1).

<sup>7</sup> As above, ss 1 to 3.

<sup>8</sup> *A Local Authority v FG* [2011] EWHC 3932 (COP) at [16].

identify the risks of any given option available, and weigh information in the balance.<sup>9</sup>

### **Provisional view**

- 6.12 The DoLS requirements provide a useful starting point for determining the criteria for supportive care, but they fulfil a different function. The DoLS requirements are designed to authorise deprivation of liberty. Supportive care is intended to authorise preventive forms of care and support, such as enhanced assessment and care planning oversight procedures (see below) – and would not authorise a deprivation of liberty
- 6.13 On this basis we provisionally do not consider it is necessary to use the Mental Health Act definition of a mental disorder. People with a pure brain injury and those dependent on alcohol or drugs should not be excluded automatically from the benefits of supportive care. We provisionally think there would be advantages, in terms of clarity, in establishing consistency with the diagnostic threshold of the Mental Capacity Act.
- 6.14 We are also minded to use the test of incapacity that applies for the purpose of the DoLS, namely capacity in relation to the question whether or not the person should be accommodated in the relevant accommodation for the purpose of being given the relevant care or treatment. The setting of a higher threshold would exclude people from the advantages of supportive care. But we are aware of concerns that the current test may cause difficulties in practice, particularly since the person may have capacity in relation to some aspects of this decision but not others. We would welcome further views on this.
- 6.15 **Provisional proposal 6-2: supportive care should cover people who may lack capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain, in relation to the question whether or not they should be accommodated in particular care home, supported living or shared lives accommodation for the purpose of being given particular care or treatment.**

### **ASSESSMENTS FOR SUPPORTIVE CARE**

- 6.16 The law regulates the admission of incapacitated people to care homes, supported living arrangements and shared lives accommodation through a number of different mechanisms. These are summarised below.

#### **Public law**

- 6.17 If the accommodation is being funded or arranged by a local authority in England, in most cases the provisions of the Care Act 2014 will apply. Except in emergencies, an adult should have first received a needs assessment under section 9 and an eligibility decision should have been made in accordance with section 13 and the relevant regulations.<sup>10</sup> In broad terms, decision-makers must determine if a person has eligible needs which are to be met by the provision of the accommodation. This determination is subject to the general duty to promote

<sup>9</sup> See, for example, *RT v LT* [2010] EWHC 1910 (COP) at [30].

<sup>10</sup> Care and Support (Eligibility Criteria) Regulations 2015 SI 2015 No 313.

individual well-being under section 1 which provides, amongst other matters, that the individual is best-placed to judge their own well-being and should participate as fully as possible in decisions.

- 6.18 In addition, section 30 of the Care Act establishes that where an adult's needs are to be met by the provision of specified forms of accommodation, and the adult expresses a preference for particular accommodation of that type, the local authority must meet the adult's preference, provided that certain conditions are met. The specified forms of accommodation are care homes, shared lives or supported living accommodation.<sup>11</sup> Where the person lacks capacity to make this decision, the statutory guidance states that local authorities should "act on the choices expressed by the person's advocate, carer or legal guardian in the same way they would on the person's own wishes" unless this would be against the person's best interests.<sup>12</sup>
- 6.19 In Wales, the local authority decision to provide residential care will in most cases be taken by reference to section 21 of the National Assistance Act 1948. This provides that a local authority must provide such accommodation to any adult who by reason of age, illness, disability or any other circumstance is "in need of care and attention not otherwise available to them". In addition, the *Choice of Accommodation Directions* require the local authority to accommodate the person at a place of their choice if certain conditions are met.<sup>13</sup> From 2016 the Social Services and Well-being (Wales) Act 2014 will replace the National Assistance Act and all other community care legislation in Wales, and provide a framework for decision-making similar to that established by the Care Act in England.
- 6.20 The provision of health care in care homes and other settings is governed by the National Health Service Act 2006 and National Health Service (Wales) Act 2006. Both Acts require the promotion of a comprehensive health service, confer wide-ranging powers to discharge the duties contained therein, and establish a general duty to provide "necessary" services, to meet all reasonable requirements, including hospital and other accommodation, and community services.<sup>14</sup> Some people may qualify for NHS continuing health care. This is a package of care arranged and funded solely by the NHS for people in hospitals, care homes or in their own home, where it has been assessed that the individual's primary need is a health need.<sup>15</sup> The national frameworks in England and in Wales set out four characteristics of need, namely *nature*, *intensity*, *complexity* and *unpredictability*. Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is

<sup>11</sup> Care and Support and Aftercare (Choice of Accommodation) Regulations 2014 SI 2014 No 2670, reg 2.

<sup>12</sup> Department of Health, *Care and Support Statutory Guidance* (2014) Annexe A, para 40.

<sup>13</sup> National Assistance Act 1948 (Choice of Accommodation) Directions 1992.

<sup>14</sup> National Health Service Act 2006, ss 1,2 and 3, and National Health Service (Wales) Act 2006, ss 1,2 and 3.

<sup>15</sup> NHS Continuing Healthcare (Responsibilities) Directions 2009, direction 2(6) and Welsh Assembly Government, *Continuing NHS Healthcare: The National Framework for Implementation in Wales* (2010) 015/2010 EH/ML/018/10 WAG, paras 4.1 to 4.3.

required to meet the individual's needs.<sup>16</sup> The assessment process is governed by regulations which establish various requirements, including an obligation to ensure that a multi-disciplinary team has carried out a needs assessment, notify the person of the decision and make a record, and provide information on how to apply for a review of the decision.<sup>17</sup>

- 6.21 In certain cases the provision of accommodation may fall under section 117 of the Mental Health Act. This requires local health and social services, in co-operation with voluntary agencies, to provide after-care to patients detained in hospital for treatment under sections 3, 37, 45A, 47 or 48 of the 1983 Act, who then cease to be detained and leave hospital. Case law has confirmed that section 117 is an enforceable joint duty on health and social services to consider the after-care needs of each individual to whom it relates.<sup>18</sup> Furthermore, responsible authorities cannot charge for services provided under section 117.<sup>19</sup>

### **Mental Capacity Act**

- 6.22 As a general rule, the Mental Capacity Act will not be relevant to the decision by a local authority or the NHS to provide accommodation. This is ultimately a public law decision – rather than a decision where the consent of the individual is central – and therefore different considerations apply. Nevertheless, the Mental Capacity Act can still often be highly relevant to decisions by public bodies. This point is considered in more detail later in this chapter.
- 6.23 A significant number of people contract directly with the relevant accommodation provider. Such people are often referred to as “self-funders”. It is estimated that two-fifths of care home provision is bought privately by self-funders.<sup>20</sup> The Mental Capacity Act will often be directly relevant in cases where accommodation is being provided to self-funders. For instance, if a self-funder lacks capacity to decide their living arrangements, then the Mental Capacity Act provides the framework for decisions about their admission to the accommodation. In general terms, this will require a best interests decision to be made for or on the person's behalf and the principles of the Mental Capacity Act to be applied.

### **Service regulation**

- 6.24 The Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales maintain a regulatory role over admissions to care homes. While the regulators have no power to approve or deny admissions into the services they regulate, they are responsible for ensuring compliance with certain essential standards of quality and safety. For instance, the Care Quality Commission's “fundamental standards” includes the need to have proper

<sup>16</sup> Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: November 2012 (Revised)* (2012) and Welsh Assembly Government, *Continuing NHS Healthcare: The National Framework for Implementation in Wales* (2010) 015/2010 EH/ML/018/10 WAG.

<sup>17</sup> The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, SI 2012 No 2996, reg 21.

<sup>18</sup> *R v Ealing DHA ex parte Fox* [1993] 1 WLR 373.

<sup>19</sup> *R (Stennett) v Manchester CC* [2002] UKHL 34, [2002] 2 AC 1127.

<sup>20</sup> J Forder and S Allen, *Competition in the Care Homes Market: A report for the OHE Commission on Competition in the NHS* (2011).

assessment and care planning procedures in place.<sup>21</sup> These standards can be enforced through certain sanctions that might apply to the registered provider including warning notices, or in some cases conditions on registration. One possible course of action is to restrict the number, or type, of service user that can be admitted to a service.<sup>22</sup>

### **Provisional view**

- 6.25 In our provisional view, the legal framework set out above is comprehensive. However, some evidence suggests that it does not always work properly. For example, the House of Lords committee concluded that “capacity assessments are not often carried out” and “when they are the quality is often poor”.<sup>23</sup> This is backed up by studies showing that formal assessments often do not occur.<sup>24</sup> Our main intention in establishing the system of supportive care is to make sure that the current law operates effectively. In other words, we seek to reinforce existing legal safeguards rather than create new legal processes.
- 6.26 We provisionally consider that local authorities should have overarching responsibility for supportive care. This should ensure clear lines of accountability. However, we also recognise the importance of promoting multi-agency working. We would expect that the new legislation will therefore enable local authorities to delegate their responsibilities to relevant partners, such as NHS bodies, or carry out their functions jointly or in partnership with such relevant partners.
- 6.27 The first level of safeguards would be generated through the provision of an assessment in cases where it appears to a local authority that a person may be eligible for supportive care. This would intentionally set a low threshold. For example, it would not be necessary for a formal request to be made for supportive care and the authority would not need to be certain that the person would be eligible. In such cases, the local authority would be required to arrange an assessment regarding the person’s capacity to determine whether they should be living in the relevant accommodation – or ensure that an appropriate assessment has taken place.
- 6.28 In order to minimise the resource implications, we do not think it would be necessary to initiate an “independent assessment” in the DoLS sense. Instead, the supportive care assessment could be undertaken by a wide range of professionals – including social workers or nurses already working with the person. In addition, the Care and Support (Assessment) Regulations 2014 currently require that assessors in England have the skills, knowledge and competence to carry out a needs or carer’s assessment and are appropriately

<sup>21</sup> Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014 No 2936, reg 9(3)(a).

<sup>22</sup> Health and Social Care Act 2008, ss 12, 17 and 26.

<sup>23</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 104.

<sup>24</sup> C Emmett and others, “Homeward Bound of Bound for a Home? Assessing the Capacity of Dementia Patients to make decisions about Hospital Discharge: Comparing Practice with Legal Standards”, (2013) 36(1) *International Journal of Law and Psychiatry* 73 and V Williams and others, *Making Best Interests Decisions: People and Processes* (2012).



trained (other than in the case of supported self-assessment).<sup>25</sup> There is also a requirement to consult a person with expertise in relation to the condition or circumstances of the individual being assessed, where the local authority considers that the needs of the individual require it to do so. We think that these provisions could usefully be applied to all supportive care assessments.

- 6.29 The assessor would be required to establish whether the person lacks capacity in relation to the question whether or not they should be accommodated in the relevant care home, supported living or shared lives accommodation for the purpose of being given the relevant care and treatment. If it is established that the person lacks capacity, further safeguards would apply (outlined below). Also, under our proposed scheme, if any form of “restrictive care and treatment” is being proposed, then a different assessment should be initiated (see chapter 7).
- 6.30 In most cases we do not think that the capacity assessment will require a fresh process to be initiated. Where it is proposed that a person who may lack capacity be moved into the relevant accommodation, we would expect that an assessment process would already have been carried out, for instance under the Care Act or NHS continuing health care regulations. So it should be just a matter of making sure these additional capacity considerations form part of the existing assessments. But for some self-funders, this may be the first independent check of their capacity, and care and treatment arrangements, and therefore resource implications may arise.
- 6.31 On the other hand it is likely that, as a result of the reforms to the care and support funding system to be implemented in England from April 2016, many more self-funders (or persons on their behalf) will seek local authority assessments or support. This is because self-funders with assessed eligible needs will become eligible for independent personal budgets which will count towards the new cap on care costs and will have new rights to require the local authority to arrange their care and support package. The Government estimates that 80% of self-funders are likely to come forward to be part of the funding reform system.<sup>26</sup> It may be that this figure will be higher for those in care homes and other forms of specialist accommodation. The Welsh Government has confirmed it will introduce reforms to the arrangements for paying for social care in Wales but the precise detail has yet to be confirmed.
- 6.32 **Provisional proposal 6-3: the local authority should be required to undertake or arrange an assessment, or ensure that an appropriate assessment has taken place, where it appears that a person may be eligible for supportive care in care home, supported living or shared lives accommodation**
- 6.33 **Provisional proposal 6-4: the local authority must ensure that the assessor has the skills, knowledge and competence to carry out the assessment and is appropriately trained. The assessor must consult a person with expertise in relation to the condition or circumstances of the individual, where the**

<sup>25</sup> Care and Support (Assessment) Regulations 2014, SI 2014 No 2827, reg 5. A supported self-assessment is a form of assessment carried out jointly by the person or carer themselves and the local authority.

<sup>26</sup> Department of Health, *Social Care Funding Reform Impact Assessment* (2015).

**assessor considers that the needs of the individual require them to do so.**

## **CARE PLANNING SAFEGUARDS**

- 6.34 Once a person who lacks capacity has been admitted into care home, supported living or shared lives accommodation they should, in law, be subject to ongoing oversight of their care and treatment regime through a process often referred to as “care planning”. The following gives a brief overview of the legal framework for this process.

### **Public law**

- 6.35 In England, care and support planning is governed largely by the Care Act. For instance, a person who has had accommodation arranged or provided by a local authority under the Care Act will be eligible for a care and support plan which must, amongst other matters, specify their personal budget, how the person’s needs will be met, advice and information about prevention, and the outcomes that the person wishes to achieve. In preparing a plan, the local authority must involve the adult, any carer, and anyone else the adult may ask to be involved. The local authority must take all “reasonable steps” to reach agreement with the person about how their needs will be met. A local authority must generally keep under review care and support plans that it has prepared and, on a reasonable request by or on behalf of the person, review the plan.<sup>27</sup>
- 6.36 In Wales, the care planning process for local authorities is contained in a range of statutory and practice guidance. These include requirements to develop a care plan and involve the service user in its development.<sup>28</sup> Statutory guidance in Wales is issued under section 7 of the Local Authority and Social Services Act 1970, and can only be deviated from where there is good reason to do so.<sup>29</sup> From 2016, the Social Services and Well-being (Wales) Act 2014 will provide a new framework for care planning similar to that established by the Care Act in England.
- 6.37 The care planning process for health services falls under the National Health Service Act 2006 and National Health Service (Wales) Act 2006. For example, reviews of NHS continuing health care are required no later than three months after the initial eligibility decision, in order to reassess care needs and eligibility, and ensure that those needs are being met. As a minimum, reviews should then take place annually. Reviewers are advised to use the *Decision Support Tool* for this purpose and to consult with the person being reviewed, and any other relevant people. If a local authority is also responsible for any part of the care, joint reviews are advised where practicable.<sup>30</sup>
- 6.38 The care planning process for after-care services falls under the Mental Health Act. This applies in England and in Wales. The codes of practice for the Mental

<sup>27</sup> Care Act 2014, ss 25 to 27.

<sup>28</sup> Welsh Assmbley Government, *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care* (2002) NAFWC 09A/2002, para 6.22.

<sup>29</sup> *R v Islington LBC ex parte Rixon* (1997-98) 1 CCLR 119, 123(J).

<sup>30</sup> Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: November 2012 (Revised)* (2012) paras 139 to 144.

Health Act set out the key elements in broad terms.<sup>31</sup> In England, care planning will also fall under the framework of the Care Programme Approach.<sup>32</sup>

- 6.39 The Mental Health (Wales) Measure 2010 provides a framework for care planning for people with mental health problems in Wales. Under the Measure, health boards and local authorities are required to agree a scheme which secures the provision of primary mental health support services for the local area. The Measure also establishes the duties of these bodies to undertake a primary mental health assessment where an individual has been referred by the GP or when a request is made from a former mental health service user. There is also a requirement to appoint a care coordinator for every person receiving secondary mental health services, and to produce a written care and treatment plan in partnership with the service user.

### **Mental Capacity Act**

- 6.40 The Mental Capacity Act provides that any decision made for or on behalf of a person who lacks capacity must be in that person's best interests.<sup>33</sup> However, the Mental Capacity Act is often not directly relevant when a public authority is making a care planning decision. Fundamentally, most care planning decisions by the NHS or local authority are public law decisions. In contrast, decisions taken under the Mental Capacity Act are made when the consent of an individual is required. Nevertheless, the Mental Capacity Act is often highly relevant to care planning decisions by public bodies. This is considered in more detail below.
- 6.41 Care planning and review procedures for self-funders who lack capacity should be undertaken in accordance with the Mental Capacity Act. For example, a best interests decision in accordance with section 4 of the Mental Capacity Act would normally be required when considering changes to the person's care plan, such as increasing or decreasing the amount of care provided, or moving the person into different accommodation.
- 6.42 However, it has been reported to us that practice (including procedures, assessment tools and care plan formats) will vary across providers and service user groups. Some providers will always seek a local authority assessment where a person lacks capacity even if they are not required to do so. It is possible that some housing providers without a care arm may not recognise they have a role in undertaking mental capacity assessments and, in the context of care, will leave it to the care provider.

### **Service regulation**

- 6.43 Where the provider is registered with the Care Quality Commission, Care and Social Services Inspectorate Wales or Healthcare Inspectorate Wales, they will have to meet the relevant standards. This will include requirements intended to ensure the provision of proper care planning procedures.

<sup>31</sup> Department of Health, *Mental Health Act 1983: Code of Practice* (2015) paras 33.10 to 33.16 and Welsh Assembly Government, *Mental Health Act 1983: Code of Practice for Wales* (2008) paras 31.9 to 31.10.

<sup>32</sup> Department of Health, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008).

<sup>33</sup> Mental Capacity Act 2005, s 1(5).

6.44 But where support is provided that does not constitute personal care and therefore is not regulated, it is unlikely that anyone has an overview of practice. In cases where there is no family member or other supporter interested in the person's welfare (including a solicitor or donee of a lasting power of attorney) we would expect that a referral would be normally made to the local authority or GP. But we would welcome feedback on whether this is the case in practice, and on whether assistance is forthcoming from the local authority or GP in such cases.

### **Discussion**

6.45 In our provisional view, the legal framework for care planning, as set out above is comprehensive. However, some evidence suggests that it does not always work effectively. For example, the position of self-funders remains to some extent uncertain. The Care Quality Commission has noted that, in mental health and learning disability residential settings, it is often not made explicit how the decision to restrict a person's freedom is reached, and sometimes family members reported being excluded from decision-making. It also identified capacity assessments which had been made only on admission and which were unlikely to remain relevant to current decision-making.<sup>34</sup> Our main intention is therefore to make sure that the current law operates effectively.

6.46 We provisionally propose that if a person has been assessed as being eligible for supportive care, a number of further and ongoing safeguards should be made available to that person. These safeguards are as follows:

- (1) the local authority would be required to keep under review the person's health and care arrangements and whether a referral to the restrictive care and treatment part of protective care is needed;
- (2) care plans must include a record of capacity and best interests assessments and any restrictions imposed (including confirmation that the restrictions are in the person's best interests);
- (3) the local authority would have discretion to appoint an "Approved Mental Capacity Professional" to oversee the case (see chapter 7 on this new role which will replace that of the Best Interests Assessor);
- (4) an advocate or appropriate person (see chapter 9) must be appointed (if not already appointed); and
- (5) the advocate and appropriate person would be responsible for ensuring that the person has access to the relevant review or appeals process.

6.47 Key to these safeguards is the requirement on the local authority to keep the person's situation under review. This could be relatively light-touch in some cases, for instance where the person's condition or situation is relatively static. It could also be discharged in conjunction with or by other agencies, for instance the NHS where the person has been placed in a health setting.

6.48 In most cases we think that ongoing review procedures will already be in place

<sup>34</sup> Care Quality Commission, *Restrictive Practices in Mental Health and Learning Disability Settings* (October 2012) p 5.

(for instance under the Care Act in England or community care procedures in Wales), and it should therefore simply be a matter of the local authority linking with existing reviews to discharge this responsibility. However, for some self-funders, this may be the first independent check of their ongoing care and treatment arrangements. We consider this to be a positive outcome for self-funders, but it is nevertheless also important to recognise that there will be resource implications. As set out in our impact assessment, we expect the impact of the reforms on the care and support funding system in England to reduce the resourcing implications of this aspect of our provisional proposals.

- 6.49 We also think that the local authority should have the ability, where appropriate, to appoint an Approved Mental Capacity Professional to oversee the case (this new role is discussed in chapter 7). This may be appropriate, for instance, if there are safeguarding concerns or if the person is a self-funder and has no-one else to speak on their behalf.
- 6.50 The advocate and appropriate person would be required to ensure that the person has access to the relevant review or appeals process. This would include the new appeals system under the Care Act, review panels for NHS continuing healthcare, and the Court of Protection for the purposes of Mental Capacity Act decisions.
- 6.51 **Provisional proposal 6-5: local authorities should be required to keep under review the health and care arrangements for any person who falls within supportive care. This would include ensuring that a care plan and proper capacity assessments have been undertaken.**

#### **PUBLIC LAW AND THE MENTAL CAPACITY ACT**

- 6.52 The courts have warned of the danger of a blurring of the distinction between statutory duties in a private law context (namely considering the best interests of a person lacking capacity), and public law decisions.<sup>35</sup> Many of the assessment and care planning provisions outlined above are concerned with matters that fall to the relevant public body to decide. Fundamentally, the decision by the NHS or local authority to provide a service is a public law decision, and judicial review remains the proper vehicle through which to challenge unreasonable or irrational decisions.<sup>36</sup>
- 6.53 In contrast, decisions under the Mental Capacity Act are made when the assent of the affected individual is required. Section 1(5) requires that “an act done, or decision made ... for or on behalf of the person who lacks capacity” must be in their best interests. The best interests decision-making criteria and procedures contained in section 4 are, therefore, “designed to be a substitute for the lack of independent capacity of the person to act or take decisions for him or herself” and “they come into play in circumstances where a person with capacity would take, or participate in the taking of, a decision”.<sup>37</sup> The Mental Capacity Act gives those making decisions on behalf of those who lack capacity no greater powers

<sup>35</sup> *Re MN* [2013] EWHC 3859 (COP) at [34].

<sup>36</sup> *Re MN* [2015] EWCA Civ 411.

<sup>37</sup> *R (Chatting) v Viridian Housing* [2012] EWHC 3595 (Admin) at [100] by Nicholas Paines QC.

than the person themselves would have if they were of full capacity.<sup>38</sup>

6.54 Nevertheless, the Mental Capacity Act can still often be highly relevant to public law decisions. First, many elements of the care planning process are based on the consent of the person and, therefore, where they lack capacity to give such consent, the Mental Capacity Act will become relevant. For instance, section 30 of the Care Act applies if the adult expresses a preference for accommodation of the specified type, and this includes an adult who lacks capacity to make this decision. Similarly, the provision of direct payments requires a request to be made by the person or, where the person lacks capacity to make a request, the request can be made on a best interests basis by someone authorised under the Mental Capacity Act or a "suitable person".<sup>39</sup>

6.55 Secondly, if a public authority has assessed that a person who lacks capacity will be provided with services and has identified alternative packages of care that it is willing to fund, a best interests decision should be taken on the person's behalf in order to choose between the available options.<sup>40</sup> In effect, this would place the person in the same position as a person who had capacity who would normally participate in deciding which of the options should be provided.

6.56 There have been a number of cases where the courts have explored with providers the possibility of funding being made available for alternative packages of care, and they sometimes have been assertive in doing so – for example by directing the local authority to make a decision whether it is prepared to fund an alternative package of support, or to ensure that within available resources reasonable steps are taken to increase the number of home visits.<sup>41</sup> But, the court cannot create options where none exist,<sup>42</sup> and any such negotiations:

are however a far cry from the court embarking on a "best interests" trial with a view to determining whether or not an option which has been said by care provider (in the exercise of their statutory duties) not to be available, is nevertheless in the patient's best interest.<sup>43</sup>

6.57 Finally, the Mental Capacity Act may become relevant at the care planning stage when a person decides whether to agree to the care package on offer. If the person had capacity, they would be able to accept the offer, privately fund their preferred package elsewhere, or seek to negotiate with the authority.<sup>44</sup> If the person lacks capacity, a best interests decision would need to be made under the Mental Capacity Act. This could therefore lead to a scenario where the care

<sup>38</sup> *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591.

<sup>39</sup> Care Act 2014, ss 31 and 32, and Care and Support (Direct Payments) Regulations 2014, SI 2014 No 2871.

<sup>40</sup> *Re MN* [2013] EWHC 3859 (COP).

<sup>41</sup> *A Local Authority v PB* [2011] EWCOP 2675 at [21] to [22] and *Bedford BC v C* [2015] EWCOP 25 at [182].

<sup>42</sup> *Holmes-Moorhouse v Richmond-upon-Thames LBC* [2009] UKHL 7, [2009] 1 WLR 413 at [30].

<sup>43</sup> *Re MN* [2013] EWHC 3859 (COP) at [57].

<sup>44</sup> *Re S (Vulnerable Adult)* [2007] 2 FLR 1095 at [11] and *Re MN* [2013] EWHC 3859 (COP) at [53] (approved in *Re MN* [2015] EWCA Civ 411 at [54]).

package is rejected on the basis that it is not in the person's best interests, but the public authority does not think that an alternative care package would meet the person's needs. In such cases the best interests decision-maker would need to consider whether an alternative care package (which they consider is in the person's best interests) could be privately funded elsewhere, or seek to negotiate with the authority.

- 6.58 It is hoped that such cases would ultimately be settled on the basis of consensus.<sup>45</sup> Ultimately the issue may need to be determined by the Court of Protection. Since the court has no greater powers than the person themselves would have if they had capacity, it is being asked whether or not to consent to the proposed package of care and any alternatives. It is not uncommon that the court will want to explore very fully the possibility of alternative packages of care. But whilst "rigorous probing, searching questions and persuasion are permissible, pressure is not".<sup>46</sup> The court cannot create options where none exist.<sup>47</sup> The only power of the court is to approve or refuse the care plan put forward, and it "cannot dictate to the public authority what the care plan is to say".<sup>48</sup> The role of the court in such cases is discussed further in chapter 11.

### **Provisional view**

- 6.59 We think that a key safeguard under supportive care would be to make sure that public bodies are much clearer in future about the basis on which decisions are being made. Under our scheme, we provisionally propose that if an NHS body or local authority is considering a placement on the basis of the person's best interests, it will need to record what choices have been considered, and confirm that the principles and best interests checklist in the Mental Capacity Act have been applied. Alternatively, if the NHS body or local authority is making a public law decision, it must demonstrate that the accommodation meets the needs of the person, taking into account all relevant considerations including the views of the person and their family, resources, and the likely benefits for the person.<sup>49</sup>
- 6.60 This will mean that the division between care planning (which is not, broadly speaking, a best interests process) and decisions taken on behalf of an adult in the context of care delivery (which is a best interests process) will need to be more carefully delineated. This will also have a knock-on effect for which judicial process will be relevant – judicial review or the Mental Capacity Act. This is considered in further detail in chapter 11.
- 6.61 **Provisional proposal 6-6: local authorities should be required to ensure that assessments and care plans record, where appropriate, what options have been considered and the reasons for the decisions reached.**

<sup>45</sup> This was envisaged by Baker J in *G v E* [2010] EWCOP 2512 at [57].

<sup>46</sup> *Re MN* [2015] EWCA Civ 411 at [36] and [81].

<sup>47</sup> *Holmes-Moorhouse v Richmond-upon-Thames LBC* [2009] UKHL 7, [2009] 1 WLR 413 at [30].

<sup>48</sup> *Re MN* [2015] EWCA Civ 411 at [34].

<sup>49</sup> *R (Gunter) v South Western Staffordshire PCT* [2005] EWHC 1894 (Admin), (2006) 9 CCLR 121 at [20] and *R (Khana) v Southwark LBC* [2001] EWCA Civ 999, (2001) 4 CCLR 267 at [56].

## **MENTAL CAPACITY AND TENANCIES**

- 6.62 As noted above, supportive care is intended to provide safeguards for people who lack capacity moving into care home, supported living or shared lives arrangements. It is therefore important to consider the tenancy arrangements that would apply in such cases and whether adequate protections are provided. This part of the chapter outlines the law regarding the entry into a tenancy by a person who lacks mental capacity, and discusses issues which may be in need of reform.

### **The current legal framework**

#### ***The Mental Capacity Act***

- 6.63 Whereas entry into a tenancy involves entry into a contract and the creation of legal relations, the decision to move does not. If a person lacks capacity to consent to a move, the decision-maker must consider if the move is in their best interests and whether there is a less restrictive option. In some cases the use of force and restraint may be justified in order to move the person. Section 5 of the Mental Capacity Act provides an exemption from liability when such actions are taken.<sup>50</sup> However, section 5 does not give power to enter into legal relations on behalf of an incapacitated person, including by signing a tenancy.
- 6.64 Other provisions in the Mental Capacity Act do allow a person to obtain the necessary legal authority to enter into legal relations, including a tenancy, on another person's behalf. A person can create a Lasting Power of Attorney to give another person (the donee) the power to make these decisions. The Court of Protection can also grant the relevant authority to a deputy, or simply provide a one off authorisation to a person to sign the tenancy.<sup>51</sup> The Mental Capacity Act Code of Practice also states that the decision to end a tenancy agreement must be taken by the Court of Protection if no Lasting Power of Attorney or Enduring Power of Attorney is in place.<sup>52</sup>

#### ***The common law***

- 6.65 There is no general rule that people who lack capacity are unable to enter into contracts. Rather, the validity of contracts entered into by such people falls to be determined by rules established by common law. These rules seek to balance the protection of parties who lack an understanding of what they are agreeing to, whilst providing certainty to their counterparties or to other third parties who may suffer hardship if apparently valid agreements are rendered unenforceable.<sup>53</sup>
- 6.66 Where a person who lacks capacity to contract nevertheless purports to sign or otherwise enter into a contract (including a tenancy), they will remain bound by that contract unless they can show that they do in fact lack the relevant capacity,

<sup>50</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) paras 6.8 to 6.14.

<sup>51</sup> Mental Capacity Act 2005, ss 15 to 21. See also, Court of Protection, *Guidance: Applications to the Court of Protection in Relation to Tenancy Agreements* (2012).

<sup>52</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) para 8.27.

<sup>53</sup> E Peel, *Treitel: The Law of Contract* (12th ed 2007) p 587.



and that the other contracting party knew this.<sup>54</sup> Where the person can show these two matters, the contract becomes voidable at their option.<sup>55</sup> This means that the person can choose whether or not to continue to be bound by the contract. This common law rule does not give any rights to the counterparty, or to any other third parties, to avoid the contract with the incapacitated person.

- 6.67 Secondly, the common law provides protection in a situation where a person never intended to sign a contract at all (including as a result of mental incapacity).<sup>56</sup> Thus a person who has apparently entered into a contract can avoid being bound by it where they are under some disability, there is some sufficient difference between the agreement that was signed and what the person thought they were entering into, and the person has not been careless in arriving at this misunderstanding.<sup>57</sup> Where this can be shown, the contract is held automatically to have never been binding. This means that the person who lacks capacity cannot now decide to continue to be bound by it.
- 6.68 Ultimately, however, this rule is unlikely to be of great significance when applied to tenancies in practice, as it is likely to apply only in very limited circumstances. Additionally, it would be unlikely for an incapacitated tenant to seek to rely upon it, given that tenancies can readily be terminated in any event.
- 6.69 Thirdly, where someone provides certain “necessaries” to a person who lacks capacity, that person will come under an implied obligation to pay a reasonable amount for the necessaries provided, notwithstanding that the contract may be unenforceable.<sup>58</sup> Whether the subject matter of the contract will be classified as “necessary” is determined by considering the “reasonable requirements” of the person who lacks capacity, having regard to their “station in life and means”.<sup>59</sup> The provision of accommodation is capable of being a “necessary”, depending upon the accommodation provided and the needs of the person.<sup>60</sup>
- 6.70 The rule may therefore assist landlords if a person who lacks capacity sought to resile from a tenancy and avoid the payment of rent. Nevertheless, the doctrine gives rise only to an obligation to make fair payments in lieu of rent, and so does not provide a means by which a landlord can rely upon other terms of a tenancy in circumstances in which the contract is otherwise void.
- 6.71 The common law doctrine of necessaries, as it relates to those who lack capacity, has been codified by section 7 of the Mental Capacity Act. But this is not intended to affect the general common law position.<sup>61</sup> Whilst some doubt has been expressed over whether the reference in section 7 to “goods and services”

<sup>54</sup> *Imperial Loan Co v Stone* [1892] 1 QB 599, 603.

<sup>55</sup> As above, 601.

<sup>56</sup> This is known as the common law doctrine of *non est factum* (it is not my deed).

<sup>57</sup> *Saunders v Anglia Building Society* [1971] AC 1004, 1015 to 1020 by Lord Reid.

<sup>58</sup> H Beale, *Chitty on Contracts* (31st ed 2014) para 8-075.

<sup>59</sup> *Re Rhodes* (1890) 44 Ch D 94, 109.

<sup>60</sup> *Wycharon DC v EM* [2012] UKUT 12 (AAC), (2012) 15 CCLR 221 at [28] and *Aster Healthcare Ltd v Shafi* [2014] EWHC 77 (QB) at [54].

<sup>61</sup> *Aster Healthcare Ltd v Shafi* [2014] EWHC 77 (QB) at [52]. See also H Beale, *Chitty on Contracts* (31st ed 2014) para 8-076.

includes tenancies, it is likely that little turns on this question because, whichever view is ultimately adopted, the statutory provisions and the common law operate to equivalent effect.<sup>62</sup>

- 6.72 Finally, the common law can prevent a tenancy from ever being formed (as opposed to being voidable) where the severity of the person's condition prevents them from indicating any acceptance of the contract. This situation was illustrated in *Wychavon District Council v EM* regarding a purported tenancy agreement between a father and his severely disabled daughter. Although the daughter had not signed the contract, or otherwise indicated acceptance of the contract, she had been moved into the adapted property and her money was being used towards paying the rent. The Upper Tribunal found that in these circumstances there was no tenancy, although there was an obligation to pay a reasonable sum in lieu of rent under the doctrine of necessities.<sup>63</sup>
- 6.73 The legal position outlined in this decision appears consistent with higher authority, which assumes that a contract must be first formed, prior to the various common law rules regarding incapacity discussed above coming into play.<sup>64</sup> However, caution may be warranted before relying on the decision in similar factual circumstances. Arguably, because the daughter had moved into the property, there were grounds to find that an implied contract had been formed, despite the conclusion that there was no written or oral agreement for a tenancy. While the decision was not appealed, questions have therefore been raised about the extent to which the decision can be relied upon in practice in this area.
- 6.74 It is also important to consider the position of a person who has entered into a tenancy arrangement and subsequently loses capacity. In most cases the contract would continue. But there are exceptions such as where the contract gives either party an express right to terminate in such circumstances, or where the loss of capacity undermines substantially the basis for the contract, and so amounts to frustration.<sup>65</sup>

### **Provisional view**

- 6.75 The common law rule which allows those known by their counterparties to lack capacity to elect whether or not to be bound to contracts operates appropriately to prevent such counterparties from taking advantage of such people. However, this protection offered by the law appears to present a potential risk for landlords that tenants will seek to resile from fair tenancy agreements. If so, this might appear to justify use of the formal statutory procedures (such as an application to the Court of Protection) to ensure the contract is properly signed. However, we believe that this risk may not cause significant difficulties in practice. Where a person no longer wishes to be subject to a tenancy, it would ordinarily be simpler to comply with the terms of the lease and give notice to terminate in the usual manner. Even if the tenant does elect to avoid the tenancy, they would be required to leave the property immediately and, therefore, the effect for the

<sup>62</sup> *Aster Healthcare Ltd v Shafi* [2014] EWHC 77 (QB) at [52] to [58] and *Wychavon District DC v EM* [2012] UKUT 12 (AAC), (2012) 15 CCLR 221 at [28].

<sup>63</sup> *Wychavon DC v EM* [2012] UKUT 12 (AAC), (2012) 15 CCLR 221 at [11] and [32].

<sup>64</sup> *Hart v O'Connor* [1985] AC 1000, 1023.

<sup>65</sup> *National Carriers Ltd v Panalpina (Northern) Ltd* [1981] AC 675.

landlord will ordinarily be limited to the loss of the right to notice and, therefore, to the ability to collect rent during this period. Further, we have heard from stakeholders that this situation does not frequently arise in practice in any event. Nevertheless, we understand that some landlords do require that tenants who lack capacity utilise formal procedures and seek the appointment of a deputy from the court. This can cause delay and costs to be borne by these tenants.

- 6.76 By contrast, in a situation where the person never intended to sign the contract and it is therefore void, the risks for a landlord may be greater. If the tenancy is void, no rent may have been payable, and there may be a risk that, if the tenant is in arrears, the landlord will be unable to recover this debt. However, again, this risk seems very unlikely to eventuate in practice, given that the common law rule is likely to apply only in extremely narrow circumstances. Even if it were to arise, the landlord may well be able to rely on the common law or statutory doctrine of necessities to recover a reasonable sum in lieu of rent during the period in which the tenant remained in the property.
- 6.77 While the current risks for landlords and tenants might be minimal, we have mentioned that some landlords (including local authorities) require tenancies to be signed by a donee of a Lasting Power of Attorney or deputy, or that an application must be made to the Court of Protection. This appears to be on the basis that it would provide greater transparency and certainty for both parties. However, these options come with significant practical problems. For instance, a Lasting Power of Attorney can only be made when the person has the relevant decision-making capacity. Applications to the Court of Protection involve the payment of a £400 court fee along with other associated legal costs. Although this approach does have the virtue of bringing theoretically greater legal certainty, it can mean that, in practice, delays and expense may accompany a person's placement. It can also lead to the risk that an offer for a tenancy may lapse whilst court procedures are pursued. Indeed, many have argued that this approach is disproportionate and potentially discriminatory.
- 6.78 We have been informed by stakeholders that, in some cases, a relative or carer of the incapacitated person will sign the tenancy. The result is that the tenancy is then entered into with the third party (rather than the person themselves) who then becomes liable for the rent and other obligations under the tenancy. In practice, the relative or carer then consents to the person moving into the accommodation and uses the person's money towards the payment of rent. This approach may give rise to risks for the person who lacks capacity, as their rights may become dependent upon their relationship with the third party. In most cases the relative or carer will act in their best interests, but this might not always be the case.
- 6.79 We are also aware that some landlords prefer leaving the tenancy document unsigned. In most cases an implied tenancy is thought to arise once the person physically moves into the property and their money is applied to pay rent. It is argued that in such cases a combination of the duty to act in the person's best interests and the immunity from liability under section 5 of the Mental Capacity Act provide adequate protections for the landlord, the person who lacks capacity and their carers. Nevertheless, there may be a risk that if the decision in *Wychevon District Council v EM* is followed, no tenancy will have been created and that the person will therefore have minimal protection.

- 6.80 We have heard from stakeholders that these risks can, however, be managed in practice as many landlords who offer tenancies to people who lack capacity are registered housing providers under separate obligations to act fairly and take account of the needs of tenants.<sup>66</sup> Although private landlords are not under such obligations, any actions or decisions on behalf of the person lacking capacity must be made in the person's best interests, which may serve to limit some of the risks involved through selection of an appropriate landlord. Again, we consider these risks to therefore be more theoretical than practical.
- 6.81 Our provisional view is that the current law offers a number of legally based (as well as some more informal) mechanisms to ensure, in practice, that people who lack capacity and their carers and landlords are protected. We therefore provisionally consider that the present operation of the law is not, in practice, causing problems sufficient to justify substantive reform. We would however welcome further views on this issue.
- 6.82 But we do think that decision-makers should be clearer about the basis on which accommodation is being arranged. We therefore propose that, as a requirement of supportive care, local authorities must ensure that this is stated clearly in the person's care plan.
- 6.83 We also remain concerned that, despite the risks being reasonably small, some landlords do require that the formal procedures are used, and this can cause detrimental effects for disabled people in certain cases. We would welcome suggestions on how these effects could be addressed through law reform.
- 6.84 **Provisional proposal 6-7: under supportive care, a person's care plan must make clear the basis on which their accommodation has been arranged.**
- 6.85 **Question 6-8: are any changes needed to provide greater protection and certainty for people who lack capacity and their landlords in relation to tenancies?**
- 6.86 **Question 6-9: what difficulties arise when landlords require tenancies to be signed by a donee or deputy, and how might these be addressed?**

#### **SAFEGUARDS WHEN A PLACEMENT IS BEING CONSIDERED**

- 6.87 As noted earlier, supportive care applies to people who are living in, or moving into, care home, supported living or shared lives accommodation. However, for many people the key issues arise at an earlier stage when a placement is first being considered or proposed.
- 6.88 The decision to move into care home, supported living or shared lives accommodation can have significant consequences. This decision will often need to be taken at a point of crisis and at a time of great distress, by a person with significant needs. The Strasbourg jurisprudence establishes that particular protection is required under the Convention in such cases, especially where the person or their family does not agree with the residential package of care and,

<sup>66</sup> Homes and Communities Agency, *The Regulatory Framework for Social Housing in England from April 2012* (2012) p 22.

therefore, an “obvious” interference with family life under article 8 arises.<sup>67</sup>

- 6.89 The domestic courts have also emphasised the importance of family life and the significance to be attached to it. For example, Lord Justice Munby (as he was then) stated that:

I am not saying that there is in law any presumption that mentally incapacitated adults are better off with their families: often they will be; sometimes they will not be. But respect for our human condition, regard for the realities of our society and the common sense to which Lord Oliver of Aylmerton referred in *Re KD* ... surely indicate that the starting point should be the normal assumption that mentally incapacitated adults will be better off if they live with a family rather than in an institution – however benign and enlightened the institution may be, and however well integrated into the community – and that mentally incapacitated adults who have been looked after within their family will be better off if they continue to be looked after within the family rather than by the State.<sup>68</sup>

- 6.90 Mr Justice Hedley has recognised – when considering whether an 83 year old man should be discharged from hospital to the home where he had lived for many years with his nephew – that the apparent choice between a return to private family life and an unwilling entry into state care “is not a true choice” and the court applying the principle of least restriction “must really conclude that a return to private family life is inconsistent with the welfare of the person with whose best interests it is concerned, before it considers the alternatives”.<sup>69</sup>

- 6.91 However, these decisions must be read in the light of *K v LBX* where the Court of Appeal made clear that “principles and generalisation can rarely be stated since each case is so much fact dependent”. The Mental Capacity Act requires a balancing exercise and the decision-maker is required to take into account all relevant circumstances. But it is of great importance that regard must be had to article 8 of the European Convention.<sup>70</sup>

- 6.92 A number of high-profile cases have brought to the fore instances of flawed decision-making by public authorities, which involved overriding the wishes of the person concerned or of their family or carers. One of the most prominent was *London Borough of Hillingdon v Neary* where a young man with autism and learning disabilities was maintained in a behaviour support unit by a local authority against his own wishes and those of his father, at whose request the young man had originally entered the unit for short-term respite. In finding breaches of both article 5 and article 8, Mr Justice Jackson noted in particular that the local authority had failed to give proper weight to the benefits of care at home with the family, did not “seriously listen” to the objections of the man’s father, and sought to prevent scrutiny of the situation by suggesting that it might

<sup>67</sup> *Gunter v South Western Staffordshire PCT* [2005] EWHC 1894 (Admin), (2006) 9 CCLR 121 at [20] by Collins J.

<sup>68</sup> *Re S* [2002] EWHC 2278 (Fam), [2003] 1 FLR 292 at [48] and *Re MM* [2007] EWHC 2003 (Fam), [2009] 1 FLR 443 at [115].

<sup>69</sup> *Re GC* [2008] EWHC 3402 (Fam) at [18].

withdraw support for the man at home.<sup>71</sup>

- 6.93 A 2015 investigation by the Local Government Ombudsman found fault causing injustice, against a local authority in the case of an older man with dementia who had been moved into nursing care some 14 miles away from his marital home, against both the man's and the family's wishes. The report found a failure to complete the proper mental capacity and best interests assessments when he was moved, and when the records were later completed, they were incomplete. It also criticised the local authority for failing to consider the family's preferred accommodation and for failing to provide reasons for rejecting this placement.<sup>72</sup>
- 6.94 Cases of this sort have generated calls for law reform. In 2005, a Government Green Paper put forward for discussion the introduction of "a right to request not to live in a residential or nursing home setting", which would require service providers to "make explicit the reasons behind their decision to recommend residential care, including cost considerations".<sup>73</sup> However, this was not taken forward in the resulting White Paper.<sup>74</sup>
- 6.95 More recently, the Scottish Law Commission consulted on whether there should be a provision to the effect that the family or carers of a person who lacks capacity, who are willing and able to provide a home for that person, should not be prevented from doing so.<sup>75</sup> However, the Commission was persuaded not to include any such provision for a number of reasons, including that it cannot be assumed that accommodation within a family is necessarily benign, that there could be a danger of families feeling obliged or being pressured to offer care which is in fact beyond them, and that families can be unrealistic in their expectation of the level of care that will be necessary for someone, with consequent lack of adequate care for that person when they return to the family home.<sup>76</sup>
- 6.96 The draft Disabled People (Community Inclusion) Bill 2015 (commonly referred to as the "LB Bill") contains a number of proposals which are relevant to this discussion.<sup>77</sup> For example, it would:

<sup>70</sup> *K v LBX* [2012] EWCA Civ 79, (2012) 15 CCLR 112 at [31] by Thorpe LJ.

<sup>71</sup> *Hillingdon LBC v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [155].

<sup>72</sup> Local Government Ombudsman, *Report of the Local Government Ombudsman: Investigation into a Complaint against Cambridgeshire County Council (Reference Number: 13 016 935)* (2015).

<sup>73</sup> Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England (2005) Cm 6499, para 4.17. This took forward recommendations set out in: Prime Minister's Strategy Unit, *Improving the Life Chances of Disabled People: A Final Report* (2005).

<sup>74</sup> Our Health, Our Care, Our Say: A New Direction for Community Services (2006) Cm 6737.

<sup>75</sup> Discussion Paper on Adults with Incapacity (2012) Scottish Law Commission Discussion Paper No 156, paras 6.45 to 6.51.

<sup>76</sup> Report on Adults with Incapacity (2014) Scot Law Com No 240, paras 3.2 to 3.8.

<sup>77</sup> This has been put together by the Justice for LB campaign in memory of Connor Sparrowhawk (whose nickname was "Laughing Boy") who died in an assessment and treatment unit for people with learning disabilities in 2013.

- (1) prohibit the practice of setting personal budgets for disabled people living at home by reference to the cost of meeting the person's needs in residential care (it is argued that this practice means that a disabled person must either have to accept less care at home than they need or go into residential care);
- (2) require local authorities and the NHS, when making a living arrangement for a disabled person, to:
  - (a) secure the most appropriate living arrangement – which is to be determined primarily by the person's choice and views (but other facts including resources could be a relevant consideration);<sup>78</sup> and
  - (b) seek the approval of the person themselves, a donee or deputy, or the Court of Protection; and
- (3) place a duty on local authorities and the NHS to report on issues relating to living arrangements and community support, such as the number of living arrangements made and how often these arrangements were inconsistent with the person's wishes and feelings.<sup>79</sup>

6.97 In 2015 a Government Green Paper discussed – in more general terms – similar issues, such as requiring local authority and NHS commissioners when making decisions on living arrangements to have regard to factors such as staying close to home, links with family and friends, and the least restrictive alternative, and requirements to ensure that community plans are considered. It also considers the “duty to involve” disabled people in decisions made about their care – which is addressed by clause 10 of the LB Bill.<sup>80</sup>

### **Provisional view**

6.98 We currently see the main form of protection for the person, and their families and carers, when a move into accommodation is being considered as lying in greater access to advocacy both under the Care Act and under our proposals. We are nevertheless interested in exploring the possibility of additional safeguards for the person, and their family and carers, when a move into accommodation is being considered. We are persuaded by the Scottish Law Commission's reasoning on the specific proposals considered in its consultation paper but we would welcome views on the proposals put forward in the LB Bill.

6.99 In doing so, we do not wish to imply that cases like *London Borough of Hillingdon v Neary* represent the norm. Indeed, our discussions with stakeholders have provided many examples of innovative practice by health and social care practitioners, and a commitment to enhancing human rights. But where a person

<sup>78</sup> The duty to secure the most appropriate living arrangement in the LB Bill needs to be seen in the context of both specific and general duties to put in place community support. See for example, clauses 1 and 3 of the LB Bill.

<sup>79</sup> Justice for LB, *Disabled People (Community Inclusion) 2015 (LB Bill) Draft 2*, see: <https://lbbill.files.wordpress.com/2014/11/lbbill-draft-2.pdf> (last visited 22 June 2015).

<sup>80</sup> No Voice Unheard, No Right Ignored – A Consultation for People with Learning Disabilities, Autism and Mental Health Conditions (2015) Cm 9007.

is being considered for admission to a care home or other forms of specialist accommodation, it is likely that they will be in a vulnerable position and in need of additional safeguards. The provision of supportive care may help to ensure that an assessment takes place, proper care and support is in place, and the need for more restrictive forms of care and treatment is prevented or at least delayed.

- 6.100 The LB Bill specifically raises concerns in relation to the setting of personal budgets. Personal budgets apply in England, but have not been introduced in Wales. The Care Act 2014 provides that a personal budget must specify the cost to the local authority of meeting the person's care and support needs.<sup>81</sup> We have been informed by stakeholders that some local authorities in England have adopted a policy under which personal budgets for service users living in the community are based on the cost of meeting the person's needs in residential care where the cost is lower. We note that under the LB Bill this practice would be prohibited. Whilst it is outside the remit of our review to address local authority funding of social care services, we would be interested in consultees' views on the prevalence and the merits or otherwise of this practice.
- 6.101 We also envisage that our provisional proposals for strengthening supported decision-making and best interests decision-making, discussed in chapter 12, will contribute towards ensuring that moves into care home, supported living or shared lives accommodation reflect the views and wishes of the person.
- 6.102 **Question 6-10: should local authorities and the NHS in England ever set personal budgets for disabled people living at home by reference to the cost of meeting the person's needs in residential care?**
- 6.103 **Question 6-11: should there be a duty on local authorities and the NHS, when arranging care home, supported living or shared lives accommodation for a person who lacks capacity to decide where to live:**
- (1) to secure the most appropriate living arrangement for that person, which as far as possible reflects the person's wishes and feelings; and
  - (2) to seek the agreement of any donee of a Lasting Power of Attorney or deputy, or a declaration from the Court of Protection.
- 6.104 **Question 6-12: should local authorities and the NHS be required to report annually on issues relating to living arrangements and community support, such as the number of living arrangements made and how often these arrangements were inconsistent with the person's wishes and feelings?**

## REFERRALS

- 6.105 In the past, the DoLS have been hampered by lack of awareness and low referral rates.<sup>82</sup> This was due partly to the general confusion over what constitutes a deprivation of liberty. Our intention is that such confusion should not arise under protective care due to the use of much more straightforward entry criteria. But the

<sup>81</sup> Care Act 2014, ss 26(1) and 28(1).

<sup>82</sup> See, for example, Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013/14* (2015) pp 15 to 16.



problem may also be cultural, with low awareness levels amongst the wider health and care sector – particularly NHS and private care providers.

- 6.106 This may be addressed through non-legal solutions such as information awareness campaigns. Other options include a duty on certain public bodies (such as the NHS and regulators of health and social care) to inform the local authority if there is reasonable cause to believe that a person is eligible for the new protective care scheme. This would include supportive care, restrictive care and treatment, and the hospital scheme. But this type of duty would not apply to private body providers (such as housing associations) who provide housing to self-funding individuals, and where there is no state involvement. Public law is limited on the extent to which it may place duties on purely private bodies.
- 6.107 As argued above, it is likely that the reforms to the care and support funding system in England will mean more self-funders will seek local authority assessments or support. This should mean that far fewer self-funders will have no state involvement whatsoever in their care arrangements. Other options include the introduction of regulatory requirements which are enforced by the Care Quality Commission, Care and Social Services Inspectorate Wales, and Healthcare Inspectorate Wales.
- 6.108 **Provisional proposal 6-13: all registered care providers should be required to refer an individual for an assessment under the relevant protective care scheme if that person appears to meet the relevant criteria.**
- 6.109 **Question 6-14: should the duty to make referrals for protective care be a regulatory requirement which is enforced by the Care Quality Commission, Care and Social Services Inspectorate Wales, or Healthcare Inspectorate Wales?**

## CHAPTER 7

# RESTRICTIVE CARE AND TREATMENT

- 7.1 Under our provisional proposals, restrictive care and treatment provides the direct replacement for the DoLS. But, importantly, it is not organised around the concept of deprivation of liberty. Instead it provides safeguards for those whose care and treatment arrangements are becoming sufficiently restrictive or intrusive to warrant this. This will include individuals deprived of liberty, but also some whose arrangements fall short of this.
- 7.2 Our intention is to design a system that is more readily understandable for health and social care practitioners than the current DoLS. We have attempted to identify a cohort of people who, based on any ordinary understanding of their situation, warrant extra safeguards. Restrictive care and treatment should be easier to explain to the relevant person and their families and carers since it is not loaded with the immediately negative connotations of deprivation of liberty. There is also an important preventive aspect behind restrictive care and treatment, since it recognises that, for some, a deprivation of liberty may be likely in the short to medium term. Our scheme aims to delay or reduce this likelihood.

### QUALIFYING REQUIREMENTS

#### Mental Disorder

- 7.3 In order for the DoLS to apply, the person must be suffering from a “mental disorder” within the meaning of the Mental Health Act. As we noted in chapter 6, this includes “any disorder or disability of mind”, apart from dependence on alcohol and drugs. It also extends to all learning disabilities.<sup>1</sup> In contrast, the rest of the Mental Capacity Act applies to a broader range of people who lack decision-making capacity as a result of “an impairment of, or a disturbance in the functioning of, the mind or brain”.<sup>2</sup>
- 7.4 The definition of a mental disorder for the purposes of the DoLS includes mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression, as well as personality disorders, autistic spectrum disorders and learning disabilities. But it does not include disorders or disabilities of the brain. Those with brain disorders include people in a persistent vegetative state or minimally conscious state caused by a concussion or brain injury, or someone suffering from a stroke or locked in syndrome (a condition describing someone who is conscious but cannot move or communicate verbally). However, someone suffering from a disorder of the brain which gives rise to a mental disorder would be within the remit of the DoLS.
- 7.5 If a person with a pure brain disorder (rather than a mental disorder) needs to be deprived of liberty in their best interests, this cannot be authorised by the Court of Protection. This is because, for the purposes of deprivation of liberty, the Court of

<sup>1</sup> Mental Capacity Act 2005, sch A1, para 14. The distinction in the 1983 Act between learning disabilities depending on whether or not they are associated with abnormally aggressive or seriously irresponsible behaviour is not relevant.

<sup>2</sup> As above, s 2(1).

Protection is also bound by the eligibility criteria prescribed by the DoLS.<sup>3</sup> Therefore, the only available mechanism to ensure that the person receives the safeguards guaranteed by article 5 would be the High Court acting under its inherent jurisdiction.

- 7.6 Statutory gateways of this nature serve two main objectives. First, they aim to ensure that the relevant legislative provisions should not apply to everyone, but only to people who are suffering from some form of impairment or disorder. However, as set out in chapter 3, this approach has been criticised as discriminatory and incompatible with article 14 of the Convention on the Rights of Persons with Disabilities.
- 7.7 Secondly, they intend to ensure that the person is medically diagnosed as being of “unsound mind”, and so comes within the scope of article 5(1)(e) of the European Convention on Human Rights.<sup>4</sup> The starting point on the meaning of unsound mind is the case of *Winterwerp v Netherlands*. The Strasbourg court in that case held that “the very nature of what has to be established before the competent national authority - that is, a true mental disorder - calls for objective medical expertise”.<sup>5</sup> The term “a person of unsound mind” does not lend itself to precise definition since psychiatry is an evolving field, both medically and in social attitudes. However, it cannot be taken to permit the detention of someone simply because his or her views or behaviour deviate from established norms.<sup>6</sup> The Strasbourg court has accepted that “unsound mind” has an autonomous meaning which is independent from the definitions of mental disorder in domestic legal systems, and that a mental health condition must be of a certain gravity in order to be considered as a “true” mental disorder.<sup>7</sup> Incapacity under the Mental Capacity Act and unsoundness of mind are not necessarily coterminous.

### **Discussion**

- 7.8 In chapter 6 we discussed the qualifying requirements for supportive care. It was argued that because supportive care enables the provision of additional safeguards for people, it was not appropriate to use the relatively restrictive definition of a mental disorder. Instead we provisionally proposed that there should be consistency with the Mental Capacity Act and the safeguards should be provided to people who lack decision-making capacity as a result of “an impairment of, or a disturbance in the functioning of, the mind or brain”.
- 7.9 However, the arguments are less straightforward for restrictive care and treatment, since at this level a person might be deprived of liberty. Any proposal to adopt the Mental Capacity Act definition would mean that those with a pure brain injury and those dependent on alcohol or drugs could be deprived of liberty under our scheme – whereas currently they are excluded from the DoLS. In raising this issue, it is appreciated that we are entering controversial territory.

<sup>3</sup> Mental Capacity Act 2005, s 16A(1) and (4).

<sup>4</sup> Art 5(1)(e) of the European Convention authorises the detention of “persons of unsound mind” in accordance with a procedure prescribed by law.

<sup>5</sup> *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [39].

<sup>6</sup> As above, at [37].

<sup>7</sup> *Glien v Germany* App No 7345/12 at [83] and [85].

Proposals by previous Governments to extend the definition of mental disorder in the Mental Health Act to include any disability or disorder of mind or brain were highly contentious.<sup>8</sup> For example, the Joint Committee on Human Rights argued that this would extend the remit of the Mental Health Act inappropriately to people who have suffered traumatic brain damage, and those suffering from neurological disorders such as multiple sclerosis, Parkinson's disease or metabolic disorders.<sup>9</sup> On the other hand, such people are not excluded altogether from the definition of unsoundness of mind for the purposes of article 5(1)(e). Whilst the Mental Health Act may not be the appropriate vehicle for deprivations of liberty in these cases, the state still needs to guarantee their article 5 rights in cases where such action is necessary.

### ***Provisional view***

- 7.10 We have considered whether entry into restrictive care and treatment should be based on the DoLS definition and automatically exclude incapacitated people with a pure brain disorder and incapacitated people who are dependent on alcohol or drugs. These individuals would therefore be ineligible for restrictive care and treatment safeguards, including the enhanced assessment and care planning oversight procedures. Any deprivation of liberty would have to be authorised by the High Court. However, we have concerns over whether the use of the High Court is the most proportionate approach in such cases.
- 7.11 We have also considered whether restrictive care and treatment should include these groups of people, except in respect of deprivation of liberty. In other words, the individual would be eligible for the enhanced assessment and care planning of restrictive care and treatment safeguards, but any deprivation of liberty would need to be authorised separately by the High Court. However, such an approach may be unnecessarily cumbersome and lead to protracted legal arguments about the nature of a person's condition. For instance, the establishment of a bright line distinction between mental disorders and pure brain disorders is not always satisfactory. In the different context of the criminal law defence of insanity, the courts have on occasion argued that the law should not be concerned with the origin or cause of a condition, but rather the consequences for the individual concerned.<sup>10</sup> Furthermore, it has been held that drawing a distinction between a physical disease causing a defect of reason and a mental disorder would depend on "a doubtful medical borderline".<sup>11</sup> It is, however, worth noting that these criminal cases are all heavily criticised and regarded as unsatisfactory.<sup>12</sup>
- 7.12 We provisionally consider that the right approach would be to apply the scheme to those who lack decision-making capacity as a result of "an impairment of, or a

<sup>8</sup> For example, Reforming the Mental Health Act 1983: Part 1: The new legal framework (2001) Cm 5016-I, para 3.3 and Department of Health, *Improving Mental Health Law: Towards a new Mental Health Act* (2004) para 3.11.

<sup>9</sup> Legislative Scrutiny: Mental Health Bill, Report of the Joint Committee of Human Rights (2004-05) HL 79/HC 95, para 88.

<sup>10</sup> See, for example, *R v Kemp* [1957] 1 QB 399, 407, *R v Sullivan* [1984] AC 156, 172, and *Hennessy* [1989] 1 WLR 287, 292.

<sup>11</sup> *R v Kemp* [1957] 1 QB 399, 407.

<sup>12</sup> Criminal Liability: Insanity and Automatism (2013) Law Commission Discussion Paper.

disturbance in the functioning of, the mind or brain". This would have the advantage of providing consistency with the approach taken in the Mental Capacity Act, as well as supportive care. It would provide a proportionate system for authorising the person's care arrangements rather than requiring a court application in all cases. It should also be borne in mind that people with a pure brain disorder and those dependent on alcohol or drugs could only be subject to our scheme if additionally they lacked capacity to consent and the action proposed was in their best interests.

- 7.13 **Provisional Proposal 7-1: the restrictive care and treatment scheme should apply to people who lack decision-making capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain.**

#### **Restrictive care and treatment**

- 7.14 The DoLS set out "qualifying requirements" that must be met before a standard authorisation can be given. In total there are six such requirements:

- (1) the person must be aged 18 or over (the age requirement);
- (2) the person must be suffering from a mental disorder within the meaning of the Mental Health Act – see discussion above (the mental health requirement);
- (3) the person must lack capacity to decide whether or not they should be accommodated in the hospital or care home for the purpose of being given the relevant care or treatment (the mental capacity requirement);
- (4) it must be in the person's best interests to be deprived of liberty (the best interests requirement);
- (5) the person must be eligible for deprivation of liberty in the sense that they are not already detained or detainable or subject to certain powers under the Mental Health Act (the eligibility requirement); and
- (6) the deprivation of liberty cannot conflict with a valid advance decision to refuse any part of the treatment to be provided, or the decision of a deputy appointed by the Court of Protection or donee of a Lasting Power of Attorney (the no refusals requirement).<sup>13</sup>

#### **Discussion**

- 7.15 The DoLS qualifying requirements have been criticised for being overly formulaic and legalistic. Every aspect of the process has been isolated and re-packaged as a separate "assessment" – even something as relatively straight-forward as confirming the person's age. In contrast, the Mental Health Act detention criteria are relatively brief and straightforward. In general terms, the patient must be suffering from a mental disorder of a nature or degree which warrants

<sup>13</sup> Advance decisions allow people with capacity to refuse specified medical treatment at a point in the future when they lack the capacity to consent to that treatment. If an advance decision is valid and applicable in the particular circumstances, it has the same effect as a contemporaneous refusal of treatment by a person with capacity. See also chapter 13.

assessment or treatment, and detention must be necessary for the health or safety of the patient or the protection of others.

- 7.16 The DoLS are also criticised for undermining professional discretion. For instance, a standard authorisation must be issued if the assessors find that each of the six qualifying requirements are met. If any are not met, the supervisory body may not grant any such authorisation. In contrast, the Mental Health Act gives decision-makers discretion to determine if the person should be detained even if the criteria are met. Proponents of the Mental Health Act approach argue that it gives practitioners flexibility to take into account the individual circumstances of the case and situations where, for example, family members and carers may want to try – at least initially – to support the person at home rather than seeing them admitted to hospital.
- 7.17 The best interests requirement is arguably the most significant of the qualifying criteria for the DoLS, and is often the most time consuming of the six assessments. It requires the assessor to confirm that it is in the person’s best interests to be deprived of liberty, and thereby ensures that provision of any safeguards is linked inextricably to article 5. However, as set out in chapter 2, this link is argued to be a fundamental flaw in the current system. The concept of a deprivation of liberty appears to cause difficulty for practitioners, and the focus on article 5 means that other crucial areas are neglected, such as whether the person should be in that regime in the first place and whether removal from the family home was a proportionate and necessary response.
- 7.18 The Scottish Law Commission did not favour a scheme designed around a definition of deprivation of liberty, but instead recommended utilising a concept of “significant restriction of liberty”. This concept does not expressly match the concept of deprivation of liberty. The intention is not to make it a wider concept than deprivation of liberty, but to capture the situations which the Strasbourg court would regard as deprivation of liberty. The Commission’s draft Bill (which deals with adults) sets out three categories of restrictions:
- (1) the adult either is not allowed, unaccompanied, to leave the premises in which placed, or is unable, by reason of physical impairment, to leave those premises unassisted;
  - (2) barriers are used to limit the adult to particular areas of those premises; and
  - (3) the adult’s actions are controlled, whether or not within those premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication.
- 7.19 When two or more of these apply on a regular basis, this will give rise to what is referred to as “a significant restriction of liberty”. But measures applicable to all residents and intended to facilitate the “proper management of the premises

without disadvantaging residents excessively or unreasonably” are not to be regarded as giving rise to significant restriction.<sup>14</sup>

**Provisional view**

- 7.20 We provisionally consider that the Scottish Law Commission’s approach has significant advantages, not the least of which is the clarity that it provides for decision-makers on when the safeguards must be initiated and its use of terms which are straightforward and easy to understand and apply. On the other hand, we are concerned that the notion of a “significant restriction of liberty” may be drawn more narrowly than the definition of a deprivation of liberty in the *Cheshire West* judgment. Our proposed scheme therefore builds upon and expands the Scottish Law Commission’s general approach. Our intention is to develop a concept wider than deprivation of liberty, which also takes into account the article 8 rights of individuals.
- 7.21 We provisionally propose that entry into the restrictive care and treatment scheme should be determined by reference to a non-exhaustive list of different types of care and treatment. The proposed list is set out below. Each category in the list is intended to describe a situation where an individual’s care and treatment arrangements are becoming sufficiently restrictive or intrusive that where there is a clear need for additional safeguards or oversight. This is intended to be a more straightforward approach which makes sense to practitioners, and is easier to explain to the relevant person and their families and carers. The list has in part been constructed on the basis of analysis of the Strasbourg and domestic case law. It consists of the individual elements that have been identified as relevant to deciding whether there is a deprivation of liberty, and also includes key article 8 considerations from the relevant case-law. Some elements are also intended to reflect the Scottish Law Commission’s concept of “significant restriction of liberty”. We welcome further views on the use of a list and the individual elements of the list.
- 7.22 In respect of the “continuous supervision and control” limb of the *Cheshire West* test we have opted for “continuous or complete supervision and control”. In our view, “continuous” and “complete” are more or less synonymous when used in this sense, and using the former on its own can lead to unnecessary and protracted legal argument about periods of time.
- 7.23 We also wish to consult on other factors which might trigger the restrictive care and treatment scheme. In particular we wondered whether in some cases those with relatively high levels of need should be included automatically, rather than this decision being determined solely by the nature of the care and treatment regime. This could include people who lack capacity to consent to aspects of their care plan and who have relatively high levels of need overall. We also would welcome views on whether there are treatments that should bring a person into the restrictive care and treatment scheme (for example, certain forms of psychiatric medication).

<sup>14</sup> Report on Adults with Incapacity (2014) Scot Law Com No 240, paras 4.52 to 4.53 and appendix A (draft Bill) s 52A.

- 7.24 We also consider it might be useful to enable this list to be amended through secondary legislation. Strasbourg case law is capable of evolution and it could be important to ensure that the list can be updated relatively speedily in response to new developments.
- 7.25 We are aware that the low threshold for deprivation of liberty established by *Cheshire West* may mean that, in practice, there is only a small gap between the supportive care and the restrictive care and treatment schemes. If a person has reached a stage where they can no longer consent to their living arrangements and need to be placed in specialist accommodation, it is likely that the new arrangements will involve a substantial degree of supervision and control, and restrictions on their movement. Thus, many people under the supportive care scheme will be close to the *Cheshire West* threshold.
- 7.26 Nevertheless, we think that there is an appreciable cohort of people who would fall within our restrictive care and treatment scheme but not be deprived of liberty. For instance, people in supported living arrangements may have care plans establishing that diversion techniques should be considered when they seek to leave, but not be continuously supervised within the facility. Equally, people may be allowed to leave, but monitored by way of a door alarm or a GPS tracking device when they do so. Likewise, people may have restrictions put upon their article 8 rights by having their communications monitored, or their interactions with friends or family restricted, but not be deprived of liberty. In any event, we consider that a two-level scheme remains attractive since it would encourage full compliance with the Mental Capacity Act before the important decisions need to be taken, and not at a later stage when an Approved Mental Capacity Professional or the court becomes involved. We would welcome further views on this point.
- 7.27 Our proposed restrictive care and treatment criterion requires that the person must lack capacity to consent to the relevant care and treatment. This differs from the relevant supportive care criterion which is based on a lack of capacity to consent to the relevant living arrangements. Most people under restrictive care and treatment would also satisfy the supportive care criterion; however it is possible that a small number will retain capacity to consent to their living arrangements but lack capacity to consent to their care and treatment. Our provisional proposals aim to ensure that those under restrictive care and treatment would receive similar safeguards to those under supportive care. This is explained further throughout this chapter of the consultation paper.
- 7.28 The other individual elements of the DoLS qualifying requirements are considered elsewhere in this consultation paper. The age requirement and eligibility requirement are discussed in more detail in chapters 15 and 10 respectively. The no-refusals determination is considered in the context of advance decision-making in chapter 13.
- 7.29 Under our proposed scheme, if any form of “restrictive care and treatment” is being proposed, then an assessment should be initiated. As under supportive care, this would be the responsibility of the local authority. The purpose of the assessment would be to establish that the person lacks capacity to consent to the proposed care and treatment. The assessor would also need to confirm that the person lacks capacity and the proposed care and treatment is in their best



interests. This would include applying the principle of the least restrictive option and confirming that the relevant restrictions are necessary to prevent harm, and are proportionate. Furthermore, where the care and treatment proposed amounts to deprivation of liberty the assessor would also need to ensure that the requirements of article 5 are met – which is considered in more detail below.

**7.30 Provisional proposal 7-2: a person would be eligible for safeguards if: they are moving into, or living in, care home, supported living or shared lives accommodation; some form of “restrictive care and treatment” is being proposed; and the person lacks capacity to consent to the care and treatment.**

**7.31 Provisional proposal 7-3: restrictive care and treatment should include, but should not be limited to, any one of the following:**

- (1) continuous or complete supervision and control;**
- (2) the person is not free to leave;**
- (3) the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted;**
- (4) barriers are used to limit the person to particular areas of the premises;**
- (5) the person’s actions are controlled, whether or not within the premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication – other than in emergency situations;**
- (6) any care and treatment that the person objects to (verbally or physically);**
- (7) significant restrictions over the person’s diet, clothing, or contact with and access to the community and individual relatives, carers or friends (including having to ask permission from staff to visit – other than generally applied rules on matters such as visiting hours).**

**7.32 The Secretary of State and Welsh Ministers could add to and amend this list by secondary legislation.**

**7.33 Question 7-4: should the restrictive care and treatment safeguards be available to people who lack capacity to consent to their care plan, in any of the following cases:**

- (1) the person is unable, by reason of physical or mental disability, to leave the premises, including:**
  - (a) unable to leave without assistance;**

- (b) able to leave without assistance but doing so causes the adult significant pain, distress or anxiety;
  - (c) able to leave without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or
  - (d) able to leave without assistance but takes significantly longer than would normally be expected;
- (2) the person has high care needs and consequently is dependent on paid carers; and
  - (3) the person has limited ability to direct their own care or to access existing safeguards?

7.34 **Question 7-5: are there any specific forms of care and treatment that should automatically mean that the person is eligible for the restrictive care and treatment safeguards?**

7.35 **Provisional proposal 7-6: the local authority should be required to ensure that an assessment for restrictive care and treatment takes place, and confirm that the restrictive care and treatment is in the person's best interests.**

#### **The sequence of decision-making**

7.36 The DoLS assessments have been criticised for failing to make best interests the starting point. According to the *DoLS Code of Practice* the starting point is to decide if a deprivation of liberty is occurring or likely to occur – and if so, the assessor should proceed to a best interests assessment.<sup>15</sup> This has been described to us as illogical. According to the legislation, the purpose of the deprivation of liberty is for “giving care or treatment”.<sup>16</sup> Therefore, the assessor will have already considered the purpose of the care and treatment, and whether or not it is in the person's best interests.

7.37 In contrast, the approach taken by the courts is first to decide whether the proposed care and treatment is in the person's best interests and, if so, whether it is necessary to deprive a person of liberty in order to provide it and, in particular whether the risk of harm is sufficient to justify depriving them of their liberty. Mr Justice Charles has argued:

<sup>15</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) paras 4.62 to 4.65.

<sup>16</sup> *Mental Capacity Act 2005*, sch 1A, para 15.

If you have a process that starts with, "I am being deprived of my liberty", it carries with it habeas corpus points, and so very emotive points that go to the core of a number of British institutions. However, if you start with the test being whether the restrictions are promoting someone's best interests, it is less emotive and a much easier test to exercise. It should also get to the right answer, provided you have an ability to challenge it.<sup>17</sup>

7.38 We would be interested in views from consultees on whether an approach which started with a best interests assessment could be adopted for the purposes of a restrictive care and treatment care assessment.

7.39 **Question 7-7: should the restrictive care and treatment assessment require a best interests assessment to determine whether receiving the proposed care or treatment is in a person's best interests, before deciding whether it is necessary to authorise restrictive care and treatment?**

#### **The notion of best interests and harm to others**

7.40 The best interests requirement under the DoLS requires the assessor to confirm that the deprivation of liberty is necessary to protect the person from harm.<sup>18</sup> However, for the purposes of the rest of the Mental Capacity Act, a best interests decision should not focus only upon the direct benefits and detriments to a person which stem from a certain course of action. Wider consequential benefits may flow to the person from certain actions, and these should also be considered.<sup>19</sup> For instance, in the case of *Re Y*, a woman who lacked capacity was found to be the best tissue donor for her sister who was suffering from a bone marrow disorder.<sup>20</sup> Although the donation was not directly necessary for her own care and treatment, it was found to be in her best interests on the basis that it would prolong her sister's life which would, in turn, enable her sister to continue to provide her with various emotional and social supports. Similarly, wider benefits may flow to a person from preventing harm to third parties. For instance, in *J Council v GU*, strip searches and correspondence monitoring were put in place to stop the person distributing sexually explicit material which might harm others, and put him in potential breach of criminal laws.<sup>21</sup> By contrast, actions designed purely to benefit others, or to avoid harm to them, will ordinarily not be relevant to determining a person's best interests where there are no positive flow on effects for the person.<sup>22</sup> However, exceptions to this may arise if, for instance,

<sup>17</sup> House of Lords Mental Capacity Act 2005 Select Committee, *Oral and Written Evidence - Volume 1 (A-K)* (2014) p 485 (Q297).

<sup>18</sup> Mental Capacity Act 2005, sch A1, para 16(4).

<sup>19</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) para 5.48.

<sup>20</sup> *Re Y* [1997] Fam 110.

<sup>21</sup> *J Council v GU* [2012] EWHC 3531 (COP), (2013) 16 CCLR 31 at [6] to [7].

<sup>22</sup> *Re Y* [1997] Fam 110, 113.

the benefit or avoidance of harm would be a factor that the person would themselves have considered.<sup>23</sup>

- 7.41 It has been reported to us by Best Interests Assessors that the DoLS encourage a narrow view of best interests and force them not to apply the safeguards when others are at risk of harm (rather than just the person themselves). We would welcome further views on this issue and whether it should be addressed under our new scheme.
- 7.42 **Question 7-8: should a person be eligible for the restrictive care and treatment scheme if restrictive care and treatment is necessary in their best interests – taking into account not just the prevention of harm to the person but also the risks to others?**

#### **Cases where a court authorisation must be sought**

- 7.43 The law requires that certain decisions concerning a person who lacks capacity must be taken to the Court of Protection. For instance cases concerning “serious medical treatment” should be brought before the court. Whether or not procedures can be regarded as serious medical treatment depends on the circumstances and consequences for the patient, but it can include where a degree of force is needed to restrain the person (which is more than “transient forcible restraint”) and where there is a serious dispute, for example as to what obstetric care is in the person’s best interests.<sup>24</sup> The *Mental Capacity Act Code of Practice* advises that, for instance, non-therapeutic sterilisation and “cases where there is a doubt or dispute over whether a particular treatment will be in the person’s best interests” should be brought before a court.<sup>25</sup>
- 7.44 Case law has confirmed that “significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection”.<sup>26</sup> In *C v Blackburn and Darwen Borough Council* Mr Justice Jackson stated that “genuinely contested issues about the place of residence of a resisting incapacitated person” ought to be decided by the Court.<sup>27</sup> Mr Justice Hedley in *LBB v JM* recognised that where there is an intervention by the state which engages article 8 and where there are “significant factual issues between the parties” over whether it is justified under article 8(2), it may often be right that the matter should be placed before the court.<sup>28</sup> The *Mental Capacity Act Code of Practice* advises that a court decision might be appropriate if, for example, there is a “major disagreement regarding a serious decision” (such as deciding where a person should live) or where the person is at risk of harm or abuse from a third

<sup>23</sup> Mental Capacity Act 2005, s 4(6)(c).

<sup>24</sup> Court of Protection, Practice Direction 9E – Applications Relating to Serious Medical Treatment (2014), and *NHS Trust v FG* [2014] EWCOP 30, [2015] 1 WLR 1984, annex.

<sup>25</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) paras 8.18.

<sup>26</sup> *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [33].

<sup>27</sup> *C v Blackburn and Darwen BC* [2011] EWHC 3321 (COP) at [37].

<sup>28</sup> *LBB v JM* (2010) Case No 1155000T (COP) (unreported) at [7] to [8].

party.<sup>29</sup> The Department of Health has advised that the Court should be the arbiter for “matters of no contact” which concern the stopping or limiting of contact with a named individual because of a risk of harm or abuse to the person lacking capacity.<sup>30</sup>

### **Provisional view**

- 7.45 Whilst our new scheme enables restrictive forms of care and treatment to be authorised, we provisionally consider that certain decisions are so serious that, in each case, an application to a court should continue to be required. This would certainly be the case for serious medical treatment, and we would also welcome views on whether other decisions should always be decided by a court.
- 7.46 In chapter 11, we provisionally propose that there should be a right to appeal to a tribunal under restrictive care and treatment (and in respect of the hospital scheme) with a further right of appeal to the Court of Protection or the Upper Tribunal). Our provisional view is that the Court of Protection should continue to authorise serious medical treatment. But we would welcome views on this point.
- 7.47 It must be borne in mind, however, that the Court of Protection is already facing significant challenges coping with the volume of cases being referred post *Cheshire West*. There will also be resource implications for public bodies if required to apply to the court. Indeed, we consider that one of the benefits of restrictive care and treatment is that it would enable a more proportionate approach to decision-making that does not require a court decision in every case.
- 7.48 **Provisional proposal 7-9: cases involving serious medical treatment should be decided by the Court of Protection.**
- 7.49 **Question 7-10: should all significant welfare issues where there is a major disagreement be required to be decided by the Court of Protection?**

### **ROLE OF THE BEST INTERESTS ASSESSOR**

- 7.50 The role of the Best Interests Assessor is a particularly important one. They must decide whether a deprivation of liberty is occurring, or is likely to occur, and, if so, whether it is in the person’s best interests. They must also decide if the deprivation of liberty is necessary in order to prevent harm to the person and is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.<sup>31</sup>
- 7.51 In undertaking the assessment, the Best Interests Assessor is required to have regard to the person’s care plan and any relevant needs assessments, and consult with, or take into account the views of, a range of persons including any carer, anyone named by the person as someone to be consulted, anyone interested in the person’s welfare, and any donee of a lasting power of attorney

<sup>29</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) paras 8.27 to 8.28.

<sup>30</sup> Department of Health, *The Mental Capacity Act 2005 – Deprivation of Liberty Safeguards – The Early Picture* (2010) paras 19 to 22.

<sup>31</sup> *Mental Capacity Act 2005*, sch A1, para 16.

or deputy.<sup>32</sup> The consultation requirements are broader than the formal requirements for detention under the Mental Health Act where Approved Mental Health Professionals only have a statutory obligation to consult the Nearest Relative.<sup>33</sup>

- 7.52 There is a requirement on a mental health assessor to consider what effect being deprived of liberty will have on a person's mental health, and to notify the Best Interests Assessor accordingly so that the Best Interests Assessor can take the information into account in compiling their assessment.<sup>34</sup> Best Interests Assessors have a power, at all reasonable times, to examine and take copies of any health record, social services record or record held by a registered care provider which the assessor considers may be relevant to the assessment that is being carried out.<sup>35</sup>
- 7.53 In deciding that the deprivation of liberty will be in the best interests of the person being assessed, the Best Interests Assessor must state what the maximum period for the standard authorisation should be, consider whether any conditions should be attached to a standard authorisation, and consider whether there is anybody suitable to be appointed as a relevant person's representative.
- 7.54 A Best Interests Assessor can undertake up to four other DoLS assessments. These are the age assessment, no refusals assessment, mental capacity assessment and eligibility assessment. There is also a requirement, where the Best Interests Assessor and the eligibility assessor are not the same person, for the Best Interests Assessor to provide any relevant eligibility information that the eligibility assessor requests from the Best Interests Assessor.<sup>36</sup> In addition to completing initial assessments, the Best Interests Assessor may undertake reviews of standard authorisations and decide whether a person is being deprived of liberty without authorisation.

#### **Who can be a best interest assessor?**

- 7.55 The Best Interests Assessor for the purposes of the DoLS must be one of the following:
- (1) an approved mental health professional (this is a person approved under section 114(1) of the Mental Health Act);
  - (2) a social worker registered with the Health and Care Professions Council or Care Council for Wales;

<sup>32</sup> As above, sch A1, para 39.

<sup>33</sup> Mental Health Act 1983, s 26. However, the Mental Health Act Code of Practice emphasises the value of consulting with others, see Department of Health, *Mental Health Act 1983: Code of Practice* (2015) paras 14.66 to 14.70.

<sup>34</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 4.70.

<sup>35</sup> Mental Capacity Act 2005, sch A1, para 131.

<sup>36</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 4.54.

- (3) a first-level nurse (this is a nurse who is registered in sub-part 1 of the register maintained by the Nursing and Midwifery Council and is not limited to a nurse who is trained in mental health or learning disabilities);
- (4) an occupational therapist registered with the Health and Care Professions Council; or
- (5) a chartered psychologist listed in the British Psychological Society's register and holding a practising certificate issued by the Society.<sup>37</sup>

7.56 Therefore the following, amongst others, may not undertake a best interests assessment: a doctor, a second-level nurse (even if they are trained in mental health or learning disabilities) or a police officer.

7.57 The *DoLS Code of Practice* also recommends that supervisory bodies consider whether assessors have experience of “working with the service user group from which the person being assessed comes” (for example, older people, people with learning disabilities, people with autism, or people with brain injury), working with people from the cultural background of the person being assessed, and any other specific needs of the person being assessed (such as communication needs).<sup>38</sup>

7.58 In addition, the professional must:

- (1) not be suspended from their relevant professional register;
- (2) have at least two years post registration experience;
- (3) have successfully completed Best Interests Assessor training or completed further training; and
- (4) have the skills necessary to obtain, evaluate and analyse complex evidence and differing views and to weigh them appropriately in decision making.<sup>39</sup>

7.59 Unlike Approved Mental Health Professionals, the Best Interests Assessor must not be involved in the person's care, or in making decisions about the person's care, and the code of practice states that:

A potential Best Interests Assessor should not be used if they are in a line management relationship with the professional proposing the deprivation of liberty or the mental health assessor.<sup>40</sup>

<sup>37</sup> The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 5(2).

<sup>38</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 4.14.

<sup>39</sup> The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 5(3).

<sup>40</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 4.13.

## Discussion

- 7.60 The role and expertise of the best interest assessor is a highly regarded aspect of the DoLS. Series has argued that Best Interests Assessors must turn their attention to a broad range of issues including the suitability and quality of the particular placement and not merely the need to deprive the individual of liberty for medical treatment. In contrast, assessors under the Mental Health Act are not required to investigate the quality or conditions of the place where a person would be detained.<sup>41</sup> A 2014 report by the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales found that they were often the “linchpin” of the system, and a “skilled and valuable resource”.<sup>42</sup>
- 7.61 As part of our pre-consultation engagement exercise, we have met with individual Best Interests Assessors at regional forums. We have been highly impressed by the skills and commitment of individual best interest assessors, including their in-depth knowledge of the law. There have been many examples provided to us of innovative practice by best interest assessors such as the use of mediation and best interests meetings to resolve disputes outside the formal DoLS structures. In a relatively short space of time, the role of Best Interests Assessor has developed into a knowledgeable and well-respected quasi profession, which is comparable to the role of Approved Mental Health Professional.
- 7.62 However, the expansion in the numbers of DoLS referrals in the wake of *Cheshire West* has placed immense pressure on this resource. Many have argued that the existing role of the Best Interests Assessor is no longer sustainable, and that an independent best interests assessment for every referral cannot be guaranteed (and that, in some cases, it may not be necessary). Some have argued that the best interests assessment should be “mainstreamed” and become part and parcel of the everyday role of social workers and other professionals. To some extent, this echoes the concerns raised by the House of Lords committee that the principles of the Mental Capacity Act need to be firmly embedded in mainstream professional practice. It also reflects recent policy developments. In response, the Department of Health has stated that in the future all qualified social workers will have received training in the Mental Capacity Act and must be able to conduct best interests decisions to fulfill their professional responsibilities.<sup>43</sup> The “knowledge and skills statement” for social workers who have finished their assessed and supported year in employment includes a strong emphasis on the Mental Capacity Act.<sup>44</sup>

<sup>41</sup> L Series, *The Mental Capacity Act 2005 and the Institutional Domination of People with Learning Disabilities* (2013) pp 251 to 252.

<sup>42</sup> Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *A National Review of the use of the Deprivation of Liberty Safeguards (DoLS) in Wales* (2014) p 2.

<sup>43</sup> Valuing Every Voice, Respecting Every Right: Making the Case for the Mental Capacity Act: The Government’s Response to the House of Lords Select Committee Report on the Mental Capacity Act 2005 (2014) Cm 8884, para 6.12.

<sup>44</sup> Department of Health, *Knowledge and Skills Statement for Social Workers in Adult Services* (2015) para 5.



### **Provisional view**

- 7.63 In our provisional view, Best Interests Assessors should be central to the new system of restrictive care and treatment. We want to develop a new approach which recognises the specialist role undertaken by Best Interests Assessors and which, alongside this, utilises the skills of mainstream professionals who are often already working with the person. In some cases the person would benefit from a restrictive care and treatment assessment carried out by a health or social care professional who already knows them, and which is undertaken in the course of the normal assessment and care planning processes. Examples might include cases where the proposed restrictive care and treatment is short-term or where no one disagrees with the proposed care plan. This would mean that the role of the best interest assessor could be targeted on the most difficult cases.
- 7.64 We provisionally consider that Best Interests Assessors should have an important role to play in identifying which restrictive care and treatment assessments might benefit from an assessment by a professional that the person already knows. We think that this should not be an all or nothing approach, but rather that the Best Interests Assessor should be given flexibility in deciding how to take cases forward. Some assessments will only need a light-touch level of oversight, while others may benefit from an independent assessment. In addition, the Best Interests Assessor could act as a general resource for professionals, the person, and family members about best practice and how the Mental Capacity Act should be applied.
- 7.65 Under our proposed approach, a Best Interests Assessor would retain overarching responsibility for all restrictive care and treatment assessments. However, they would be given wide discretion as to how this oversight is implemented. In some cases the role of the Best Interests Assessor might be similar to that of the local authority in respect of supported self-assessments under the Care Act.<sup>45</sup> In other words, the assessment would be carried out by the professional already working with the person and the Best Interests Assessor would be required to ensure that it is an accurate and complete reflection of the person's needs and situation, and is in accordance with the principles of the Mental Capacity Act. This assurance could be secured by, for example, consulting with other relevant professionals and people who know the person, subject to first obtaining their consent. The Best Interests Assessor might also act as a general source of advice for the assessor – to assist them to apply the principles of the Mental Capacity Act and share good practice. The duty to carry out a restrictive care and treatment assessment will continue until the process of assurance is complete and the Best Interests Assessor has ensured that the assessment is accurate and appropriate.<sup>46</sup>
- 7.66 In other cases, the Best Interests Assessor could become a chair or facilitator of the process. Their role would be to support the assessor to apply the principles of the Mental Capacity Act – for example, by ensuring the family is involved and multi-disciplinary meetings take place – and reach a decision on the assessment. The Best Interests Assessor would need to sign off the process as being valid

<sup>45</sup> Care and Support (Assessment) Regulations 2014, SI 2014 No 2827, reg 2.

and complete, much like a chair of a safeguarding conference. The Best Interests Assessor could be given power to give “directions” if necessary as to what (if any) additional action should be taken, such as convening a meeting of all parties and requiring a capacity assessment if they thought there was not already adequate evidence on this issue.

- 7.67 In other cases, the Best Interests Assessor could take charge of the restrictive care and treatment assessment themselves and thereby ensure that an independent assessment takes place. This would be similar to the best interests assessment undertaken under the DoLS. This option would enable Best Interests Assessors to focus their skills and experience on those cases which would benefit from independent oversight. These might include cases where the professionals agree that the person needs restrictive care and treatment, but the person or family members disagree, and where the effect of the proposed restrictive care and treatment is likely to involve a deprivation of liberty and therefore article 5 safeguards will need to be ensured.
- 7.68 In order to reflect fully the revised role of the Best Interests Assessor, we think that several consequential changes should follow. First, the title “Best Interests Assessor” will need to be changed to reflect fully this new expanded role. We provisionally suggest “Approved Mental Capacity Professional” – in order to reflect the equivalence of the level of skills and knowledge of this role and that of the Approved Mental Health Professional under the Mental Health Act. Secondly, we think that the Approved Mental Capacity Professional should be given direct responsibility for decision-making. Thirdly, we think that professional regulation should recognise the role of Approved Mental Capacity Professionals. These latter two points are discussed in the next section of the report.
- 7.69 We do not provisionally propose to amend the list of professionals who are eligible to be Best Interests Assessors. But we would be interested in further views on this point.
- 7.70 We envisage that there would be transitional provisions to enable current Best Interests Assessors to become Approved Mental Capacity assessors without significant administration or expense.
- 7.71 **Provisional proposal 7-11: restrictive care and treatment assessments should be referred to an “Approved Mental Capacity Professional” (currently, the best interests assessor) who would be required to arrange for the assessment to be undertaken by a person already involved in the person’s care (eg the person’s social worker or nurse) and quality assure the outcome of that assessment or oversee or facilitate the assessment; or undertake the assessment themselves.**

<sup>46</sup> For an outline of how this approach works for supported self-assessment see, Department of Health, *Care and Support Statutory Guidance* (2014) paras 6.44 to 6.53.

## DURATION

- 7.72 In giving authorisation under the DoLS, the supervisory body must specify its duration, which may not exceed 12 months and may not be for longer than recommended by the best interests assessor.<sup>47</sup> According to the *DoLS Code of Practice* the underlying principle is that deprivation of liberty should be for the minimum period necessary so, for the maximum 12-month period to apply, the assessor “will need to be confident that there is unlikely to be a change in the person’s circumstances that would affect the authorisation within that timescale”.<sup>48</sup>
- 7.73 Under the Mental Health Act, admissions for short-term detentions can be for up to 72 hours in the case of section 4, and 28 days in the case of section 2. Longer term detentions under section 3 can be authorised for up to two periods of 6 months and then for periods of 12 months.
- 7.74 The Strasbourg case law has not specified any generally applicable limit on the duration of an authorisation. Instead the courts tend to focus on whether there have been periodic clinical assessments establishing that the person continued to suffer from a mental disorder throughout their detention.<sup>49</sup> The approach of the domestic courts is to take into account the individual circumstances of the case when setting the maximum length of the deprivation of liberty, and it is not uncommon for one to be authorised for up to 12 months, with regular internal reviews.<sup>50</sup>
- 7.75 We provisionally propose that, in broad terms, restrictive care and treatment should follow the approach established by the DoLS. The duration of restrictive care and treatment should be for a period which may not exceed 12 months and may not be for longer than recommended by the Approved Mental Capacity Professional. In line with our proposals above for an expanded role for the Approved Mental Capacity Professional, the duration of the restrictive care and treatment would be set by the Approved Mental Capacity Professional.
- 7.76 **Provisional proposal 7-12: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) would be required to specify the duration of restrictive care and treatment, which may not exceed 12 months.**

## PROCESS OF ASSESSMENT

### Equivalent assessments

- 7.77 The Mental Capacity Act provides that where an “equivalent assessment” to any of the required DoLS assessments has already been obtained, the supervisory body may rely upon that instead of obtaining a fresh assessment. An equivalent

<sup>47</sup> Mental Capacity Act 2005, sch A1, para 42.

<sup>48</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 4.71.

<sup>49</sup> See, for example, *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99) at [120] and *Kedzior v Poland* App No 45026/07.

assessment may, for example, have been carried out as part of the relevant person's care plan. Such an assessment may only be used if:

- (1) it is in writing;
- (2) it complies with the requirements of the assessment for which it is standing;
- (3) it has been carried out within the previous 12 months (unless it is an age assessment); and
- (4) the supervisory body is satisfied that it remains accurate and up-to-date.<sup>51</sup>

7.78 If the equivalent assessment is being used in respect of a best interests assessment, then for the supervisory body to be satisfied that it remains accurate they must take account of any information received from the relevant person's representative or any Independent Mental Capacity Advocate.<sup>52</sup>

7.79 The DoLS Code of Practice advises that:

Great care should be taken in deciding to use an equivalent assessment and this should not be done routinely. The older the assessment is, even if it took place within the last 12 months, the less likely it is to represent a valid equivalent assessment (unless it is an age assessment).<sup>53</sup>

### **Timescales for completion of assessments**

7.80 The Mental Capacity Act requires that a managing authority must request a standard authorisation if, at some time with the next 28 days, the person is likely to be deprived of liberty in the relevant hospital or care home.<sup>54</sup>

7.81 The timescales for assessments are set out in regulations. In respect of a request for a standard authorisation, an assessor must complete the assessment within 21 days from the date on which the supervisory body receives a request from a managing authority (in England) or the assessors were instructed by the supervisory body (in Wales). If an urgent authorisation is already in force, the

<sup>50</sup> *Re GJ* [2008] EWHC 1097 (Fam), [2008] 2 FLR 1295 at [44] and [56].

<sup>51</sup> Mental Capacity Act 2005, sch A1, para 49(1) to (5).

<sup>52</sup> As above, sch A1, para 49(6).

<sup>53</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 4.6.

<sup>54</sup> Mental Capacity Act 2005, sch A1, para 24.

assessments must be completed before the urgent authorisation expires (in England) or within five days of the date of instruction (in Wales).<sup>55</sup>

- 7.82 Where a request for consideration of an unauthorised deprivation of liberty has been received, the Best Interests Assessor must complete their assessment within seven days of the request being received (in England) or being instructed by the supervisory body (in Wales).<sup>56</sup>

#### **Records of assessments**

- 7.83 The regulations set out the information to be provided in a request for a standard authorisation. In England, this information includes:

- (1) the person's details;
- (2) the purpose for which the authorisation is requested;
- (3) any relevant medical information;
- (4) the diagnosis of the mental disorder; and
- (5) any relevant care plans or needs assessments.<sup>57</sup>

- 7.84 There are differences regarding some of the information required under the Welsh regulations.

#### **Provisional view**

- 7.85 The DoLS regime leaves much of the detail of the assessment process to secondary legislation. This includes matters such as the timescales for assessments. Our provisional view is that the DoLS achieve the right balance between primary and secondary legislation and, so allow for an appropriate degree of flexibility. We do not propose to alter this basic structure.

- 7.86 In this consultation paper we do not make any formal proposals regarding matters such as the timescales and information, as this would be a matter to be taken forward by the Government separately in regulations. But we would welcome further views on these matters.

- 7.87 We also think that there should be provision for equivalent assessments to be used under the restrictive care and treatment scheme. It is important to note that restrictive care and treatment is not based around formal assessments that could be directly substituted. We propose the new scheme should make clear that the

<sup>55</sup> Urgent authorisations may be given by managing authorities for an initial period not exceeding seven days. If there are "exceptional reasons", this can be extended by the supervisory body for up to a further seven days. Mental Capacity Act 2005, sch A1, paras 78 and 84.

<sup>56</sup> Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 14 and Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations and Disputes about Residence) (Wales) Regulations 2009, SI 2009 No 783 (W69), reg 10.

<sup>57</sup> Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 16.

matters that need to be confirmed under restrictive care and treatment can be based on existing assessments, but also give the Approved Mental Capacity Professional flexibility to determine when this should apply.

- 7.88 **Provisional proposal 7-13: the Secretary of State and Welsh Ministers should have powers in secondary legislation to provide for equivalent assessments, timescales for the completion of assessments and records of assessments.**
- 7.89 **Question 7-14: what should the timescales be for the assessments under protective care and what records should be contained in the assessment?**
- 7.90 **Provisional proposal 7-15: restrictive care and treatment should enable Approved Mental Capacity Professionals (currently, Best Interests Assessors) to use equivalent assessments where this is necessary.**

### **THE SUPERVISORY BODY AND BEST INTERESTS ASSESSOR**

- 7.91 The role of the supervisory body is central to the operation of the DoLS. In England, the supervisory body is the relevant local authority, and in Wales the role is performed by the relevant local authority or, in respect of hospitals, the relevant Local Health Board. The supervisory body is responsible for the appointment, selection and instruction of assessors. This includes general responsibilities regarding the appointment of professionals to be assessors who have the appropriate skills and experience, as well as the individual selection of an assessor in relation to a request for a standard authorisation for a particular relevant person (for instance ensuring that the Best Interests Assessor is not involved in the care or treatment of the person). The supervisory body should also determine if all six assessments must be completed by different professionals or that, where lawful, some of the assessments should be combined.
- 7.92 The supervisory body must give a standard authorisation if all assessments are positive. If the supervisory body is required to give a standard authorisation, it must decide the length of the authorisation and whether the authorisation will be given subject to conditions. However, the supervisory body cannot exceed the maximum authorisation period stated in the best interests assessment and must have regard to any recommendations made by the Best Interests Assessor about such conditions.<sup>58</sup>
- 7.93 The supervisory body must appoint the relevant person's representative as soon as practicable after a standard authorisation is given, normally following a recommendation by the Best Interests Assessor. The person recommended may be someone chosen by the person themselves (if they have capacity to make this decision), or by a donee or deputy. Alternatively the Best Interests Assessor can make their own recommendations.<sup>59</sup> If the Best Interests Assessor has not made a recommendation then the supervisory body will choose someone to act (for example a paid relevant person's representative).

<sup>58</sup> Mental Capacity Act 2005, sch A1 paras 50 to 51.

<sup>59</sup> As above, sch A1 para 143.

- 7.94 According to *London Borough of Hillingdon v Neary* the role of the supervisory body is not a rubber stamping exercise. For instance, the supervisory body is required to scrutinise the best interests assessment “with independence and a degree of care that is appropriate to the seriousness of the decision”. It does not have to follow the recommendations of the Best Interests Assessor on matters such as the length of the authorisation or conditions. In order to make these decisions rationally the supervisory body must have “a sufficient knowledge base about the circumstances of the person affected” and it can go back to the assessor for discussion or further enquires to be made. The court also considered that since a standard authorisation has the same effect as a court order, “there is no reason why it should receive lesser scrutiny”.<sup>60</sup>

### **Responsibilities for detention under the Mental Health Act**

- 7.95 The relationship between assessors and the supervisory body under the DoLS can be usefully contrasted to the equivalent structure under the Mental Health Act. The Approved Mental Health Professional is key to the operation of the Act and is given a number of key statutory functions including making applications for patients to be detained in hospital based on two medical recommendations.
- 7.96 Approved Mental Health Professionals are approved by local social services authorities. They can be drawn from social workers, first-level nurses (whose field of practice is mental health or learning disability), occupational therapists and chartered psychologists.<sup>61</sup> The Approved Mental Health Professional acts “on behalf” of the local authority, and therefore the authority will be vicariously liable for any lack of care or bad faith.<sup>62</sup> But importantly, the Approved Mental Health Professional acts as an independent decision-maker, who cannot be directed by the local authority to make a particular decision, nor can his or her decisions be overturned by the authority.<sup>63</sup>
- 7.97 The hospital managers are the detaining authority under the Mental Health Act.<sup>64</sup> The application for hospital admission is sufficient authority to detain the patient provided that it “appears to be duly made” and is founded on the necessary medical recommendations.<sup>65</sup> The Mental Health Act Code of Practice distinguishes between receiving admission documents and scrutinising them:

<sup>60</sup> *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [175] to [181].

<sup>61</sup> Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008, SI 2008 No 1206 and Mental Health (Approval of Persons to be Approved Mental Health Professionals) (Wales) Regulations 2008, SI 2008 No 2436 (W209).

<sup>62</sup> *TTM v Hackney LB* [2010] EWHC 1349 (Admin), [2010] MHLR 214 at [35].

<sup>63</sup> *Hansard* (HL), 17 Jan 2007, vol 688, col 681.

<sup>64</sup> Mental Health Act 1983, ss 6(2) and 40.

<sup>65</sup> As above, s 6(3).

Receipt involves physically receiving documents and checking that they appear to amount to an application that has been duly made (since that is sufficient to give the managers the power to detain the patient). Scrutiny involves more detailed checking for omissions, errors and other defects and, where permitted, taking action to have the documents rectified after they have already been acted on.<sup>66</sup>

- 7.98 After checking the documents, the hospital managers are entitled to act on the application without further proof of the facts stated therein. In other words, a hospital is “not obliged to act like a private detective” in scrutinising the application.<sup>67</sup> If it turns out subsequently that the application is fundamentally flawed – for example the facts stated in the application were not true – the detention of the patient will be rendered unlawful. The fact that the hospital has a lawful basis to detain a patient does not mean that the unlawful act of an Approved Mental Health Professional is cured.<sup>68</sup>

### Discussion

- 7.99 The courts have described the supervisory body role as the “cornerstone of the protection that the DoLS safeguards offer to people facing deprivation of liberty, if they are to be effective as safeguards at all”.<sup>69</sup> However, the position of the supervisory body can also be seen as rich in contradiction, and a fundamental problem for the DoLS.
- 7.100 The statutory scheme gives the supervisory body direct responsibility for many key decisions. This suggests that an active role in decision-making was envisaged by the drafters. But this can be difficult to reconcile with reality. The supervisory body is not an active player. It oversees the decisions of others. It is trite law that decisions cannot be rubberstamped, and inadequate or defective assessments must be identified and remedied. But to expect the supervisory body to conduct a forensic examination – similar to the scrutiny undertaken in court with the benefit of cross examination and expert evidence – could at best be described as unrealistic. The supervisory body is presented with the paperwork after the event, and it would be highly challenging to reach down into the assessments to scrutinise the facts and reasoning of the decisions in any meaningful sense. We would welcome further views on these points.
- 7.101 Concerns have also been raised regarding the position of the individual officer who must carry out the supervisory body’s assigned tasks. In *London Borough of Hillingdon v Neary*, this role was given to a service manager who was also responsible for service planning (with authorisations signed off by the Director of Adult Social Care) and, as noted in chapter 6, this led to accusations of conflicts of interest. The 2014 DoLS monitoring report by the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales raised concerns that the

<sup>66</sup> Department of Health, *Mental Health Act 1983: Code of Practice* (2015) para 35.6.

<sup>67</sup> *Re S-C (Mental Patient: Habeas Corpus)* [1996] 1 All ER 532, 537.

<sup>68</sup> *TTM v Hackney LB* [2011] EWCA Civ 4, [2011] 3 All ER 529.

<sup>69</sup> *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [174].



supervisory body signatory was “not always at the level you would expect given the significance of the legislation and impact on the relevant person”.<sup>70</sup>

- 7.102 There are also concerns that the important role of the Best Interests Assessor is not given sufficient recognition under the DoLS. In contrast, the Mental Health Act sets out that Approved Mental Health Professionals – who perform a role not dissimilar to that of the Best Interests Assessor – are independent decision-makers and key to its operation. This in turn seems to ensure that the vital role of the Approved Mental Health Professional is acknowledged both in law and in practice. However, the Best Interests Assessor role does not attract equivalent status. The 2014 report by the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales found that the Best Interest Assessor role was too often perceived as an “add on” by managers and professionals, and has no particular status – unlike the Approved Mental Health Practitioner role. Best Interest Assessors stated that they often had to negotiate with their manager to be released to undertake assessments.<sup>71</sup>

### **Provisional view**

- 7.103 Under our proposed protective care scheme as a whole, the Best Interests Assessor (which will be known as the Approved Mental Capacity Professional) will continue to play a crucial role. As noted previously, we have been impressed by the levels of skills and knowledge demonstrated by these professionals. We are attracted to the approach taken under the Mental Health Act whereby decision-making is more coherently and clearly defined than under the DoLS.
- 7.104 We provisionally propose that Approved Mental Capacity Professionals should be in the same position legally as Approved Mental Health Professionals. In other words, they will be acting as independent decision-makers on behalf of the local authority. The local authority would be required to ensure that applications for protective care appear to be “duly made” and founded on the necessary assessments. The level of scrutiny expected of any application would be the same as that expected of hospital managers under the Mental Health Act.
- 7.105 As well as providing for a more realistic approach to decision-making, we hope that this will lead to greater efficiencies through the dismantling of the layers of bureaucracy that have been developed by supervisory bodies to sign off DoLS decisions. We appreciate that some may be concerned that a layer of oversight for professional decision-making is being removed. In cases such as *London Borough of Hillingdon v Neary* a key issue was the lack of independent scrutiny of poor best interests assessments. However, we provisionally consider that, in practice, the supervisory body is unable to deliver this level of scrutiny. Moreover, further oversight could be provided through the role of the regulator (see chapter 14). Alternatively, it might be possible to make available a right to request an alternative assessment, where a “second opinion” might be needed because of a

<sup>70</sup> Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *A National Review of the use of the Deprivation of Liberty Safeguards (DoLS) in Wales* (2014) p 4.

<sup>71</sup> As above, p 11.

poor relationship with family or because of concerns about the quality of the assessment. We welcome views on these points.

- 7.106 In order to further reflect the importance of the Approved Mental Capacity Professional role we think there is a strong case for ensuring the approval and monitoring of education and training programmes leading to the qualifying award and continuing professional development. Currently, the Health and Care Professions Council and Care Council for Wales approve courses for Approved Mental Health Professionals.<sup>72</sup> The requirements of such courses include practice placements. In our provisional view, similar oversight over the training of Approved Mental Capacity Professionals would help to encourage similar high standards of education and training. Moreover, in order to further “gold-plate” the Approved Mental Capacity Professional’s independence we think that this role could be recognised formally as a specialist professional role in its own right. The Law Commission has received evidence in a previous project calling for the roles of Best Interests Assessor and Approved Mental Health Professional to be recognised in specialist lists or annotations in the relevant professionals register. We provided the UK Government and devolved administrations with an analysis of this evidence.<sup>73</sup>
- 7.107 The role of the local authority and Local Health Boards as a “supervisory body” would remain in the sense that they would be responsible for approving Approved Mental Capacity Professionals and accepting applications for protective care. In cases where the person needs to be deprived of liberty, they will also be the detaining authority. Local authorities and Local Health Boards would remain vicariously liable for the actions of the Approved Mental Capacity Professionals they have approved.
- 7.108 This reform would also mean that local authorities and Local Health Boards could approve a range of people to act as their Approved Mental Capacity Professional for these purposes. Such persons would not necessarily be employed by that body, which would mean that if they are authorised by one local authority or health board they could also undertake functions on behalf of other local authorities and health boards. This may secure some cost efficiencies.
- 7.109 **Provisional proposal 7-16: the new scheme should establish that the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) acts on behalf of the local authority but as an independent decision-maker. The local authority would be required to ensure that applications for protective care appear to be duly made and founded on the necessary assessment.**
- 7.110 **Provisional proposal 7-17: the Health and Care Professions Council and Care Council for Wales should be required to set the standards for, and**

<sup>72</sup> Health and Social Work Professions Order 2001, SI 2002 No 254, art 15A and 5.1.c of the Approval And Visiting Of Post Qualifying Courses For Social Workers (Wales) Rules 2012, r 5.1(c).

<sup>73</sup> Regulation of Health Care Professionals: Regulation of Social Care Professionals in England (2014) Law Com No 345, Scot Law Com No 237, NILC 18, paras 5.7 and 5.14.

approve, the education, training and experience of “Approved Mental Capacity Professionals” (currently, Best Interests Assessors).

- 7.111 **Provisional proposal 7-18: the ability to practise as an “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) or Approved Mental Health Professional should be indicated on the relevant register for the health or social care professional.**
- 7.112 **Question 7-19: should there be additional oversight of the role of the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) and a right to request an alternative assessment?**

### **CONDITIONS**

- 7.113 The Best Interests Assessor may include in an assessment recommendations about conditions to which the standard authorisation is, or is not, to be subject. Before deciding whether to give the authorisation subject to conditions, the supervisory body must have regard to any such recommendations. The managing authority of the relevant hospital or care home must ensure that any conditions are complied with.<sup>74</sup> The following are examples provided to us of specific conditions that are given in practice:
- (1) additional staff support for the person to ensure they can leave the premises;
  - (2) the person should be allowed to go out of the premises more frequently (for instance, to go on outings with their family or attend a religious service);
  - (3) a referral should be made for support from an Independent Mental Capacity Advocate;
  - (4) an immediate application to the court is made (for instance, where the person or their family is objecting); and
  - (5) where persons have been placed a long distance from their family, that they are enabled to visit the family on a regular basis.
- 7.114 In some cases the conditions are more oblique, for instance, requiring that other professionals involved should explore less restrictive alternatives. Mr Justice Jackson in *London Borough of Hillingdon v Neary* pointed to shortfalls in the wording of a condition where the issue was the need for the local authority to assess the possibility of the person returning home as an alternative to detention. The condition was worded as requiring “consideration to be given to the most appropriate place to provide care”.<sup>75</sup>
- 7.115 Particular attention has been paid to the use of conditions that limit or require supervision of contact between the person and others. Advice issued by the Department of Health states that where the supervisory body is seeking to

<sup>74</sup> Mental Capacity Act 2005, sch A1, paras 43 and 53.

<sup>75</sup> *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [76].

prevent contact, there may be a short-term need to rely on the conditions of an authorisation to authorise this but otherwise a court decision may be appropriate.<sup>76</sup>

- 7.116 The *DoLS Code of Practice* states that “it is not the Best Interests Assessor’s role to specify conditions that do not directly relate to the issue of deprivation of liberty”.<sup>77</sup> It also advises that:

Conditions should not be a substitute for a properly constructed care plan ... In recommending conditions, Best Interests Assessors should aim to impose the minimum necessary constraints, so that they do not unnecessarily prevent or inhibit the staff of the hospital or care home from responding appropriately to the person’s needs, whether they remain the same or vary over time.<sup>78</sup>

- 7.117 The supervisory body is not required to follow the recommendations of the Best Interests Assessor on conditions. If the supervisory body does impose the recommended conditions, it should nevertheless discuss the matter with the Best Interests Assessor “in case the rejection or variation of the conditions would significantly affect the other conclusions the Best Interests Assessor reached in their report”.<sup>79</sup>

- 7.118 A review must be held where there is a change in the person’s “case” and, as a result, the amendment, omission and inclusion of a condition is appropriate. If, however, having considered the nature of the change and the period the change is likely to last, the supervisory body considers that the change is not significant, it can vary the condition without the need for a best interests assessment.<sup>80</sup> The *DoLS Code of Practice* states that supervisory bodies should, when considering whether a full assessment is needed, consider if the conditions or detention are being contested.<sup>81</sup>

## Discussion

- 7.119 The 2014 report by the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales found evidence that conditions have been used to “great effect to protect an individual’s human rights and improve their outcomes”. However, that report also found that, in practice, conditions had not been used extensively. Furthermore, where conditions were used they had not always been

<sup>76</sup> Department of Health, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards – the Early Picture* (2010) paras 20 to 21.

<sup>77</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 4.74.

<sup>78</sup> As above, para 4.75.

<sup>79</sup> As above, para 5.5.

<sup>80</sup> Mental Capacity Act 2005, sch A1, paras 107, 111 and 114.

<sup>81</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 8.14.

understood by the managing authority as requiring their oversight and application to the person's care and support arrangements.<sup>82</sup>

- 7.120 Particular difficulties arise in monitoring compliance with conditions. The DoLS do not require any specific person to undertake this role. In practice it is often left to the Best Interests Assessor when reviewing the authorisation. Indeed we have been made aware of examples where Best Interests Assessors have recommended short authorisations in order to monitor the implementation of conditions. Mr Justice Jackson in *London Borough of Hillingdon v Neary* was critical of a Best Interests Assessor who failed to review if conditions relating to previous authorisations had been complied with.<sup>83</sup> Monitoring compliance may also be undertaken in practice by any allocated health and social care professional, the relevant person's representative and the Independent Mental Capacity Advocate. We are aware that some supervisory bodies have internal processes to monitor compliance but this is not commonplace.
- 7.121 The DoLS do not state expressly who the conditions can relate to. But since the managing authority must ensure compliance, it is likely that conditions can only be set on the managing authority, and not the supervisory body or those commissioning the care and support. This causes difficulties when compliance with conditions would require additional expenditure by the managing authority. Some Best Interests Assessors address this by including a condition that the managing authority should raise the matter of funding with the supervisory body, while others raise the matter in their report without making it a condition.
- 7.122 Where compliance with a condition requires additional funding, the condition may not be agreed by the supervisory body. However, it has been reported to us that, since the *Cheshire West* decision, it is more likely that the supervisory body will "rubber stamp" the recommended conditions – often without the extra funding in place – and the conditions therefore become inoperative while the funding decision is made, or are not acted on at all. Much concern has been raised about the potential conflict of interest for local authorities. As supervisory bodies they are expected to agree recommendations for conditions made on the basis of a person's best interests, but in many cases they will often be responsible for funding the person's care and support on the basis of public law decisions. This can lead to a perception that local authorities are less likely to approve conditions that will incur additional demands on their budgets. It is notable that the *DoLS Code of Practice* (quoted above) explicitly cautions against the use of conditions as a substitute for care planning.

### **Provisional view**

- 7.123 In our provisional view, conditions are a powerful and potentially transformative aspect of the DoLS scheme when they operate as intended. We therefore think that the ability to make conditions should be retained under protective care.

<sup>82</sup> Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *A National Review of the use of the Deprivation of Liberty Safeguards (DoLS) in Wales* (2014) p 8.

<sup>83</sup> *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [96].

However, we also want to consider a number of reforms which are intended to ensure that conditions are more effective in practice.

- 7.124 As argued previously, we see the role of the Best Interests Assessor (which will be known as the Approved Mental Capacity Professional – see above) as a key independent element of the new scheme. In line with this, we think that the responsibility for making conditions should rest directly with the Approved Mental Capacity Professional. In other words, they would not make recommendations to the supervisory body; they would issue the conditions directly.
- 7.125 However, this does raise some difficult issues about whether conditions can be binding or not. Where the condition would apply to a public law decision – for example a local authority decision to arrange extra support – it would not be appropriate for the Approved Mental Capacity Professional effectively to dictate this decision. (See chapter 6 for further discussion on this point). Similarly, a condition could not be used to require a specific form of medical treatment to be given which a doctor has concluded is not clinically appropriate, or to bind a donee acting under a lasting power of attorney or a deputy in respect to how care is arranged. However, appropriate conditions might include requiring the person to be given more access to their friends and family (assuming this does not entail the provision of additional resources).
- 7.126 To work effectively, conditions need to set out clearly the actions or decisions that must be undertaken. We share the concerns articulated by the courts that the formulation of conditions can be overly vague and generalised, for example requiring “consideration” of various matters. Indeed, it is difficult to see how compliance with such conditions can be measured. On the other hand, the use of obliquely worded conditions is often a reflection of the limited ability of assessors to force public bodies into providing additional resources. In other words, a requirement to consider options is often the only available lever for the assessor.
- 7.127 We provisionally consider that conditions must contain clear instructions. In addition, we think that best interest assessors should be given powers to make “recommendations” to public authorities about the care plan. This would provide a clearer demarcation between matters that should be a condition of restrictive care and treatment and other matters which require the consideration of options. Recommendations would not be binding in the same way as conditions but the care provider would need to have regard to such recommendations, and provide written reasons to the Approved Mental Capacity Professional if it decided not to follow them. It is intended that the use of recommendations would allow a greater degree of flexibility, and allow assessors to have an indirect impact on public law decision-making.
- 7.128 We would welcome views on whether the best interest assessor ought to be able to set conditions or make recommendations that are more restrictive than the application is asking for. For example, the assessor could recommend that consideration be given to increasing the person’s level of psychiatric medication, or set a condition that the person should only be let out if accompanied. If the assessor is essentially making decisions on the basis of the person’s best interests, then arguably such decisions are justifiable. On the other hand, it does

raise the possibility that the outcome of protective care could be more intrusive state action.

- 7.129 We would also welcome further views on what matters conditions or recommendations could address. Currently, they are limited to matters directly related to the deprivation of liberty. If this approach were applied to the new scheme, then conditions would be limited to the forms of restrictive care and treatment being proposed. However, provisionally we think this could be broadened to deal with a variety of matters related to care and treatment. The issue is of course significant because what matters to the person may not be what professionals would identify using human rights-based criteria. So for instance it might be that the person wants to gain access to or visit their pet, and the person is unable to pursue the issue on their own (with or without the support of an advocate).
- 7.130 It is debatable whether the DoLS secures any effective system for the monitoring of conditions. To the extent that monitoring happens at all, it seems to be achieved through an informal interaction between various individuals, including the Best Interests Assessor, the Independent Mental Capacity Advocate and the relevant person's representative. We seek to establish a scheme which is more transparent and effective in practice. Under our proposed scheme, the Approved Mental Capacity Professional would be responsible for setting any conditions. Therefore, the most straightforward option could be to give the Approved Mental Capacity Professional responsibility for monitoring compliance. However, it is possible that this reform could prove challenging. The Best Interests Assessor undertakes "one-off" assessments, and often undertakes this role on top of their day-to-day case load (for example on a rota system) – making assessors responsible for monitoring conditions would potentially make this a full-time role with ongoing responsibility. This would not only change the nature of the role, but it could have resource implications. It might also mean that the ability to use freelance Approved Mental Capacity Professionals (as many supervisory bodies do currently in respect of Best Interest Assessors) would be limited in the future. We would welcome further views on the potential implications.
- 7.131 We provisionally consider that the Approved Mental Capacity Professional should be given responsibility for monitoring conditions. But to address some of the issues raised above, we think that in practice the day-to-day responsibility for monitoring conditions could be undertaken by the health and social care professionals allocated to the case. In effect, the Approved Mental Capacity Professional would retain over-arching responsibility – but this could be delegated to the professionals working with the person. There might also be a requirement that professionals should report back regularly to the Approved Mental Capacity Professional on the effectiveness or otherwise of the conditions. Also, the advocate or appropriate person could be given responsibility for raising concerns about lack of compliance with conditions and reporting this to the assessor.
- 7.132 We do not propose to introduce any new sanctions for failure to comply. It is hoped that local authorities and NHS bodies would not be prepared to defend a care plan which was defective under public law or raised serious human rights concerns as not being in a person's best interests. Nevertheless, it would be open to the Approved Mental Capacity Professional to use existing avenues,

such as raising the matter with the relevant body or where appropriate informing the Care Quality Commission, Care and Social Services Inspectorate Wales or Healthcare Inspectorate Wales. In some cases an application to the Court of Protection might be necessary – for instance where there are disputes about whether the conditions are in the person’s best interests and the primary issue does not concern care planning or resources.

- 7.133 **Provisional proposal 7-20: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be responsible for setting conditions and making recommendations in respect of the person’s care and treatment.**
- 7.134 **Provisional proposal 7-21: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be given responsibility for monitoring compliance with conditions. This could be delegated to health and social care professionals who are allocated to the case, and advocates and the appropriate person would be required to report any concerns about non-compliance with conditions.**
- 7.135 **Question 7-22: should the new scheme allow for conditions or recommendations to be made that are more restrictive of liberty than the application is asking for?**
- 7.136 **Question 7-23: should there be specific sanctions for a failure to comply with a condition, and if so, what should they be?**

#### **ONGOING OVERSIGHT AND REVIEWS**

- 7.137 The DoLS set out a detailed procedure for the review of a standard authorisation. However, the responsibility for monitoring authorisations on an ongoing basis is not clearly defined. The relevant provisions are summarised below.

#### **Monitoring standard authorisations**

- 7.138 The managing authority or relevant person’s representative is required to alert the supervisory body to any change in the person’s circumstances which may mean the qualification requirements are no longer met.<sup>84</sup> This implies that both the managing authority and relevant person’s representative are expected to take on the on-going monitoring role. The *DoLS Code of Practice* establishes an expectation that the managing authority must set out in the care plan “clear roles and responsibilities for monitoring and confirm under what circumstances a review is necessary”, for example, if a person’s condition fluctuates, their situation should be reviewed more frequently.<sup>85</sup>

#### **Review by the supervisory body**

- 7.139 The supervisory body has a power to carry out a review of a standard authorisation at any time. It is required to carry out a review if requested to do so

<sup>84</sup> Mental Capacity Act 2005, sch A1, paras 102 and 103.

<sup>85</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) p 86.



by the relevant person, the relevant person's representative or the managing authority of the hospital or care home. The managing authority must request a review if any of the qualifying requirements appear to be reviewable.<sup>86</sup>

7.140 The grounds for a review are that:

- (1) the relevant person no longer meets one or more of the qualification requirements, or the eligibility requirement because they now object to receiving mental health treatment in hospital and they meet the criteria for admission under section 2 or section 3 of the Mental Health Act;
- (2) the reason for the initial authorisation has changed; or
- (3) the conditions need to be varied.<sup>87</sup>

7.141 A review may not be carried out on any other grounds, and the supervisory body is not required to take any action if none of the qualifying requirements appear to be reviewable.<sup>88</sup>

7.142 The process of review is detailed and mandatory. For example, the supervisory body must:

- (1) give notice of the review to the person, their relevant person's representative and the managing authority;<sup>89</sup>
- (2) decide which of the requirements is reviewable and, where there is more than one, ensure they are subject to separate review assessments (except where the best interests assessment is "non-assessable", in which case a separate review of the best interests requirement is not necessary);<sup>90</sup>
- (3) complete the review by deciding whether or not the requirements are reviewable and, if so, whether or not to terminate or vary the authorisation;<sup>91</sup>
- (4) give notice stating the outcome and any variation of terms of authorisation, to the person, their relevant person's representative, the managing authority and any section 39D Independent Mental Capacity Advocate;<sup>92</sup> and

<sup>86</sup> Mental Capacity Act 2005, sch A1, paras 102 and 103.

<sup>87</sup> As above, paras 105 to 107.

<sup>88</sup> As above, paras 104 and 110.

<sup>89</sup> As above, para 108.

<sup>90</sup> As above, paras 109 and 111.

<sup>91</sup> As above, paras 112 to 119.

<sup>92</sup> As above, para 120.

- (5) keep records of each request for a review, the outcome of each request, each review, the outcome of each review, and any variation of an authorisation.<sup>93</sup>
- 7.143 If one or more of the review assessments reach a “negative conclusion”, the supervisory body must terminate the authorisation.<sup>94</sup>

### **Managers’ hearings under the Mental Health Act**

- 7.144 It is instructive to compare the monitoring and review procedures under the DoLS with those in place under the Mental Health Act. Section 23 of the Mental Health Act gives hospital managers, and the responsible clinician, general discretion to discharge a patient. Moreover, the responsible clinician must discharge a patient if the criteria that would justify renewing their detention are no longer met.<sup>95</sup> This implies that the responsible clinician should generally keep a patient’s case under review, and this is normally undertaken in accordance with the care planning process and (in England) the provisions of the Care Programme Approach.<sup>96</sup>
- 7.145 Hospital managers also have a power to discharge certain patients, which is normally exercised in response to a formal application made by a patient. The *Mental Health Act Code of Practice* states that in exercising this power, managers must “either consider discharge themselves or arrange for their power to be exercised on their behalf by a ‘managers’ panel”.<sup>97</sup> Therefore, although the Act does not require a hearing, in practice, many cases are reviewed by a three member managers’ panel following the receipt of a request from a patient.
- 7.146 The managers’ hearing can be characterised as a quasi-judicial body, which must abide by the rules of natural justice and, for instance, are placed under a common law duty to give reasons for their decision.<sup>98</sup> The essential consideration is whether the grounds for continued detention or continued Supervised Community Treatment under the Act are satisfied. The *Mental Health Act Code of Practice* sets out questions that should be addressed and in general terms, the procedure that should be followed.

### **Discussion**

- 7.147 The DoLS review process is densely drafted and highly specific. In many places, it micro-manages decision-making by identifying who must be involved and which records must be retained. It also imposes formal procedures when arguably none are necessary. For example, all standard authorisations that are no longer

<sup>93</sup> As above, para 121.

<sup>94</sup> As above, para 117.

<sup>95</sup> See, *R v Drew* [2003] UKHL 25, [2003] 1 WLR 1213 at [10] and Department of Health, *Mental Health Act 1983: Code of Practice* (2015) para 32.18.

<sup>96</sup> Department of Health, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008).

<sup>97</sup> Department of Health, *Mental Health Act 1983: Code of Practice* (2015) para 38.3.

<sup>98</sup> *R (O) v West London Mental Health NHS Trust* [2005] EWHC 604 (Admin), [2005] MHLR 188.

necessary must be formally terminated through the review process by the supervisory body. There is no ability to discharge outside this process. In contrast, the Mental Health Act gives managers and clinicians general discretion to discharge patients at any time (and requires responsible clinicians to discharge the patient if the renewal criteria are no longer met).<sup>99</sup>

7.148 There is some evidence that the numbers of reviews of DoLS authorisations is low overall. In Wales, for example, less than 10% of all authorisations were reviewed in 2013-14. There were only 25 reviews recorded in that period, which represent 8% of the total number authorised.<sup>100</sup> It is also notable that few DoLS reviews are initiated by the person subject to the authorisation or their relevant person's representative. The Care Quality Commission has estimated that in England fewer than 10% of reviews happen at the request of these people.<sup>101</sup> Most reviews are initiated by the managing authority or supervisory body. There may be several reasons for this. For example, although both the person and the relevant person's representative can request a review, the supervisory body is not obliged to carry out a review "if no qualifying requirements appear to be reviewable".<sup>102</sup> There is some evidence to suggest that supervisory bodies are particularly reluctant to carry out a review if the authorisation is due to run out.<sup>103</sup> It has also been found that care homes are not always aware of their responsibilities to monitor and request reviews and rely heavily on the Supervisory Bodies to prompt them.<sup>104</sup> It may also be that the person and their family are reluctant to seek reviews for fear of damaging their relationship with the managing authority and supervisory body, and facing a reduction in care and support provision as an outcome of the review.

7.149 It is also argued that, even when reviews take place, they are of limited assistance. For instance, there is no right to a different Best Interests Assessor or an independent second medical opinion. It might also be argued that they offer little by way of independent review, since the supervisory body is the same body which authorised the deprivation of liberty in the first place, and may well be the same body which made and funded the placement.

### **Provisional view**

7.150 We provisionally consider that the monitoring and review process should provide a robust safeguard which protects the rights of the person, and also enable health and social care practitioners to respond to changing circumstances. The

<sup>99</sup> See, Mental Health Act 1983, s 23 and Department of Health, *Mental Health Act 1983: Code of Practice* (2015) para 32.18.

<sup>100</sup> Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2013-14* (2015) p 11.

<sup>101</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13* (2014) p 31.

<sup>102</sup> Mental Capacity Act 2005, sch A1, paras 109 to 111.

<sup>103</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013/14* (2015) p 27.

fact that, under the DoLS, most reviews are initiated by the managing authority or supervisory body merely reinforces the impression that, in practice, the rights of the person who is deprived of liberty are not the paramount consideration.

7.151 We also provisionally consider that the monitoring and review process can play an important role in alleviating the pressure on the courts. It has been suggested that managers' review hearings under the Mental Health Act can focus the minds of clinicians on whether the continued detention of the patient is necessary and increase the chances of early discharge. This is helped by giving clinicians powers to discharge patients outside the formal review process. However, it is important to emphasise that we would not want the review process to interfere with rights to speedy access to a court hearing under article 5(4).

7.152 As noted earlier, under our provisional proposals, Approved Mental Capacity Professionals (currently Best Interests Assessors – see above) would become independent decision-makers and have new responsibilities. In line with this, we provisionally propose that the role of the Approved Mental Capacity Professional should become central to our proposed system of reviews and monitoring. Where a person becomes subject to restrictive care and treatment, an Approved Mental Capacity Professional should be allocated to their case. We think that for the purposes of perceived independence, the assessor should not be the same person as the assessor who authorised the restrictive care and treatment. But we would welcome further views on this point. The Approved Mental Capacity Professional would be required to ensure that:

- (1) the on-going decision-making processes and care arrangements continue to comply with the relevant legal requirements – such as those established under Care Act 2014, Mental Capacity Act, NHS continuing health care regulations, and the Human Rights Act 1998;
- (2) appropriate consideration is given to any supported decision made by the person – for example by making the care provider aware that the person has made a supported decision in relation to a care and treatment decision being made (see chapter 12);
- (3) an advocate or “appropriate person” has been appointed and is involved in the person's care (see chapter 9).

7.153 The Approved Mental Capacity Professional would be required to keep under review generally the restrictive care and treatment that has been authorised, and have a general discretion to discharge the person from the restrictive care and treatment scheme. We do not think it is necessary to specify a review period, but instead the Approved Mental Capacity Professional would need to ensure that reviews take place at the most appropriate time for the individual. We also think there should be a duty to review the care and treatment following a reasonable request by the person (including someone making the request on their behalf),

<sup>104</sup> Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *A National Review of the use of the Deprivation of Liberty Safeguards (DoLS) in Wales* (2014) p 9.

the representative, a family member or carer, the care provider, and the advocate or the appropriate person.

- 7.154 Where the Approved Mental Capacity Professional thinks that the conditions may need to be changed – or a request is made to this effect – there is no need for a full reassessment of best interests. They could simply vary the conditions as appropriate. In deciding whether a full reassessment is necessary, they could consider whether the grounds for restrictive care and treatment, or the nature of the conditions, are being contested by anyone as part of the review request.
- 7.155 Moreover, the Approved Mental Capacity Professional would be expected (subject to the wishes of the person) to identify close family and carers who should be informed and invited to meetings. The review process could be amalgamated into existing reviews already taking place, for instance under the Care Act, Mental Capacity Act or NHS continuing healthcare processes. This would need to be co-ordinated by the Approved Mental Capacity Professional.
- 7.156 We have considered whether or not there should be an automatic referral to the local authority if the person has not exercised their right to appeal within a set period of time (for instance every 3 years).<sup>105</sup> Provisionally we do not think this is necessary given that the Approved Mental Capacity Professional must keep a person's case under review and will have powers to refer cases to the court (see chapter 9). But we would welcome further views on this point.
- 7.157 In addition, we provisionally consider that the local authority should be given a general discretion to discharge a person from the restrictive care and treatment scheme. In making this proposal we envisage that, in practice, this would operate in a similar way to the equivalent power given to hospital managers for the purposes of section 23 of the Mental Health Act. In other words, local authority managers could consider discharge themselves or arrange for their power to be exercised by a panel or other person. In order to reduce the resource implications of this proposal, the expectation is that local authorities could use the Independent Reviewer or alternative system that will be established from April 2016 under the Care Act to review a care and support appeal.<sup>106</sup>
- 7.158 It might be argued that that having two rights of appeal (to the Approved Mental Capacity Professional to hold a review meeting and to the local authority for discharge) might create confusion arising from the potential duplication of efforts, resources and overlapping responsibilities. One possible solution would be to legislate to set the order in which decisions must be made (for instance requiring a local authority decision only once the matter has been considered by the Approved Mental Capacity Professional). However, subject to the views of consultees we would prefer to avoid using legislation in this way. In our view, pragmatic solutions could be found to the potential practical problems by giving decision-makers an appropriate degree of discretion. Moreover, the duplication of

<sup>105</sup> This is roughly in line with many automatic referrals to the Mental Health Tribunal.

<sup>106</sup> Department of Health, *The Care Act 2014: Consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support* (2015).

powers does not appear to cause intractable difficulties under section 23 of the Mental Health Act. But further views on this issue are encouraged.

- 7.159 **Provisional proposal 7-24: an “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be allocated to every person subject to the restrictive care and treatment scheme. This should not be the same professional who authorised the restrictive care and treatment.**
- 7.160 **Provisional proposal 7-25: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be required to keep under review generally the person’s care and treatment, and given discretion to discharge the person from the restrictive care and treatment scheme.**
- 7.161 **Provisional proposal 7-26: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be able to review and vary conditions without necessarily holding a full reassessment of best interests.**
- 7.162 **Provisional proposal 7-27: the local authority should be given general discretion to discharge the person from the restrictive care and treatment scheme. Local authorities could consider discharge themselves, or arrange for their power to be exercised by a panel or other person.**
- 7.163 **Provisional proposal 7-28: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) and local authority must review the care and treatment following a reasonable request by the person, a family member or carer, or an advocate or appropriate person.**

#### **DEPRIVATIONS OF LIBERTY**

- 7.164 As noted earlier, the restrictive care and treatment scheme would include people who are deprived of liberty but would not be coterminous with the concept of deprivation of liberty. In other words, people who are deprived of liberty would form an important subset of those under the restrictive care and treatment scheme, but the safeguards would extend to others who are subject to restrictive care and treatment.
- 7.165 Our intention is that the restrictive care and treatment scheme care plan would be sufficient authority for the care provider named in the plan to deprive the person of liberty if necessary, in accordance with the terms of the plan. In our view this would satisfy the requirements of article 5. It would be a procedure prescribed by law, the “best interests” requirements of the Mental Capacity Act would all have been met and the Approved Mental Capacity Professional would ensure an independent element. The duration of the authority would be set by the Approved Mental Capacity Professional (with a limit of 12 months) and there would be rights to reviews and to appeal to a judicial body thereby satisfying article 5(4). As discussed below, the care and treatment being provided would be authorised by “objective medical expertise”.
- 7.166 However, it is important to emphasise that the care plan would need to authorise deprivation of liberty explicitly, if this were necessary in the person’s best interests. This is in part because the person (and professionals) needs to be clear that a deprivation of liberty has been authorised and in what circumstances it has

been authorised. It would not be acceptable for the care plan to, for example, give the care provider a blanket authorisation to provide treatment to the person irrespective of whether or not it might deprive the person of liberty. Moreover, the courts have made it clear that such an important matter as a deprivation of liberty must be "prescribed by law", and this can be interpreted as requiring a clear and unambiguous statutory provision where this is the intention.<sup>107</sup> In addition, there are convincing administrative reasons for identifying deprivations of liberty. For example, this may ensure that the courts can focus their resources and establish fast-track procedures in cases where someone is deprived of liberty. It may also enable the Government to target the provision of legal aid (see chapter 11) and coroners to manage their statutory responsibilities more effectively (see chapter 15).

7.167 The Approved Mental Capacity Professional would therefore need to be vigilant to the possibility that the care regime might potentially amount to a deprivation of liberty. If so, he or she would need to certify in the care plan that objective medical expertise had been provided and that the deprivation of liberty was in the person's best interests. Unauthorised deprivations of liberty are discussed below. However, it is important to emphasise that an authorisation of deprivation of liberty does not require the person to be deprived of liberty. It means that a person can rely on that authority to deprive the person of liberty safe in the knowledge that that action is lawful. Moreover, none of this would require the issue of deprivation of liberty to be determined conclusively. Even if the person is not subsequently deprived of liberty, the benefit of article 5 compliant safeguards would still be provided. Therefore, issues of fluctuating capacity and changes to the person's care regime will not necessarily affect whether the person receives safeguards. Much sterile legalistic argument would be avoided in this way.

7.168 **Provisional proposal 7-29: if a person who is eligible for the restrictive care and treatment scheme needs to be deprived of liberty in his or her best interests, this must be expressly authorised by the care plan.**

### **Domestic settings**

7.169 Our provisional proposals for protective care extend to people living within care homes, hospitals, supported living and shared lives accommodation. They have, up to this point, included those living within other domestic settings. However, as set out in chapter 4, we do not think it is appropriate for all deprivations of liberty of people who lack capacity within domestic settings to be authorised by the court. This would be overly burdensome for the local authorities involved, and potentially distressing for the person and their carers. As a result, we consider that, where a deprivation of liberty is proposed as a part of care or treatment offered in a domestic setting, the safeguards of the restrictive care and treatment scheme should apply. That is, the local authority would be required to refer the case to an Approved Mental Capacity Professional and all of the various safeguards already outlined as a part of the restrictive care and treatment scheme should apply. The deprivation of liberty could then be authorised, if appropriate, by the Approved Mental Capacity Professional, by explicitly dealing

<sup>107</sup> *Secretary of State for Justice v RB* [2011] EWCA Civ 1608, [2012] 1 WLR 2043 at [53] and [54].

with it in the care plan. We recognise that the use of an administrative system (rather than a judicial system) to authorise deprivations of liberty within a domestic setting may be perceived to be controversial. However, we provisionally consider that this would provide a proportionate response to deprivation of liberty in family and other domestic settings. We welcome comments on this provisional proposal, and in particular from those who could be affected by it.

7.170 As discussed in chapter 4, the scope of article 5 is potentially broad and can include those living in family and domestic settings. In such cases (and where there is no on-going state involvement in the person's care) the local authority may only become aware of the situation by, for example, a referral from the GP or reports from neighbours (the duty to make referrals is discussed later in this chapter). In such cases the Approved Mental Capacity Professional would need to decide whether to authorise the deprivation of liberty, or seek alternative solutions (such as the provision of services by a public authority to end the deprivation of liberty). In some cases the matter may need to be settled by the court (for example, if the assessor does not consider that a deprivation of liberty is in the person's best interests, and services cannot be put in place to end the deprivation of liberty).

7.171 **Provisional proposal 7-30: cases of deprivation of liberty concerning those living in a family or domestic setting must be authorised by the Approved Mental Capacity Professional and subject to the same safeguards as those provided under the restrictive care and treatment scheme.**

#### **Objective medical expertise**

7.172 The Strasbourg court has confirmed on numerous occasions that, in order to avoid arbitrariness, individuals cannot lawfully be deprived of liberty in accordance with article 5(1)(e) without first seeking "objective medical expertise". The exceptions are urgent cases or arrests for violent conduct where such evidence must be obtained immediately after the detention.<sup>108</sup>

7.173 The Strasbourg court has not stated clearly what qualifications or competencies the state should require of medical experts. A line of cases can be interpreted as suggesting that the medical expert must be a psychiatrist.<sup>109</sup> However, these cases have been distinguished on the basis of their individual circumstances and, in particular, that the individuals concerned had no previous history of mental disorder.<sup>110</sup> Recent case law has used the terms "medical expert"<sup>111</sup> and "psychiatric expert"<sup>112</sup> – rather than psychiatrist – which have been interpreted as including a psychologist and psychotherapist.<sup>113</sup>

<sup>108</sup> See, for example, *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [39] and *Varbanov v Bulgaria* App No 31365/96 at [47].

<sup>109</sup> See, for example, *CB v Romania* App No 21207/03 at [56] and *Ťupa v Czech Republic* App No 39822/07 at [47].

<sup>110</sup> See *Rivera v Switzerland* App No 8300/06 at [59].

<sup>111</sup> *Varbanov v Bulgaria* App No 31365/96 at [47].

<sup>112</sup> *Rivera v Switzerland* App No 8300/06 at [59].

<sup>113</sup> *Backer v Germany* App No 44183/12.



7.174 In certain circumstances, there may be a right to insist that at least one medical expert must be independent of the detaining institution; for example if the refusal to engage with the prescribed therapy can be explained by a breakdown in the relationship of trust with the treatment team,<sup>114</sup> and where “the continuation of confinement in involuntary care [in a psychiatric hospital] is concerned”.<sup>115</sup> However, the state is not necessarily required to provide an independent assessment, even when concerns have been raised about the objectivity of the those providing medical evidence. In particular, the court has noted that a professional regulatory framework for the medical experts provided sufficient protection against a lack of integrity.<sup>116</sup>

### ***Mental Health Bill 2006-07***

7.175 The meaning of “objective medical expertise” was given extensive consideration during the passage through Parliament of the Mental Health Bill 2006-07.<sup>117</sup> The debate focused on the Government’s plans to give Responsible Clinicians the power to renew detention under the Mental Health Act. The Responsible Clinician does not need to be a doctor and could be a psychologist, nurse, occupational therapist or social worker.<sup>118</sup> The Government’s policy intention was to reflect the changes in professional roles in mental health practice, in particular the emphasis on multi-disciplinary working and allocation of functions on a competency basis – for example, members of professions other than doctors can now prescribe medication.<sup>119</sup>

7.176 However, this position was challenged by the Joint Committee on Human Rights. Relying largely on the decision in *Varbanov v Bulgaria* it argued that objective medical expertise for the purpose of the Convention required reports from psychiatrists who are doctors.<sup>120</sup> The Joint Committee clarified subsequently that the provision of evidence could come from a clinical psychologist “if the mental disorder is a learning disability, a personality disorder or an illness which calls primarily for psychological intervention”.<sup>121</sup>

7.177 The Government’s position was supported by Richard Gordon QC who described the Joint Committee’s interpretation as “a misreading of *Varbanov* and far too rigid”. He argued that the Strasbourg court “requires substance over form” and would be unlikely to hold that a medical professional qualification – as opposed to

<sup>114</sup> *Rivera v Switzerland* App No 8300/06 at [64].

<sup>115</sup> *X v Finland* [2012] ECHR 1371 (App No 34806/04) at [169].

<sup>116</sup> *Nakach v Netherlands* App No 5379/02 (Admissibility).

<sup>117</sup> This became the Mental Health Act 2007.

<sup>118</sup> Mental Health Act 1983 Approved Clinician (General) Directions 2008.

<sup>119</sup> Scrutiny of Mental Health Legislation: Follow Up, Sixteenth Report of the Joint Committee of Human Rights (2007-08) HL 86/HC 455, extract from a letter dated 1 April 2007 written by Rosie Winterton MP, then Minister of State, Department of Health at paras 25 to 27.

<sup>120</sup> Legislative Scrutiny: Mental Health Bill, Fourth Report of the Joint Committee on Human Rights (2006-07) HL 40/HC 288, para 26 (emphasis removed).

<sup>121</sup> As above, paras 1.7 and 1.8.

a demonstration of medical competence – was a pre-requisite to objective medical expertise.<sup>122</sup>

### ***Domestic case law***

7.178 The domestic courts have also considered the question of objective medical expertise. In *G v E* the Court of Appeal rejected the argument that for the purposes of article 5 it could only consider a report from a psychiatrist. This was on the basis that the Strasbourg case law derives exclusively from cases involving mental illness and detention in a psychiatric hospital. However, in this case the relevant person had learning disabilities. The court accepted that people with learning disabilities are of “unsound mind” within article 5, but stated that:

it plainly does not follow either that they are mentally ill, or that article 5 of the Convention requires psychiatric evidence as a threshold to the deprivation of their liberty. Indeed, learning difficulties often lie outside the expertise of the psychiatrist, but firmly within that of the psychologist.<sup>123</sup>

7.179 In *Re X* the Court of Protection gave guidance on applications under the Mental Capacity Act for orders depriving someone of their liberty. Sir James Munby President of the Court of Protection stated that where the facts are clear it would be compatible with article 5(1) for a general practitioner to give evidence on a mental disorder.<sup>124</sup>

### ***DoLS and the Mental Health Act***

7.180 For the purposes of the DoLS the “mental health assessment” is intended to provide the necessary medical evidence required by article 5. The assessment must confirm that the person has a mental disorder within the meaning of the Mental Health Act.<sup>125</sup> That means any disorder or disability of mind, apart from dependence on alcohol or drugs. It includes all learning disabilities. In addition, the mental health assessor must also consider how the person’s mental health is likely to be affected by being deprived of liberty.<sup>126</sup> This assessment must be carried out by a registered doctor who is approved under section 12 of the Mental Health Act as having special experience of diagnosis or treatment of mental disorder or with at least three years’ post-registration experience in the diagnosis or treatment of mental disorder. In addition, the doctor must have completed the training for the DoLS mental health assessors.<sup>127</sup>

<sup>122</sup> British Psychological Society, *Memorandum to the Mental Health Bill Committee* (2017) paras 13, 20 and 21, see <http://www.publications.parliament.uk/pa/cm200607/cmpublic/mental/memos/uc602.htm> (last visited 22 June 2015).

<sup>123</sup> *G v E* [2010] EWCA Civ 822, [2012] Fam 78 at [60].

<sup>124</sup> *Re X* [2014] EWCOP 25, [2015] 1 WLR 2454 at [15].

<sup>125</sup> Mental Capacity Act 2005, sch A1, paras 14 and 35.

<sup>126</sup> As above, sch A1, para 36(a).

<sup>127</sup> Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 4.

- 7.181 The necessary medical evidence for non-emergency detention under the Mental Health Act is provided by two medical recommendations. In general terms, the recommendations must confirm that the patient is suffering from a mental disorder of a nature or degree which warrants assessment or treatment, and detention is necessary for the health or safety of the patient and the protection of others. The recommendations are provided by two registered doctors. At least one of the doctors must be approved under 12 of the Act and if practicable, at least one of the doctors must have previous acquaintance with the patient.<sup>128</sup>
- 7.182 A detention can be renewed on the basis of a report by the patient's Responsible Clinician. As noted above, the Responsible Clinician does not need to be a doctor and could be a psychologist, nurse, occupational therapist or social worker.<sup>129</sup> Before submitting the report, the Responsible Clinician must obtain the written agreement of another professional that the criteria are met. This second professional must be professionally concerned with the patient's treatment and must not belong to the same profession as the responsible clinician.<sup>130</sup>

### **Discussion**

- 7.183 The issue of objective medical expertise arises in law when a person is to be deprived of liberty. But there are also signs that in article 8 cases the Strasbourg court is prepared to probe the nature of medical evidence, particularly where that evidence is used to justify the removal of capacity.<sup>131</sup>
- 7.184 The Strasbourg case law, on article 5 at least, can be criticised for being rooted in outmoded assumptions about professional roles and hierarchies. The European Convention was drafted in a different era where it was relatively straightforward that a doctor, and almost certainly a psychiatrist, should always provide the necessary medical evidence for the purposes of article 5. The case law largely reinforces this assumption, particularly when the person who needs to be assessed has no previous history of mental health problems. Recent case law does at least appear to extend this principle to psychologists where the person has a learning disability or personality disorder. But overall the case law appears out of kilter with modern mental health practice, where expertise is based on competencies rather than qualifications. Moreover, it fails to take into account the individual needs of the person being assessed, which may not always call for a doctor's assessment.
- 7.185 There are also more specific concerns about the utility of the DoLS mental health assessment. The assessment is not intended to determine whether the person requires treatment or lacks capacity to make the relevant decision. Its sole purpose appears to be to satisfy the technical legal requirement that a person is medically diagnosed as being of "unsound mind" under article 5(1)(e). However, many people who lack capacity and have been placed in a care home or hospital will in many cases already have a diagnosis and be supported by their GP or

<sup>128</sup> Mental Health Act 1983, s 12.

<sup>129</sup> Mental Health Act 2007, s 9 and Mental Health Act 1983 Approved Clinician (General) Directions 2008.

<sup>130</sup> Mental Health Act 1983, s 20.

specialist care.<sup>132</sup> Whilst it is important to recognise factors such as the low rates of dementia diagnosis in the general population, it is still difficult to see what an additional medical assessment provides for many such people, especially when the diagnosis is longstanding and not in dispute.<sup>133</sup> It is also hard to understand why in such cases a mental health professional (including nurses and social workers) could not confirm the unsoundness of mind based on medical evidence.

- 7.186 This might suggest that the provision of a fresh specialist medical assessment should be targeted on those cases where medical matters are in dispute. But it also raises questions about what the role of the medical assessor should be, and specifically whether it should be expanded beyond a narrow article 5(1)(e) confirmation in order to provide some tangible benefit for the person. Of course, in practice, the mental health assessor may undertake one or more of the other DoLS assessments, including the mental capacity assessment. The only assessment that the mental health assessor cannot undertake is the best interests assessment. However, there is no requirement for the mental health assessor to undertake a broader role. Moreover, a more active role for a medical assessor might help to address concerns that too often health professionals lack awareness and knowledge of the DoLS and are not actively engaged in this scheme. In some cases the confirmation of a diagnosis of a mental disorder may be the only involvement that health services have with the person and this seems at odds with the longstanding policy direction of integrated care and support.

#### **Provisional view**

- 7.187 We provisionally consider that where a person is to be deprived of liberty, the Approved Mental Capacity Professional should be required to ensure that objective medical expertise is provided. This could be provided by a section 12 approved doctor<sup>134</sup> or a psychologist, but in some cases it would be appropriate for the assessment to be carried out by some other medical expert including the person's GP. Where there is already existing medical evidence we consider that the Approved Mental Capacity Professional should be able to confirm the unsoundness of mind based on that evidence. We also think that there are substantial benefits to be gained from requiring, in all cases, that the expert should be independent of the detaining body, not least of which that the independence of the assessors is less open to question.

<sup>131</sup> *Lashin v Russia* App No 33117/02.

<sup>132</sup> See, for example, S Liffé and others, "Provision of NHS Generalist and Specialist Services to Care Homes in England: Review of Surveys" (2015) *Primary Health Care Research and Development* Doi: 10.1017/S1463423615000250.

<sup>133</sup> 48% of people with dementia in England and 42.8% of people with dementia in Wales have a formal diagnosis, see Department of Health, *Dementia: A State of the Nation Report on Dementia Care and Support in England* (2013) and Alzheimer's Society, *Wales Dementia Diagnosis* (2014).

<sup>134</sup> A section 12 approved doctor is one who has been approved by the Secretary of State (or the Welsh Ministers) under the Mental Health Act as having special experience in the diagnosis or treatment of mental disorder.

- 7.188 We also provisionally consider that it should be left to the Approved Mental Capacity Professional to decide which medical professional should undertake the assessment, having regard to the individual circumstances of the case including whether or not the diagnosis is disputed and the complexity of the medical issues under consideration. Central to this decision should also be the question of which medical assessment would provide the most benefit to the person being assessed. The purpose of the assessment would be to confirm that the person is suffering from a disability or disorder of mind or brain and lacks capacity to consent to the proposed care and treatment.
- 7.189 In our scheme, the restrictive care and treatment scheme will include people subject to restrictive care and treatment but not deprived of their liberty. In such cases, the Approved Mental Capacity Professional would have discretion to request whatever assessments would be beneficial to the person (whether it be from a consultant psychiatrist, a psychologist, the person's GP or another health or social care professional).
- 7.190 We are also interested in receiving views on expanding the role of the medical assessor. This might include allowing doctors to undertake best interests assessments. There may be tangible benefits for the person concerned if independent scrutiny of medical care could be included as an aspect of protective care. That does not necessarily mean a medical expert in every case, but it does suggest that medical assessors have a role that is broader than we now articulate. In such cases, the medical assessment would need to be undertaken by a different individual. However, any expanded role for the NHS – and particularly doctors – will have resource implications.
- 7.191 **Provisional proposal 7-31: the Approved Mental Capacity Professional (currently the Best Interests Assessor) should ensure that before a deprivation of liberty is authorised, objective medical evidence be provided by a doctor or psychologist who is independent of the detaining institution. If appropriate evidence already exists, a fresh assessment should not be required.**
- 7.192 **Provisional proposal 7-32: the medical assessment should confirm that the person is suffering from a disability or disorder of mind or brain and lacks capacity to consent to the proposed care and treatment.**
- 7.193 **Question 7-33: should the medical assessment address other matters such as providing a second opinion on treatment already being provided or proposed?**
- 7.194 **Question 7-34: should doctors be eligible to act as Approved Mental Capacity Assessors (currently Best Interests Assessors)?**

#### **URGENT AUTHORISATIONS**

- 7.195 The judgment in *Winterwerp v Netherlands* expressly identified “emergency cases” as constituting an exception to the principle that the individual concerned should not be deprived of his liberty unless they have been reliably shown to be

of unsound mind of a kind or degree warranting compulsory confinement.<sup>135</sup> In *Rakevich v Russia* the court held that the applicant's "deranged state" would not, by itself, justify emergency detention, but the psychiatric evidence suggested that this was a genuine emergency.<sup>136</sup> In *MH v United Kingdom* the court, in its discussion of article 5(4) characterised a period of detention for 28 days (in this case under section 2 of the Mental Health Act) as "one ordered on the basis of the urgency of the situation".<sup>137</sup> In effect, national authorities have a "wide margin of discretion" in deciding to deprive someone of his or her liberty on the basis of an emergency. The relevant remedy available in such cases can be habeas corpus, but this is not a sufficient remedy for reviewing "continuing confinement".<sup>138</sup>

- 7.196 The DoLS provide that a person can be deprived of liberty before the supervisory body can respond to a request for a standard authorisation. In these situations the managing authority can itself give an urgent authorisation, which allows the person to be deprived of liberty for up to seven days. It can only be extended once (for up to a further seven days) if there are "exceptional reasons" and if the supervisory body agrees to the extension.<sup>139</sup>
- 7.197 The *DoLS Code of Practice* states that "in the vast majority of cases" it should be possible to plan in advance so that a standard authorisation can be obtained before the deprivation of liberty begins. But it goes on to acknowledge that in "exceptional cases" an urgent authorisation may be needed.<sup>140</sup> It also acknowledges that urgent authorisations can be used in care planning for example to avoid delays in transfers for rehabilitation.<sup>141</sup> However, it states that urgent authorisations should not be given to legitimise short-term deprivations of liberty, for example in accident and emergency units or care homes where it is anticipated that in a few hours or days the person will no longer be in that environment.<sup>142</sup>
- 7.198 In cases where the person is being deprived of liberty without any authorisation, any "eligible person" can notify the managing authority. The managing authority must then adjust the care arrangements or apply to the supervisory body for authorisation. The *DoLS Code of Practice* states that a managing authority must respond within a "reasonable time" to the request, which would normally be 24 hours.<sup>143</sup> If it does not do so, the person can report their concerns to the supervisory authority. This triggers a duty on the supervisory body to instruct a Best Interests Assessor to consider if the person is deprived of liberty. If there is

<sup>135</sup> *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [39].

<sup>136</sup> *Rakevich v Russia* (2003) ECHR 558 (App No 58973/00) at [29].

<sup>137</sup> *MH v United Kingdom* (2014) 58 EHRR 35 (App No 11577/06) at [83].

<sup>138</sup> *X v United Kingdom* (1982) 4 EHRR 188 (App No 7215/75) at [58].

<sup>139</sup> Mental Capacity Act 2005, sch 1A, para 76 and 84.

<sup>140</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) p 28.

<sup>141</sup> As above, para 6.2.

<sup>142</sup> As above, para 6.4.

<sup>143</sup> As above, para 9.1.

an unauthorised deprivation of liberty the managing authority may adjust the care arrangements, or is deemed to have requested a standard authorisation and may give an urgent authorisation.

- 7.199 The Mental Health Act also provides for detention in hospital in urgent cases. For example, section 4 provides for the compulsory admission to hospital for assessment for up to 72 hours based on the medical recommendation of one doctor who, if practicable, should have previous acquaintance with the patient. The application is made by an Approved Mental Health Professional. In addition section 5 sets out “holding powers” that can be used in respect of informal patients. Thus, if a doctor or approved clinician concludes that an application for detention should be made, a patient can be deprived of liberty for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made. In addition, certain nurses can authorise the detention of informal patients, until the patient can be assessed by the doctor or approved clinician.

#### **Provisional view**

- 7.200 It is important that restrictive care and treatment enables professionals to respond in cases of emergency. However, we are concerned that enabling self-authorisation by care providers is one of the least satisfactory elements of the DoLS. We provisionally think that, in emergencies, the first recourse of the care provider should be an Approved Mental Capacity Professional who would be able to give temporary authority for the care and treatment pending a full assessment. This would not be dissimilar to the position of a Court of Protection judge receiving an emergency application. The Approved Mental Capacity Professional would be able to authorise restrictive care and treatment for up to 7 days, extended once (for up to a further 7 days).
- 7.201 See chapter 8 for a discussion on the options that may be relevant when emergencies arise which require an immediate response, for example due to the risk of significant harm posed to the person themselves or others and where there is no time to seek an authorisation.
- 7.202 **Provisional proposal 7-35: an Approved Mental Capacity Professional (currently Best Interests Assessor) should be able to authorise restrictive care and treatment in urgent cases for up to 7 days, and to extend this period once for a further 7 days, pending a full assessment.**

#### **TRANSPORTATION, LEAVE, SUSPENSION AND TRANSFERS**

- 7.203 Transporting a person who lacks capacity to new accommodation will not usually amount to a deprivation of liberty. In most cases the wider provisions of the Mental Capacity Act can be used. The *DoLS Code of Practice* states, for example, that a person can be lawfully taken to a hospital or a care home as long as it is considered that being in the hospital or care home will be in his or her best interests.<sup>144</sup> However, in some cases transportation will amount to a deprivation of liberty, for example where it is necessary to do more than persuade or restrain the person, or where the journey is exceptionally long. The Strasbourg case law confirms that a deprivation of liberty must last for a “non-negligible” period of

<sup>144</sup> As above, para 2.14.

time.<sup>145</sup> A DoLS authorisation cannot be used to authorise a deprivation of liberty during the journey to a care home or hospital, but it can be given before the person arrives and take effect on their arrival.<sup>146</sup> The *DoLS Code of Practice* advises that in the “exceptional circumstances” where transportation will amount to a deprivation of liberty, it may be necessary to seek an order from the Court of Protection to ensure that the journey is undertaken on a legal basis.<sup>147</sup>

- 7.204 A standard authorisation only provides authority for the person’s deprivation of liberty in a hospital or care home. There are no express provisions concerning the provision of leave. But it is common for a person subject to an authorisation to be allowed to leave the accommodation, for example for supervised access to the community or contact sessions at the family home. The courts have accepted that in such cases a standard authorisation is sufficient authority to return the person to the hospital or care home and that appropriate restraint can be used with or without the assistance of the police.<sup>148</sup>
- 7.205 A standard authorisation can be suspended for up to 28 days if a person has ceased to meet the eligibility requirement in schedule 1A other than where the person is objecting to receiving mental health treatment in hospital. Therefore, the authorisation will be suspended if the relevant person is deprived of liberty in hospital under the Mental Health Act. If the person becomes eligible within 28 days, for example he or she is discharged from detention under the Mental Health Act, the suspension will cease to apply if the managing authority is satisfied that the person meets the eligibility requirement.<sup>149</sup>
- 7.206 There is no power to enable a standard authorisation to be transferred from one hospital or care home to another. Therefore, if a person needs to be transferred a new authorisation must be sought. We have been informed by stakeholders during our pre-consultation discussions that this is causing problems, for example for people resident in care homes requiring respite care in a hospice or hospital, and people cared for in hospital who require treatment at different hospitals. Where these people are deprived of liberty under the DoLS, the authorisation for their current setting would have to be ended and a fresh authorisation granted whenever it is proposed that they are moved to a new setting.

### **Provisional view**

- 7.207 We provisionally consider that the restrictive care and treatment scheme should include express provisions for transportation, leave, suspension and transfer. It is important that the law should provide clarity on these matters and that, for example, the scheme should enable a person to be deprived of liberty when being transported to the relevant accommodation if this is in his or her best

<sup>145</sup> *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision) at [117].

<sup>146</sup> *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam), [2010] Fam 70 at [9].

<sup>147</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 2.15.

<sup>148</sup> *DCC v KH* (11 September 2009) COP Case No 11729380 (unreported) at [10].

<sup>149</sup> Mental Capacity Act 2005, sch A1, paras 91 to 97.



interests. We also consider that it should be possible to suspend the restrictive care and treatment scheme for up to 28 days in all cases, and not just for the purposes of treatment under the Mental Health Act, and that it should be possible for the care plan to authorise restrictive care and treatment in more than one setting.

- 7.208 **Provisional proposal 7-36: the restrictive care and treatment scheme should include powers to authorise transportation, leave, suspension and transfers. It should also enable care and treatment to be authorised in multiple settings.**

## **REFERRALS**

- 7.209 We ended chapter 6 with a discussion of the lack of awareness of the DoLS and the low referral rates. We discussed some possible solutions, and provisionally proposed a requirement for registered care providers to refer a person for an assessment if they appear to meet the criteria for protective care. This would apply in respect of people who appear to meet the criteria for restrictive care or treatment. It would also apply in practice in respect of people who are not already in the protective care scheme, for example self-funders moving for the first time into care home, supported living or shared lives accommodation in which they will receive one or more forms of restrictive care or treatment.

## **CHAPTER 8**

# **PROTECTIVE CARE IN HOSPITAL SETTINGS AND PALLIATIVE CARE**

- 8.1 In chapter 2, we pointed to a key criticism that the DoLS impose a single approach irrespective of setting. Thus, deprivations of liberty on an acute ward are dealt with in the same way administratively as in a care home. This would not be the case under our proposed scheme of protective care. In this chapter we consider the position of hospital settings. We set out why a separate scheme is needed and the particular challenges that arise in identifying a deprivation of liberty in these settings. We also provide an overview of the separate scheme that would apply in hospitals under protective care.
- 8.2 By hospital settings we are referring to NHS, independent and private hospitals where care and treatment is being provided for physical disorders. The position of patients in hospital for mental health treatment is considered separately in chapter 10. When referring to hospitals, we also include hospitals and hospices providing palliative care. While, strictly speaking, a hospice inpatient is not in a hospital setting we consider that our proposed approach, set out below, would also be suitable for this group.
- 8.3 We also consider that advance decision-making should be given a more central role in hospital and palliative care. This is discussed in more detail in chapter 13.

### **OUR GENERAL APPROACH**

- 8.4 In chapters 6 and 7, we set out our proposed system of protective care which would apply to those living in care homes, supported living and shared lives accommodation. We consider that a number of factors point towards the need for a separate bespoke system for hospitals.
- 8.5 In a social care context, decisions are often made by teams in advance and over a period of time. In contrast, decision-making in hospitals is not planned in advance to the same extent and, in some cases, decisions need to be made immediately, sometimes by a single clinician. Hospital patients are more frequently admitted in emergency circumstances, and for specific forms of intervention. Admissions ordinarily involve shorter stays and are based on a presumption that the person will return home as soon as possible. In palliative care settings – where the average stay in a hospice is less than 14 days – the DoLS are viewed as too slow to be of practical use. Similarly, in an accident and emergency department the person may have already been discharged before even an urgent authorisation is in place.
- 8.6 The implications of decisions made in hospitals can be different. For example, deprivation of liberty in a care home may have permanent implications; the person's former home might have to be sold, or their condition may deteriorate due to the distress of being away from their home environment. Decision-making in this context often needs to be measured and unhurried. Deprivation of liberty in a hospital setting is more likely to be of shorter duration and may have less irreversible effects. In many cases, the key issue will be whether the treatment

being provided is in the person's best interests, and checking that a deprivation of liberty is not being used to enable clinical interests to over-ride the person's best interests. In palliative care, location can be essential, and the ability for the person to choose where their last days are spent may help to minimise distress. The impact of getting this decision wrong can have severe consequences for all involved.

- 8.7 Also, the nature and degree of supervision and control in a hospital is different. Clinicians can often assume full control of the person's liberty and treatment, and it is perhaps more likely that questions of deprivation of liberty will arise. We would welcome further views on these points.
- 8.8 This is not to suggest that hospital patients who lack capacity are any more or less vulnerable than those living in care home or other specialist forms of accommodation. But we have drawn the conclusion that the nature of the safeguards should be different. In developing a hospital scheme we have tried to find a balance between safeguards that would be meaningful for patients and clinicians, but also those that can be practically made available. We have also taken into account the variety of settings within a hospital, including emergency care, intensive care, acute wards and rehabilitation.
- 8.9 **Provisional proposal 8-1: a separate scheme should be established for hospitals and palliative care settings.**

#### **DEPRIVATION OF LIBERTY IN HOSPITAL**

- 8.10 The majority of people who lack capacity to make decisions about their care and treatment can be treated in their best interests under section 5 of the Mental Capacity Act. This includes the use of restraint provided this is necessary to prevent harm to the patient, and it is a proportionate response to the likelihood and seriousness of the harm.<sup>1</sup> However, in some cases, deprivation of liberty will be necessary in hospital. As set out in chapter 1, the *Cheshire West* case established that someone is deprived of liberty where they are under continuous supervision and control, and they are not free to leave (the "acid test").
- 8.11 The *Cheshire West* case did not concern a hospital setting. However, the concept of deprivation of liberty is not context-specific, and the acid test propounded by Lady Hale was established through a line of cases dating back to *HL v United Kingdom* which concern individuals in state-run social care institutions or hospitals. It therefore follows that the *Cheshire West* judgment can be applied in this setting. For example, in *NHS Trust v FG* it was held that the "acid test" was satisfied in an acute hospital when obstetric care was being provided to a patient with mental health problems.<sup>2</sup>
- 8.12 However, the application of the acid test in a hospital can pose unique challenges. In some wards – such as intensive care units – almost all patients will lack capacity and be unable to give consent to their care and treatment. The likelihood of a deprivation of liberty may therefore be higher than in other settings.

<sup>1</sup> Mental Capacity Act 2005, s 6(1) to (4).

<sup>2</sup> *NHS Trust v FG* [2014] EWCOP 30, [2015] WLR 1984 at [96].

8.13 In deciding whether “continuous supervision and control” is being exercised, the following factors could be relevant:

- (1) the use of restraint to bring about admission;
- (2) the use of restraint/medication without the patient's consent during the course of the admission;
- (3) staff taking decisions on a person's behalf regarding treatments and contacts with visitors; and
- (4) the duration of the restrictions.<sup>3</sup>

8.14 Crucially, the Supreme Court in *Cheshire West* made it clear that, in all cases, the following principles are not relevant when considering whether deprivation of liberty is occurring:

- (1) reason or purpose behind the treatment
- (2) compliance with treatment;
- (3) lack of objection;
- (4) family/carer's agreement;
- (5) appropriateness or “relative normality” of the treatment; and
- (6) lack of an alternative safe place for treatment.<sup>4</sup>

8.15 Particular difficulties will arise in determining if a patient is free to leave in circumstances where he or she is compliant with the treatment regime, and physically incapable of leaving the hospital (for instance, in a persistent vegetative state or minimally conscious state, or have been rendered immobile by their illness, injury or treatment). We provisionally consider that the patient's inability to leave for reasons of that sort is not a relevant factor to consider when determining whether there is deprivation of liberty. Deprivation of liberty means the same thing for everyone, regardless of whether they are mentally or physically disabled.<sup>5</sup> In our view, the focus in such cases should be on what actions the staff would take if, for instance, a mobile patient sought to be discharged or to wander or if family members or carers sought to remove him or her. However, a potential problem arises if the patient is “in principle” free to leave, but in practice cannot leave because the family are unable to look after them at home, or because alternative facilities are not available. This is in

<sup>3</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 2.5.

<sup>4</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [50].

<sup>5</sup> As above, at [33].

contrast to a patient who is not free to leave irrespective of the family's wishes.<sup>6</sup> Such cases would need to be considered on their facts but we consider it conceivable that a person could be considered not free to leave in such circumstances.

- 8.16 A further issue arises in respect of a person in a persistent vegetative state or minimally conscious state (including an unconscious patient). Such a person would not be considered mentally disordered under the Mental Health Act and would therefore not be eligible for the DoLS. However, we consider they may still be of "unsound mind" for the purposes of article 5(1)(e). If such a person needs to be deprived of liberty in his or her best interests, this cannot currently be authorised by the Court of Protection. This is because, for the purposes of deprivation of liberty, the Court of Protection is also bound by the eligibility criteria prescribed by the DoLS.<sup>7</sup> Therefore, the only available mechanism to ensure that the person receives the safeguards guaranteed by article 5 would be the High Court acting under its inherent jurisdiction.
- 8.17 Identifying the point at which short-term restrictions on patients cross the line to being a deprivation of liberty can also be difficult. It has been reported that in some hospitals, as a matter of practice, applications for authorisations have not been made where a patient would cease to be deprived of liberty within seven days. This has meant that, for intensive care settings, authorisations have not been routine.<sup>8</sup> The Strasbourg case law confirms that a deprivation of liberty must last for a "non-negligible" period of time.<sup>9</sup> But there is no fixed definition of how long such a period would be. This will vary according to the individual circumstances, including the nature and consequences of the restrictions. For example, in *Rantsev v Cyprus* a deprivation of liberty within the meaning of article 5 lasted only two hours.<sup>10</sup> In the United Kingdom case of *ZH v Commissioner of Police for the Metropolis*, the Court of Appeal rejected the submission that the Strasbourg court would usually view a detention of less than 30 minutes as not coming within the scope of article 5. In this particular case it was held that the "intense" restraint of a 16 year old boy with autism for 40 minutes amounted to a deprivation of liberty.<sup>11</sup>
- 8.18 Where an emergency arises, there are various possibilities. If the person is suffering from a mental disorder the provisions of the Mental Health Act may apply, including holding powers under section 5 and police powers under section 136. Under the DoLS the managing authority (in this case, the hospital) can give an urgent authorisation. However, the *DoLS Code of Practice* is clear that urgent authorisations should not be given to legitimise short-term deprivations of liberty,

<sup>6</sup> J Brown, "Deprivation of Liberty Standards in Intensive Care Medicine" (2015) 16 *Journal of the Intensive Care Society* 87.

<sup>7</sup> Mental Capacity Act 2005, s 16A(1) and (4).

<sup>8</sup> M Crews and others, "Deprivation of Liberty in Intensive Care" (2014), 15 *Journal of the Intensive Care Society* 4, 321.

<sup>9</sup> *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision) at [117].

<sup>10</sup> *Rantsev v Cyprus* (2010) 51 EHRR 22 (App No 25965/04).

<sup>11</sup> *ZH v Commissioner of Police for the Metropolis* [2013] EWCA Civ 69, [2013] 1 WLR 3021.

for example in accident and emergency units or care homes where it is anticipated that in a few hours or days the person will no longer be in that environment.<sup>12</sup> But it may be that an application to the Court of Protection is needed, in which case it would be possible to deprive the patient of liberty while a decision is sought, in order to give life sustaining treatment or do a “vital act” which is necessary to prevent a serious deterioration in the person’s condition.<sup>13</sup> Outside such treatment or acts, the inherent jurisdiction of the High Court may extend to authorising the deprivation of liberty. It has been argued that the common law doctrine of necessity may come into play where there is no time to seek the assistance of the court prior to the deprivation of liberty.<sup>14</sup> However, it is likely that the common law doctrine of necessity has no application where the provisions of the Mental Capacity Act apply.<sup>15</sup>

- 8.19 The Law Society’s guide to deprivation of liberty suggests that the immediate provision of life sustaining treatment in an emergency will not be considered a deprivation of liberty (for instance in an ambulance or accident and emergency department). But following the initial emergency the risk of deprivation of liberty increases and authorisation should be sought if risk is identified.<sup>16</sup> We consider this is the correct legal position.

#### **THE HOSPITAL SCHEME**

- 8.20 In contrast to the restrictive care and treatment scheme, we have designed our hospital scheme around the concept of deprivation of liberty. This is in part for practical reasons. Requiring the same threshold that we proposed for restrictive care and treatment would mean that, in some wards, all patients would need to be placed on this scheme. Also, the concept of a deprivation of liberty may be less disputed in hospital cases in practice, as the focus is likely to be on the “not free to leave” limb of the acid test, since most patients will be under constant supervision and control. But we welcome views on this point.

- 8.21 The hospital scheme would authorise deprivations of liberty in NHS, independent and private hospitals where care and treatment is being provided for physical disorders, and in hospices. The hospital scheme would apply when the following conditions are met:

- (1) the hospital patient lacks capacity to consent to the proposed care or treatment as a result of an impairment of, or a disturbance in the functioning of, the mind or brain; and

<sup>12</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) para 6.4.

<sup>13</sup> Mental Capacity Act 2005, s 4B.

<sup>14</sup> A Ruck Keene and C Dobson, *Deprivation of Liberty in the Hospital Setting: Thirty Nine Essex Street: Mental Capacity Law Guidance Note* (April 2014) paras 63 to 64.

<sup>15</sup> This was suggested in the course of argument by Sir Robert Nelson in *ZH v Commissioner of Police for the Metropolis* (2012) EWHC 604 (QB). The point was not addressed by the Court of Appeal in *ZH v Commissioner of Police for the Metropolis* [2013] EWCA Civ 69.

<sup>16</sup> Law Society, *Identifying a Deprivation of Liberty: A Practical Guide* (2015) paras 4.5 to 4.6.

- (2) there is a real risk that at some time within the next 28 days the patient will require care or treatment in his or her best interests that amounts to a deprivation of liberty; or
- (3) the patient requires care or treatment in their best interests that amounts to a deprivation of liberty; and
- (4) deprivation of liberty is the most proportionate response to the likelihood of the person suffering harm, and the likely seriousness of that harm.

8.22 We also consider that the acid test may need to be elaborated in order to make it more relevant to hospitals. As set out above, in our provisional view assessors – when considering the “not free to leave” limb of the test – will often need to focus on what actions the staff would take if, for instance, family members or carers sought to remove them. We would welcome views on whether this is correct and if so, whether this should be clarified in the legislation. In effect, the legislation could state that the person lacking capacity shall be considered to be deprived of liberty if:

- (1) they are not free to leave the hospital upon expressing a wish to do so or attempting to do so, or as a result of another person expressing a wish or attempting to remove them; and
- (2) they are subject to continuous supervision and control.

8.23 We consider that hospital managers and clinicians should have responsibility for identifying where patients within their hospital are deprived of their liberty and are therefore in the scope of the hospital scheme.

8.24 We provisionally propose that, where there is an immediate need for a deprivation of liberty, the person may be deprived of liberty for up to 28 days once a registered medical practitioner has examined the person and certified in writing to the managers of the hospital that the conditions above are met. Similarly, where there is a risk that a deprivation will be necessary in the next 28 days, a prospective authorisation may be made once a registered medical practitioner has examined the person and certified in writing that there is such a need, and the conditions above are otherwise met. This prospective authorisation would then authorise any deprivation which becomes necessary within the next 28 days. The hospital managers would be the detaining authority. These certifications would be sufficient authority to deprive the patient of his or her liberty, provided that they appear to be duly made (see chapter 7).

8.25 The hospital managers would then be required to appoint a person as the responsible clinician in charge of the care and treatment of the person, and notify the local authority (in order to put them on alert that an assessment by an Approved Mental Capacity Professional – currently the Best Interests Assessor – may be necessary after 28 days). This could not be the same clinician who provided the certification for the deprivation of liberty. We would expect that in most cases the person would already have a care plan – for example a “working care plan” that was drawn up on admission. If not, the responsible clinician would be responsible for preparing a written care plan for the person. Before preparing the care plan the responsible clinician would be expected to consult the patient, any carer, and any other person interested in the person’s care. Copies of the

plan should be given to these people following the authorisation of a deprivation of liberty. Also, an advocate or an appropriate person must be appointed for the person (see chapter 9). Once a care plan is in place, it could be amended or formally reviewed to cater for changes in circumstances.

- 8.26 Our provisional view is that an advocate and a relevant person's representative must be appointed for the person (see chapter 9). It has been suggested to us that in some specialist cases (particularly intensive care settings) the provision of an advocate may not always be appropriate and that some other safeguard may be more appropriate. This might include the provision of a second medical opinion to confirm that the treatment plan is in the person's best interests. We would welcome views on this point.
- 8.27 The written care plan would provide the authority for the conveyance of the person to the hospital. We also think that the new scheme should enable patients to be transferred between clinical teams or hospitals, and allow the responsible clinician to remain the same person, or be someone in the new team. The scheme would also allow for periods of leave and transfers allowing the person to be temporarily cared for in another setting. These points are also discussed in chapter 7. Responsibility could also be delegated internally to cover periods where the responsible clinician is away.
- 8.28 Treatment can be provided before the care plan is written and circulated on the basis of section 5 of the Mental Capacity Act, or the various emergency provisions discussed above. Once a care plan is in place, it could be amended or formally reviewed to cater for changes in circumstances. Any necessary emergency interventions outside the care plan could still be provided.
- 8.29 We envisage that the responsible clinician would be the same as the clinician who takes overall responsibility for the person's clinical care. We do not think it should, for example, be a clinician who is responsible for all patients in a given hospital that are being deprived of liberty but does not have any input into their day-to-day care. However, we would welcome further views on this.
- 8.30 The responsible clinician will have responsibility for reviewing whether the conditions above continue to be met during the period of 28 days. If the conditions are no longer met the responsible clinician should certify that fact in writing to the managers of the hospital, and deprivation of liberty would no longer be authorised. The hospital managers would be required to notify the local authority. It may be necessary for someone to be deprived of liberty in a hospital for longer than 28 days. We consider that the arguments (focused on practicality and short-term treatment) for allowing deprivations of liberty without the approval of an Approved Mental Capacity Professional do not apply beyond this period. And also it is more likely that deprivations of liberty for longer than 28 days will have more irreversible effects for the individual. Therefore, we provisionally consider that a deprivation of liberty may only extend beyond 28 days if an Approved Mental Capacity Professional has also assessed the person and confirmed that the conditions are met, whereupon a deprivation of liberty is authorised for up to 12 months.
- 8.31 During the period where deprivation of liberty is authorised beyond 28 days, the Approved Mental Capacity Professional would have responsibility for reviewing



whether the conditions for authorisation continue to be met. But clinical responsibility will remain with the responsible clinician. The period of deprivation of liberty could not exceed 12 months unless the responsible clinician and a Best Interests Assessor both examine the patient and certify that the conditions continue to be met, in which case the deprivation of liberty may extend for another agreed period of up to 12 months. The person and anyone else on his or her behalf may apply to the tribunal for review of the decision to deprive the person of liberty (see chapter 11).

- 8.32 **Provisional proposal 8-2: a person may be deprived of liberty for up to 28 days in a hospital setting based on the report of a registered medical practitioner. A responsible clinician must be appointed and a care plan produced. Further authorisations for a deprivation of liberty would require the agreement of an Approved Mental Capacity Professional (currently a Best Interests Assessor).**
- 8.33 **Question 8-3: is the appointment of an advocate always appropriate in all hospital cases, or is there a need for an alternative safeguard (such as a second medical opinion)?**

## CHAPTER 9

# ADVOCACY AND THE RELEVANT PERSON'S REPRESENTATIVE

- 9.1 This chapter considers the rights of the person to the support of an independent advocate and a “relevant person’s representative”. Both of these roles are provided for under the DoLS. The following discussion considers how they would be provided for under protective care.

### RIGHTS TO ADVOCACY

- 9.2 There has long been recognition by disability groups, professionals, service providers and service users of the importance of advocacy and the valuable role it can play in supporting and representing disabled people and carers. Advocacy in health and social care refers to a particular role, distinct from advocacy in formal proceedings as understood by lawyers. The role of the advocate is to assist a disabled person to speak up for themselves or, if the disabled person is unable to do so, to communicate and represent their views, wishes and feelings. Advocacy is, therefore, seen as a vital component of achieving independent living and full citizenship for disabled people.<sup>1</sup>
- 9.3 It is estimated that there are over 1,000 advocacy organisations in the UK.<sup>2</sup> Many are small local schemes and often user-led, whilst others are run and managed by larger charities such as Mind, Age UK and the Richmond Fellowship. Funding for advocacy comes primarily from statutory bodies, notably the NHS and local authorities. This is often supplemented by charitable funding from grant making trusts such as the Community Fund and Comic Relief. There are several regional and national advocacy networks, notably the Older Persons Advocacy Alliance, Voiceability and the UK Advocacy Network. Despite the large number of schemes, advocacy provision remains patchy. Some areas are well served but, in other parts of the country, advocacy services often lack sustained funding and are not easily accessible to certain groups, such as people from black and minority ethnic communities.<sup>3</sup>
- 9.4 There is no statutory regulation scheme for advocacy. However, the National Development Team for Inclusion has published the Advocacy Quality Performance Mark award. This is a quality assurance *kitemark* scheme that sets a number of standards (in conjunction with a code of practice) that advocacy providers must meet in order to receive the award. The scheme is voluntary, but is likely to be used by commissioners of advocacy services as a guarantee of the quality of services provided. It was launched in 2008 and over 80 organisations have received the award. The scheme covers advocacy under the Mental Capacity Act, as well as Care Act advocacy.

<sup>1</sup> Prime Minister’s Strategy Unit, *Improving the Life Chances of Disabled People* (2005) p 70.

<sup>2</sup> Advocacy Consortium UK, *Investigation into the Feasibility and Desirability of Developing a National Strategic Framework for Advocacy* (2009).

<sup>3</sup> Office for Disability Issues, *Access to Independent Advocacy: An Evidence Review* (2009) p 22.

### **The legal framework for advocacy support**

- 9.5 The provision of advocacy has been developed largely through Government policy initiatives.<sup>4</sup> However, there is also a comprehensive legal framework for advocacy in specialist fields which is summarised below.

#### ***The Independent Mental Capacity Advocate***

- 9.6 The Mental Capacity Act provides that, in certain cases, people who lack capacity are eligible for support from an Independent Mental Capacity Advocate. Outside the DoLS provisions, the Act requires local authorities to appoint an advocate if it is proposed that the person:

- (1) should receive “serious medical treatment”; or
- (2) be provided with long-term accommodation in a hospital or care home by the NHS or residential care by a local authority.<sup>5</sup>

- 9.7 These duties are triggered only where there is no person (other than a professional or paid carer) who can be consulted in determining the person’s best interests. In addition, the Act sets out powers to appoint an Independent Mental Capacity Advocate which arise where a review of accommodation is taking place (and there is no other person to consult) and in adult protection cases.<sup>6</sup>

- 9.8 The functions to be carried out by the advocates are set out in the regulations. For example, once instructed to act in a particular case, the advocate is required to interview the person, examine records and consult other individuals, in order to prepare a report for the person who instructed them.<sup>7</sup> The decision-maker is required to take the report into account when determining what action to take.<sup>8</sup> In effect, Independent Mental Capacity Advocates work with and support people who lack capacity, and represent their past and present wishes to those who are making best interests decisions.

#### **DOLS ADVOCACY**

- 9.9 The circumstances in which an Independent Mental Capacity Advocate can be appointed were significantly expanded by the DoLS. There are now three additional circumstances where the duty to appoint an advocate arises. The first, set out in section 39A of the Mental Capacity Act, arises when a person “becomes subject” to the DoLS and there is no person (other than a professional or paid carer) to consult in determining the person’s best interests. This includes people who are subject to an urgent authorisation or where a request has been made for a standard authorisation. However, the powers and duties of an

<sup>4</sup> For example, see, HM Government, *Valuing People Now: A New Three-Year Strategy for People With Learning Disabilities* (2009) para 4.5 and Department of Health, *A Vision for Adult Social Care* (2010) para 4.9.

<sup>5</sup> Mental Capacity Act 2005, ss 37 to 39.

<sup>6</sup> Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006, SI 2006 No 2883 and the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) Regulations 2007, WSI 2007 No 852.

<sup>7</sup> Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006, SI 2006 No 1832, reg 6.

<sup>8</sup> Mental Capacity Act 2005, ss 37(5), 38(5) and 39(6).

advocate do not apply under section 39A when a relevant person's representative has been appointed (save for certain powers to challenge the standard authorisation under section 21A).<sup>9</sup>

9.10 The second circumstance is set out in section 39C and arises when the appointment of a relevant person's representative comes to an end, and there is no person (other than a professional or paid carer) to consult in determining the person's best interests. The duty to appoint an Independent Mental Capacity Advocate ceases when a new relevant person's representative is appointed.

9.11 The third additional circumstance is set out in section 39D whereby an advocate must be appointed if an authorisation is in force and a relevant person's representative has been appointed (but who is not being paid to act as such), in one of the following circumstances:

- (1) a request is made by the person or representative to instruct an advocate; or
- (2) the supervisory body believes that unless an advocate is appointed the person and representative would be unable to exercise a relevant right, or have failed to exercise a relevant right when it would have been reasonable to exercise it, or would be unlikely to exercise a relevant right when it would be reasonable to exercise it.<sup>10</sup>

9.12 Unlike the other circumstances in which the duty to appoint an Independent Mental Capacity Advocate arises, the trigger for appointment under section 39D does not require that there be no other person to consult to determine the person's best interests. In addition, whilst the appointment of an advocate under section 39A or 39C is designed to be temporary, pending the appointment of a relevant person's representative, the appointment of an advocate under section 39D is intended to provide advocacy assistance alongside the appointment of an unpaid relevant person's representative.

9.13 It has been held that the functions to be carried out by Independent Mental Capacity Advocates – as set out in the 2006 regulations (see above) – do not extend to advocates appointed under sections 39A to 39D.<sup>11</sup> Instead, the functions of these advocates are set out in the relevant section and supplemented by schedule A1. For example, section 39D advocates are given a number of specific functions, such as helping the person and representative to:

- (1) understand the authorisation, any conditions, the DoLS assessments and the relevant rights; and
- (2) take steps to exercise the right to apply to court and exercise the right of review (if the person or representative wishes to do so).<sup>12</sup>

9.14 The role of the section 39D advocate differs from that of the other Independent

<sup>9</sup> See the discussion relating to the relevant person's representative below.

<sup>10</sup> Mental Capacity Act 2005, s 39D.

<sup>11</sup> *AJ v A Local Authority* [2015] EWCOP 5, (2015) 18 CCLR 158 at [107].

<sup>12</sup> Mental Capacity Act 2005, s 39D(7) to (9) and sch A1, paras 49 and 95.

Mental Capacity Advocates since section 39D does not relate to determining what is in the person's best interests, but helping the person and representative to understand and exercise their rights.<sup>13</sup> This is a much stronger and more forceful role compared to the other Independent Mental Capacity Advocate provisions, and is intended to support the individual in challenging decisions.

### **Care Act advocacy**

9.15 The right to a Care Act advocate is triggered if a local authority in England considers that, if an independent advocate were not available, an individual would experience "substantial difficulty" in one or more of the following:

- (1) understanding relevant information;
- (2) retaining that information;
- (3) using or weighing that information; or
- (4) communicating their views, wishes or feelings.<sup>14</sup>

9.16 Unlike the duty to appoint an Independent Mental Capacity Advocate, the trigger is not that a person lacks capacity – but rather that they need support to make decisions or communicate their wishes. In other words, without an advocate, they would fail a functional test of mental capacity. There is also a wider range of circumstances in which advocacy is made available, including needs assessments, carer's assessments, care and support planning and safeguarding enquiries.<sup>15</sup>

9.17 The role of the Care Act advocate is to represent and support the individual for the purpose of facilitating their involvement.<sup>16</sup> This goes much further than merely writing a report on the person's best interests. For example, an advocate must:

- (1) assist the individual in understanding the relevant function, communicating their views, wishes or feelings, understanding how their needs could be met by the local authority or otherwise, making decisions in respect of care and support arrangements, and challenging the local authority's decisions if the individual so wishes;
- (2) so far as is practicable, ensure that the individual understands the local authority's duties and the individual's rights and obligations under the Care Act;
- (3) make such representations as are necessary for the purpose of securing the individual's rights; and

<sup>13</sup> *AJ v A Local Authority* [2015] EWCOP 5, (2015) 18 CCLR 158 at [111].

<sup>14</sup> Care Act 2014, ss 67(4) and 68(3).

<sup>15</sup> As above, ss 67(3) and 68(1).

<sup>16</sup> As above, ss 67(2) and 68(2).

- (4) where the advocate has concerns about the assessment or planning function, prepare a report for the local authority outlining those concerns.<sup>17</sup>
- 9.18 Moreover, where the individual lacks capacity, the advocate must communicate the person's views, wishes or feelings, to the extent that the advocate can ascertain them, and challenge the decision if the advocate considers the decision to be inconsistent with the local authority's general duty under section 1 to promote the individual's well-being. The local authority is required to "take into account any representations" made by the advocate and "take reasonable steps to assist the independent advocate to represent and support the individual". The local authority is also required to provide an independent advocate with a written response to any report made.<sup>18</sup>

#### THE APPROPRIATE PERSON

- 9.19 In addition, the Care Act provides for the role of the "appropriate person". The duty to provide an advocate does not apply if the local authority is satisfied there is an appropriate person (who is not a professional or paid carer) to represent an adult. The adult must consent to being represented by that person, or where the adult lacks capacity to consent, the local authority must be satisfied that it would be in their best interests to be represented by that person.<sup>19</sup>
- 9.20 The statutory guidance sets out an expanded role for the appropriate person. It makes clear that the appropriate person is expected to undertake an active role and, therefore, that a person would be unlikely to be able to fulfil this role if he or she lives at distance or does not understand local authority processes. The statutory guidance sets out in no uncertain terms that:

It is not sufficient to know the person well or to love them deeply; the role of the appropriate individual is to support the person's active *involvement with the local authority processes*.<sup>20</sup>

- 9.21 It also should not be someone who expresses his or her own opinions before asking the adult or is linked to safeguarding concerns.<sup>21</sup>

#### SOCIAL SERVICES AND WELL-BEING (WALES) ACT 2014

- 9.22 Rights to advocacy are provided for under section 181 of the Social Services and Well-being (Wales) Act 2014 and are due to be implemented in April 2016. The relevant provisions are likely to be similar to those set out above in respect of

<sup>17</sup> Care and Support (Independent Advocacy Support) (No 2) Regulations 2014, SI 2014 No 2889, reg 4.

<sup>18</sup> As above, regs 5 and 6.

<sup>19</sup> Care Act 2014, ss 67(5) and (6) and 68(4) and (5).

<sup>20</sup> Department of Health, *Care and Support Statutory Guidance* (2014), paras 7.35 to 7.36 (emphasis in original).

<sup>21</sup> As above, paras 7.35 to 7.36 (emphasis in original).

Care Act advocacy and provide for the role of the appropriate person.<sup>22</sup>

### ***Independent Mental Health Advocates***

- 9.23 The Mental Health Act requires local authorities to make arrangements for Independent Mental Health Advocates to be made available to help “qualifying patients”. A qualifying patient includes all those liable to detention under the Act (except those subject to emergency short term detention), subject to guardianship, a community treatment order, and conditional discharge, and transferred from prison to hospital. In certain limited cases, informal patients will be qualifying patients (for example, in respect of treatment which requires consent and a second opinion).<sup>23</sup>
- 9.24 The role of the Independent Mental Health Advocate is to assist the patient in obtaining information about and understanding:
- (1) the provisions of the Act that make them a qualifying patient;
  - (2) any conditions or restrictions to which they are subject;
  - (3) what medical treatment is being given or proposed, and why;
  - (4) the authority under which the treatment is to be given; and
  - (5) the requirements under the Act which apply in connection with the giving of treatment.<sup>24</sup>
- 9.25 In addition, the Independent Mental Health Advocate should assist the patient in obtaining information about and understanding their rights under the Act and the rights of the nearest relative, and provide help in exercising those rights. To assist in undertaking this role, the Independent Mental Health Advocate has the right to visit a patient in private, to interview the medical staff and (with patient consent) to see the patient’s medical and social services records.<sup>25</sup>
- 9.26 The Mental Health (Wales) Measure 2010 places a duty on the Welsh Ministers to make arrangements for help to be provided by Independent Mental Health Advocates to qualifying compulsory and informal patients. This is a wider duty than the equivalent provision in England, which applies only to detained patients. The Measure also amends the Mental Health Act to provide that Independent Mental Health Advocates in Wales are among the group of professionals that must have regard to the *Mental Health Act Code of Practice*.

### **Discussion**

- 9.27 The case of *London Borough of Hillingdon v Neary* is illustrative of the transformative effect that advocacy can have. Mr Justice Jackson described the

<sup>22</sup> Welsh Government, *Code of Practice on the exercise of social services functions in relation to Advocacy under part 10 and related parts of the Social Services and Well-being (Wales) Act 2014 (Draft)* (2015).

<sup>23</sup> Mental Health Act 1983, ss 130A and 130C.

<sup>24</sup> As above, ss 130B(1).

<sup>25</sup> As above, ss 130B(2) and (3).

report produced by the section 39D Independent Mental Capacity Advocate as “an impressive document” and the first time professional support was given to the father’s arguments. It also pointed the way towards a different outcome for the person and was “the first best interests assessment that deserves the name”.<sup>26</sup> Access to advocacy support is therefore generally accepted to be crucial, not only to ensure that the person receives independent safeguards, but also to assert the person’s rights actively.

9.28 Nevertheless, evidence suggests that referrals for Independent Mental Capacity Advocacy are being restricted. The Department of Health reported that about a third of local authorities had not made a single section 39D referral all year, including some with over 100 DoLS authorisations, and there had been a 17% reduction in referrals.<sup>27</sup> The Care Quality Commission has been critical of local authority practices such as only instructing an advocate if recommended by a best interests assessor, and not instructing one even where there is disagreement between the person and the representative.<sup>28</sup>

9.29 The low number of section 39D referrals is particularly striking since local authorities have a proactive duty to make such referrals where otherwise the person and representative would struggle to exercise their rights. This is intended to make sure that rights are not denied merely because people are unaware of, or do not assert, them. However, the evidence suggests that in some cases this safeguard is ineffective. Indeed, in *London Borough of Hillingdon v Neary* the local authority’s failure to appoint a section 39D advocate in a timely fashion contributed towards the finding of a breach of the relevant person’s rights under article 5(4).<sup>29</sup> However, low referral rates are not just a problem for Independent Mental Capacity Advocates. The Care Quality Commission and the Health Select Committee, in response to the difficulties faced by qualifying patients in accessing Independent Mental Health Advocates, have called for “an opt-out rather than an opt-in service”.<sup>30</sup>

9.30 But even when advocates are instructed, evidence also suggests that few support the person to appeal their deprivation of liberty. According to the Care Quality Commission, only 32% of Independent Mental Capacity Advocates reported being involved in appealing against an authorisation to the Court of Protection and 46% had been asked to act as a litigation friend. It also found that advocates found the process “lengthy and dauntingly complex”.<sup>31</sup> The case of *AJ v A Local Authority* demonstrates the problems that can arise in this area. It concerned an older woman with dementia who had been placed in residential

<sup>26</sup> *Hillingdon LBC v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [123], [124] and [155].

<sup>27</sup> Department of Health, *The Sixth Year of the Independent Mental Capacity Advocacy (IMCA) Service: 2012/2013* (2014) pp 33 and 59 to 62.

<sup>28</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13* (2014) p 28.

<sup>29</sup> *Hillingdon LBC v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [202].

<sup>30</sup> Care Quality Commission, *Monitoring the Mental Health Act in 2012/13* (2014) p 31 and House of Commons Health Committee: *Post-legislative Scrutiny of the Mental Health Act 2007: First Report of Session 2013-14* (2013) HC 584, para 45.

<sup>31</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13* (2014) p 28.



care under a standard authorisation and, despite her known opposition to the placement, no legal challenge was made for several months. A critical reason was the lack of effective communication between her and the section 39D advocate. Mr Justice Baker said that the advocate should have acted more promptly in challenging the authorisation, and concluded that:

an IMCA appointed under section 39D must act with diligence and urgency to ensure that any challenge to an authorisation under schedule A 1 is brought before the court expeditiously. Failure to do so will lead to the evaporation of P's article 5 rights.<sup>32</sup>

- 9.31 The reasons for the failure to act promptly were many, including sick leave, high caseloads and confusion over taking on the role of litigation friend. There had also been a widespread misunderstanding amongst professionals that appeals should only be initiated or supported if they were in the person's best interests. Mr Justice Baker provided a clear statement that article 5(4) gives no room to deny access to a court based on best interests.<sup>33</sup>
- 9.32 A notable feature of the existing legal framework is the extent to which advocacy provision varies between the different pieces of legislation. For instance, the provision of Independent Mental Capacity Advocacy under the DoLS is restricted to a relatively small number of defined decisions and its role is limited to assisting decision-makers to reach best interests decisions (with the notable exception of section 39D advocacy). In contrast, Care Act advocacy has a wider role which is focused on helping people to understand and exercise their rights and challenge decision-makers. They are required to be instructed in a wider range of cases. Moreover, the Care Act advocacy duty is only disapplied if there is an appropriate person to represent and support the person – not merely on the basis that there is an appropriate person to consult about the person's best interests. This means that the appropriate person is similarly expected to play an active role in protecting and asserting the person's rights.
- 9.33 There is also significant overlap between the various advocacy roles, particularly the Care Act advocate and Independent Mental Capacity Advocates. Where a person who lacks capacity is receiving a needs assessment or a review of their care and support plan, they are eligible for a Care Act advocate. If the local authority is considering long-term residential accommodation, then the person also becomes eligible for an Independent Mental Capacity Advocate. Overlap also arises in safeguarding cases concerning people who lack capacity, where they might be entitled to a Care Act advocate and the local authority retains a power to appoint an Independent Mental Capacity Advocate. There is a danger that advocacy becomes atomised, leading to a lack of continuity of support and also potentially that activities become overlapping and duplicated.
- 9.34 Statutory guidance states that in such cases the same advocate can provide the support under each Act, and that commissioning arrangements should ensure that the advocate who is appointed is qualified to carry out both roles. But the advocate must meet the appropriate requirements for advocacy under the

<sup>32</sup> *AJ v A Local Authority* [2015] EWCOP 5, (2015) 18 CCLR 158 at [121] and [138].

<sup>33</sup> As above, at [88].

applicable legislation.<sup>34</sup> It is likely that undertaking a dual role will prove challenging when, on the one hand, the advocate will be expected to advise on a person's best interests (which may not necessarily be consistent with the person's wishes and feelings), but also help the person to challenge mental capacity assessments and best interests decisions if they relate to care planning.

### **Provisional view**

- 9.35 We consider it vital that independent advocacy continues to play a central role in our new scheme. We consider that, in all cases, an advocate should be instructed for those subject to protective care. This would not depend on a request being made by the person or someone else on their behalf, or the judgement of the supervisory body that the person would benefit from the support of an advocate. The person would, however, need to consent to support from the advocate or if the person lacks capacity to consent, it must be in the person's best interests for an advocate to be appointed. We envisage that the role of the advocate would be similar to that currently undertaken by the section 39D advocate. Many people subject to our scheme should already be entitled to some form of advocacy support under, for example, the Care Act or Mental Capacity Act. This will include many self-funders. But it would not include those in receipt of NHS continuing health care. The relevant legal provisions governing NHS continuing health care in England and in Wales do not include an equivalent right to advocacy. Therefore, while we anticipate some resource implications as a result of these proposals, it is expected that these will be minimal.
- 9.36 We also consider that there may be benefits in streamlining and consolidating advocacy provision across the Care Act and Mental Capacity Act.<sup>35</sup> There is currently potential for overlap and duplication of roles, and such reform might therefore secure efficiencies in advocacy provision. Our preference would be to replace Independent Mental Capacity Advocates with a single system of Care Act advocates and appropriate persons. We provisionally consider that Care Act advocacy and the role of the appropriate person have distinct advantages over other forms of advocacy (perhaps with the exception of section 39D DoLS advocacy), and therefore should be key elements of supportive care.
- 9.37 We would also be interested in consultees' views about the role of the appropriate person under supportive care, and specifically whether they should be given similar rights to advocates under the Care Act to access a person's medical and social services records. We are aware that access to information continues to be a major issue for families.

<sup>34</sup> Department of Health, *Care and Support Statutory Guidance* (2014) paras 7.9 and 7.65.

<sup>35</sup> References to Care Act advocacy and appropriate persons in this discussion should be taken to include the equivalent provisions which will be provided for under s 181 of the Social Services and Well-being (Wales) Act 2014

- 9.38 Whilst the remit of our review does not extend to the Mental Health Act, we would welcome views on whether Independent Mental Health Advocacy should also be replaced by a single system of Care Act advocates and appropriate persons. One particular difficulty might be the role of the nearest relative and how this would fit with the appropriate person. Our provisional view is that both roles could be accommodated since they are not sufficiently distinct and in many cases they could be undertaken by the same person.
- 9.39 We do recognise that best interests advocacy will continue to play a role when decisions are being made and the person has no-one else to represent his or her views and wishes. We think however that this role could easily be incorporated into the wider advocacy role under the Care Act, and indeed as noted above, Care Act advocates are already expected to undertake both roles if the person is eligible for an Independent Mental Capacity Advocate as well. We would however welcome further views on this point.
- 9.40 **Provisional proposal 9-1: an independent advocate or an appropriate person must be appointed for any individual subject to protective care. The individual must consent to such support or if the individual lacks capacity to consent, it must be in their best interests to receive such support.**
- 9.41 **Provisional proposal 9-2: the provision of advocacy should be streamlined and consolidated across the Care Act and Mental Capacity Act (in its entirety), so that Independent Mental Capacity Advocates would be replaced by a system of Care Act advocacy and appropriate persons.**
- 9.42 **Question 9-3: should the appropriate person have similar rights to advocates under the Care Act to access a person’s medical records?**
- 9.43 **Question 9-4: should Independent Mental Health Advocacy be replaced by a system of Care Act advocacy and appropriate persons?**

#### **THE RELEVANT PERSON’S REPRESENTATIVE**

- 9.44 Under the DoLS, once a standard authorisation has been granted, the supervisory body must appoint someone to act as the “relevant person’s representative” (the representative). Regulations specify that the representative must be chosen by the person themselves if the best interest assessor determines that the person has capacity to do so. If the person lacks capacity, the representative must be chosen by a donee of a lasting power of attorney or deputy appointed by the Court of Protection if it is within the scope of their authority. Otherwise the representative must be selected by the best interests assessor. If the best interests assessor decides there is no suitable person to act as the person’s representative, the supervisory body must appoint someone to perform this role in a professional capacity (a “paid representative”).<sup>36</sup>
- 9.45 The role of the representative is crucial in the DoLS process. Their formal duties include:
- (1) maintaining contact with the relevant person;

<sup>36</sup> Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person’s Representative) Regulations 2008, SI 2008 No1315, regs 8(5) and 9.

- (2) representing the relevant person in matters relating to, or connected with, the deprivation of liberty; and
- (3) supporting the relevant person in matters relating to, or connected with, the deprivation of liberty.<sup>37</sup>

9.46 In order to fulfil their role, the representative has rights:

- (1) for their views to be considered by best interests assessors conducting assessments;<sup>38</sup>
- (2) to be kept informed regarding any assessments or reviews;<sup>39</sup>
- (3) to request reviews of standard authorisations;<sup>40</sup> and
- (4) to apply to the Court of Protection without permission.<sup>41</sup>

9.47 The managing authority is responsible for monitoring the representative and reporting to the supervisory body on the extent to which they maintain contact with the person.<sup>42</sup> The regulations stipulate that the appointment of a representative should be terminated where the supervisory body is satisfied that the representative is “not maintaining sufficient contact” with the person or “is not acting in the best interests” of the person.<sup>43</sup>

#### **The nearest relative**

9.48 The role of the representative can be usefully compared to that of the “nearest relative” under the Mental Health Act. The nearest relative for each patient is identified by reference to a hierarchical list of “relatives” set out in section 26 of the Act. The nearest relative is identified by starting at the top of the list and – if there is no one in that category – working down.

9.49 The powers of the nearest relative include:

- (1) requiring that a Mental Health Act assessment takes place;<sup>44</sup>
- (2) making an application for compulsory hospital admission or guardianship;<sup>45</sup>

<sup>37</sup> Mental Capacity Act 2005, sch A1, paras 140 and 132.

<sup>38</sup> As above, para 49(6)(a).

<sup>39</sup> As above, paras 57(2)(a), 59(6), 65(3)(c), 108(1)(b), 120(1)(c) and 135(2)(d).

<sup>40</sup> As above, para 102.

<sup>41</sup> Mental Capacity Act 2005, s 50(1A).

<sup>42</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) paras 7.27 to 7.28.

<sup>43</sup> Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person’s Representative) Regulations 2008, SI 2008 No 1315, reg 13.

<sup>44</sup> Mental Health Act 1983, s 13(4).

<sup>45</sup> As above, ss 2 to 4.

- (3) blocking compulsory admission to hospital under section 3 or guardianship;<sup>46</sup> and
- (4) ordering discharge of the patient.<sup>47</sup>

## Discussion

- 9.50 There are several difficulties associated with the role of the representative under the DoLS. It has been argued that the powers of the representative are significantly weaker than those given to the nearest relative. For example, the representative has no power to block an application for a DoLS authorisation or discharge the person from the authorisation.
- 9.51 The person subject to an authorisation faces many practical obstacles initiating a formal challenge and will often be reliant on the representative to trigger a review or litigation on their behalf. Difficulties may therefore arise where a representative is unwilling or unable to initiate a challenge. In some cases, representatives may be cautious about “rocking the boat” with those whom they rely upon to commission or provide care for their loved ones. In other cases, the representative may agree with the professionals.
- 9.52 The latter was illustrated *AJ v A Local Authority* where the representative openly recognised that there was a potential conflict of interests. He was “unwilling or at least very reluctant” to represent or support the person in challenging the authorisation because he and his wife had concluded that they could no longer safely look after her at home and he believed that it was in her best interests to live in residential care. The court held that as a result of its positive obligations under article 5(4), local authorities should scrutinise carefully the selection and appointment of representatives in such circumstances.<sup>48</sup> Ultimately, it is open to the supervisory authority to appoint a new representative. It has been reported that following the decision in *AJ v A Local Authority*, local authorities are increasingly appointing paid representatives, leading some to question whether the supply of paid representatives can meet this demand.<sup>49</sup>
- 9.53 There are also difficulties associated with the appointment process. If the person lacks capacity to choose his or her own representative, it has been suggested that close relatives who oppose the DoLS authorisation are being passed over in favour of paid representatives, or other relatives who support it.<sup>50</sup> The Department of Health has recognised these issues and cautioned supervisory bodies against avoiding challenges by appointing only representatives who

<sup>46</sup> As above, s 11(4).

<sup>47</sup> As above, ss 23 and 25.

<sup>48</sup> *AJ v A Local Authority* [2015] EWCOP 5, (2015) 18 CCLR 158 at [84] and [137].

<sup>49</sup> A McNicoll, *Deprivation of liberty: Court ruling leaves councils struggling to find representatives for people lacking capacity* (2015), see: <http://www.communitycare.co.uk/2015/06/10/deprivation-liberty-court-ruling-leaves-councils-struggling-find-representatives-people-lacking-capacity/?cmpid=NLC|SCSC|SCDDB-2015-0610> (last visited 22 June 2015).

<sup>50</sup> Mental Health Alliance, *Briefing Paper 1: Deprivation of Liberty Safeguards: An Initial Review of Implementation* (2012) p 10.

support the deprivation of liberty.<sup>51</sup>

- 9.54 As we noted in chapter 2, very few DoLS reviews are initiated by the representative. There are many possible explanations for this, including the appointment process and a reluctance to seek reviews for fear of damaging their relationship with the managing authority and supervisory body, and facing a reduction in care and support provision as an outcome of the review. However, this suggests that the safeguard is not always as effective as it should be.
- 9.55 Finally, it has been suggested that in practice managing authorities rarely monitor the effectiveness of the representative or how much contact they have with the person. Indeed, some managing authorities appear to have been unaware that this was their role.

### **Provisional view**

- 9.56 Currently, the role of the relevant person's representative is limited to cases where the person is subject to a DoLS authorisation. We do not propose to extend this role to people subject to supportive care. We have already provisionally proposed above that people subject to supportive care should have the right to be supported by an advocate or an appropriate person.
- 9.57 However, we do provisionally propose to maintain the role of the relevant person's representative for people subject to restrictive care and treatment. In cases where an advocate has been appointed, we think that the appointment of a representative will help to ensure that the important role of the family, friends or carers is recognised. However, we do not propose to maintain the paid representative role. In cases where there is no person suitable to act as the representative, we consider that an advocate should be appointed.
- 9.58 In cases where an appropriate person has been appointed we also do not propose that a representative should always be appointed. This is because otherwise it is likely that in many cases the same person would be appointed to both roles, which are very similar. However, it is possible that in some individual cases the additional support of a representative may be helpful, and we therefore provisionally propose that the Approved Mental Capacity Professional should have discretion to appoint a representative where this would improve the person's outcomes.
- 9.59 We have also considered whether the role of the representative should be enhanced, for example by introducing similar powers to those given to the nearest relative. However, this is not straightforward. Unlike under the Mental Health Act, actions taken on behalf of the relevant person must be in their best interests. Therefore, the representative could not, for example, discharge the person from a deprivation of liberty or block an application for a DoLS authorisation unless this was in the best interests of the person, in which case the detention would be unlawful anyway. But we would welcome views on whether any new powers could usefully be introduced.

<sup>51</sup> Department of Health, *The Mental Capacity Act 2005 – Deprivation of Liberty Safeguards – The Early Picture* (2010) para 11.

- 9.60 Where an appropriate person has been appointed for the person (rather than an advocate) we provisionally do not consider that the legislation should require the appointment of a relevant person's representative. This is because it is likely that in many cases the appropriate person and the representative would be the same person. But the Approved Mental Capacity Professional would retain the ability to appoint a representative in these circumstances, for instance if the person requested this or it would otherwise be appropriate to the circumstances of the case.
- 9.61 We have considered whether it is necessary to reform the way in which a representative is appointed. One possibility might be to adopt a statutory list of relatives which offers supervisory bodies very little discretion in who they appoint as the person – such an approach is taken for the appointment of the nearest relative. This could be used if the person lacked capacity to consent to the appointment of the person and there was no donee or deputy to make this decision. Another might be to use a statutory list but to allow the person to exercise a right of veto for any person they do not want. If they get to the bottom of the list, a paid representative could be appointed.
- 9.62 On balance we have provisionally concluded not to introduce such reform. The use of such a list has been widely criticised for being a “lottery” which can produce the best person for this role or the worst. For some relatives this can be a “burdensome imposition”.<sup>52</sup> This might be addressed by some form of process of applying through the county court to displace the nearest relative with someone more appropriate. However, under the Mental Health Act this can be a complex and protracted process which may appear daunting to most people, let alone someone who might lack mental capacity and is deprived of liberty. The identification of a nearest relative can also be unclear – particularly when more than one person falls within a single category. The identification rules are rooted in the 1950s and reflect many of the assumptions about the structure and role of the family that were prevalent in that period.
- 9.63 We also propose that responsibility for monitoring the effectiveness of the representative should be given to the Approved Mental Capacity Professional (currently known as the best interests assessor – see chapter 7). We would welcome views on whether there should also be a requirement on the institution where the person is living to report back to the Approved Mental Capacity Professional on the contact between the person and the appropriate person.
- 9.64 **Provisional proposal 9-5: a “relevant person’s representative” should be appointed for any person subject to the restrictive care and treatment scheme (or the hospital scheme) and who is being represented by an advocate. The person must consent to being represented by the representative, or if they lack capacity to consent, it must be in the person’s best interests to be represented by the representative.**
- 9.65 **Provisional proposal 9-6: where there is no suitable person to be appointed as the representative, the person should be supported by an advocate or appropriate person.**

<sup>52</sup> T Spencer-Lane, “The Nearest Relative and Nominated Person: A Tale of Parliamentary Shenanigans” (2011) *Journal of Mental Health Law* (Spring) 156.

- 9.66 **Provisional proposal 9-7: the Approved Mental Capacity Professional (currently best interests assessor) should have discretion to appoint a representative where the person is being supported by an appropriate person.**
- 9.67 **Provisional proposal 9-8: the Approved Mental Capacity Professional (currently best interests assessor) should be required to monitor the relevant person's representative and ensure they are maintaining contact with the person.**
- 9.68 **Question 9-9: does the role of relevant person's representative need any additional powers?**
- 9.69 In this chapter we have made a number of provisional proposals concerning the role of advocacy and the relevant person's representative. Currently people subject to the DoLS are provided with support from a professional (the section 39D Independent Mental Capacity Advocate) and a non-professional (the relevant person's representative). Where there is no suitable person to be the representative, the person is supported by a paid representative. The underlying policy intention appears to be that most people should be supported by a professional and a non-professional, and where this is not possible a paid representative should be appointed.
- 9.70 Our provisional proposals would alter this position by allowing people to be supported by a professional, or by a non-professional, or by both, according to the circumstances. Under restrictive care and treatment, people would be provided with support from an advocate (whether a professional advocate or an appropriate person). Where a professional advocate is provided, they would also be eligible for an unpaid relevant person's representative. In effect we have now provided that everyone will be supported by some form of advocate, rather than by some form of representative. We would welcome views on whether this is the right approach.
- 9.71 There is some overlap between the roles of the advocate and the relevant person's representative, for example both involve representing and supporting the person in matters relating to the authorisation. This overlap would continue under our proposed scheme. Moreover, in chapter 12 we discuss the role of a professional or non-professional "supporter" who might assist a person to make a particular decision, which could also overlap with the role of the advocate and relevant person's representative. We would like to examine further whether some of these roles could be simplified or streamlined. Our review does provide an opportunity to rethink some of these premises and consider what form of support would be more beneficial for the person concerned and their family.
- 9.72 **Consultation question 9-10: should people always where possible be provided with an advocate and a relevant person's representative, and could these roles be streamlined?**



# CHAPTER 10

## THE MENTAL HEALTH ACT INTERFACE

- 10.1 In England and Wales, the non-consensual care and treatment of people with mental health problems is governed largely by two parallel legal schemes – the Mental Health Act and the Mental Capacity Act. In very broad terms, the Mental Health Act provides for detention based on protection of the patient and the public, and irrespective of mental capacity. The Mental Capacity Act applies only to those who lack capacity, and deals with the person’s best interests and the consideration of less restrictive alternatives. But there is considerable overlap between the two regimes, and the relationship can be extremely complex.
- 10.2 This chapter considers the interface between our new scheme and the Mental Health Act. It first of all considers schedule 1A to the Mental Capacity Act, which provides the legal basis of the existing interface between the DoLS and the Mental Health Act, and discusses the development of case law in this area. Finally, it sets out the options for reform in our new scheme.

### SCHEDULE 1A

- 10.3 The provisions governing the “eligibility” requirement are contained in schedule 1A to the Mental Capacity Act. In simplified terms, a person is ineligible for the DoLS in any of the following five cases:
- (1) Case A: detained patients – the person is detained in hospital under the Mental Health Act, or another similar enactment;<sup>1</sup>
  - (2) Case B: patients on leave of absence or conditional discharge – where they are subject to a requirement which would be inconsistent with the DoLS authorisation, or the DoLS authorisation would be for medical treatment for mental disorder in hospital;
  - (3) Case C: patients subject to a community treatment order – where they are subject to a requirement which would be inconsistent with the DoLS authorisation, or the DoLS authorisation would be for medical treatment for mental disorder in hospital;
  - (4) Case D: people subject to guardianship – where they are subject to a requirement which would be inconsistent with the DoLS authorisation, or the DoLS authorisation would be for medical treatment for mental disorder in hospital (and the person objects, or a donee/deputy does not consent); and
  - (5) Case E: people “within the scope” of the Mental Health Act and objecting to the proposed psychiatric treatment.
- 10.4 It is the final category (case E) that has caused professionals and the courts most difficulties. First, the DoLS assessor must decide if the person is “within the scope” of the Mental Health Act. This depends on whether the person could be detained under sections 2 or 3 of that Act. The assessor is required to assume that two

medical recommendations have been provided and that the treatment cannot be given under the Mental Capacity Act.<sup>2</sup> The assessor should not consider what a reasonable doctor would decide, or whether the person would inevitably be admitted.<sup>3</sup>

- 10.5 The assessor must then determine whether the DoLS authorisation would authorise the person to be a “mental health patient” (defined as a person accommodated in a hospital for the purpose of being given medical treatment for a mental disorder). In *GJ v The Foundation Trust*, Mr Justice Charles held that assessors should apply the “but for” test. Put simply, this test provides that if “but for” their *physical* treatment needs the person would not be detained, they are eligible under DoLS. This test would also, in general, determine whether the person was within the scope of the Mental Health Act.<sup>4</sup>
- 10.6 The assessor is then required to establish whether the person objects to being a mental health patient or to some or all of the proposed mental health treatment. If so, they are ineligible for the DoLS.<sup>5</sup> Some objections are verbal and persistent. But other cases are not so clear-cut. In deciding whether a person objects, consideration must be given to all the circumstances including their behaviour, wishes, views, beliefs, feelings and values, including those expressed in the past to the extent that they remain relevant.<sup>6</sup> The *DoLS Code of Practice* states that “if there is reason to think that a person would object if able to do so, then the person should be assumed to be objecting”. The assessor’s role is simply to establish whether the person objects or not, and not to consider whether any objection is reasonable.<sup>7</sup>
- 10.7 The Department of Health has confirmed that its policy intention in respect of case E was to treat people who lack capacity but who are objecting to being admitted in the same way as people who have capacity and are refusing to consent to mental health treatment. If it is necessary to detain the former category of people in hospital, and if they would be so detained if they had capacity to refuse treatment, then the Mental Health Act should be used in preference to the DoLS.<sup>8</sup>
- 10.8 In *GJ v The Foundation Trust*, Mr Justice Charles undertook a lengthy and detailed analysis of the relationship between the Mental Health Act and the DoLS. In the context of discussing case E, he concluded that the Mental Health Act has “primacy” in the sense that decision-makers should approach the questions relating to the application of the Mental Health Act on the basis of an assumption

<sup>1</sup> For example, the Criminal Procedure (Insanity) Act 1964.

<sup>2</sup> Mental Capacity Act 2005, sch 1A, para 12.

<sup>3</sup> *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam), [2010] Fam 70 at [80].

<sup>4</sup> As above, at [87] to [90].

<sup>5</sup> Mental Capacity Act 2005, sch 1A, para 5(4).

<sup>6</sup> As above, sch 1A, paras 5(6) to (7).

<sup>7</sup> Ministry of Justice, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) paras 4.46 to 4.47.

<sup>8</sup> *DN v Northumberland Tyne and Wear NHS Foundation Trust* [2011] UKUT 327, (AAC), [2011] MHLR 249 at [18].

that an alternative solution is not available under the DoLS. In essence, mental health professionals cannot pick and choose between the two statutory regimes as they see fit having regard to general considerations such as the preservation or promotion of a therapeutic relationship with the person.<sup>9</sup>

10.9 If the person is within the scope of the Mental Health Act and does not object (and so does not fall within case E), assessors can choose whether to use the Mental Health Act or DoLS. In *AM v South London and Maudsley NHS Foundation Trust*, Mr Justice Charles considered that in such circumstances decision-makers must consider three cumulative questions:

- (1) Does the person have capacity to consent to admission as an informal patient? If the person has capacity then the Mental Capacity Act is irrelevant, and the Mental Health Act will be determinative;
- (2) Can the hospital rely on the Mental Capacity Act to assess or treat the person lawfully? This question involves first considering if the person will comply with what is being proposed. Generally the DoLS regime does not apply to a non-compliant incapacitated person. But if the person is compliant, the assessor should consider whether the person “is or is likely to be” deprived of liberty and if so, whether the person is eligible for the DoLS and if an authorisation is required; and
- (3) If there is a choice between detention under the Mental Health Act or DoLS, which is the least restrictive way of achieving the proposed assessment or treatment? This will involve a “fact sensitive approach”, having regard to all the relevant circumstances, to the necessity test as between the choices that are available. But it was accepted that it will generally but not always be more appropriate to rely on the DoLS in such circumstances.<sup>10</sup>

## Discussion

10.10 At first blush, the interface between the Mental Health Act and DoLS appears to be relatively straightforward in cases A to D. These cases relate to people currently subject to the Mental Health Act or similar enactments, and their effect is to prevent the DoLS being used to achieve an outcome that is already provided for by the Mental Health Act. However, recent court decisions suggest that complexities can arise even in these cases. For example, in *A Local Health Board v AB* it was held that the Court of Protection could not exercise its powers to authorise a deprivation of liberty in respect of a Mental Health Act patient who required surgery for physical health problems (and was placed on section 17 leave for this purpose) – and instead the court had to fall back on the inherent jurisdiction of the High

<sup>9</sup> *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam), [2010] Fam 70 at [58] to [59]. He went on to suggest at [61] that the primacy principle was also evident in cases A to D. However he subsequently clarified that his comments were limited to case E, see *AM v South London and Maudsley NHS Foundation Trust* [2013] UKUT 0365 (AAC) at [78].

<sup>10</sup> *AM v South London and Maudsley NHS Foundation Trust* [2013] UKUT 0365 (AAC).

Court.<sup>11</sup> We would welcome further views on the practical and legal issues that arise in respect of cases A to D.

10.11 We are also aware of concerns about the use of dual authorisation in cases A to D – where the person is made subject to the DoLS in addition to being on leave of absence, conditional discharge, a community treatment order or guardianship. The case of *KD v A Borough Council* considered the jurisdiction of the First-tier Tribunal (Mental Health) when a person is subject concurrently to the DoLS and guardianship, and set out a checklist of factors that the tribunal should consider when deciding whether a patient should be discharged from guardianship on the basis that an alternative care regime is available involving the Mental Capacity Act.<sup>12</sup> It is possible that the practice of dual authorisation has increased post *Cheshire West* as more people who are subject to a community treatment order or guardianship may also be deprived of liberty as the concept is now understood; this cannot be authorised by the community treatment or guardianship provisions and therefore the DoLS are used for this purpose. It may also work the other way where, for example, leave of absence or guardianship is added to the DoLS because they contain explicit conveyance and return powers which are missing from the DoLS. This seems unsatisfactory, not just because of the additional bureaucracy and duplication, but also because of the confusion and conflict that can arise. We would welcome consultees' views on the use of dual authorisations.

10.12 Notwithstanding the complex issues that can occur in cases A to D, most of the interface problems arise in respect of case E. The key problem is that DoLS assessors are expected to make a speculative determination about the availability of an alternative detention regime, a matter which will ultimately be decided by different assessors. This is not only a difficult determination to make, but is also one that will not necessarily reflect the decision which is actually taken by those assessors. The decision to detain under the Mental Health Act is a power, not a duty, if the relevant criteria are met. It is therefore possible for a person to be “within the scope” of the Mental Health Act but not detained. For example, the treatment team might decide that detention under the Mental Health Act would damage the therapeutic relationship irrevocably and that the person's carers could look after the person. This would mean that the person is not detained under the Mental Health Act but is ineligible for the DoLS.

10.13 Whether this indicates a deficiency or a gap in the law is debatable. An outcome where the person has not been detained under the Mental Health Act and is ineligible for the DoLS is not in itself irrational. At least one assessor has concluded that detention is not necessary – and normally this conclusion will have been reached following discussion with the other assessors, the person's nearest relative and a treatment team.<sup>13</sup> However, difficulties will arise if the reason the person has not been detained under the Mental Health Act is that the clinician has concluded that the DoLS should be used instead. This can lead to an impasse

<sup>11</sup> *A Local Health Board v AB* [2015] EWCOP 31. However, the validity of this decision has been questioned by some commentators – see for example 39 Essex Chambers, *Mental Capacity Law Newsletter June 2015: Issue 57 (Court of Protection: Health, Welfare and Deprivation of Liberty)* (2015) pp 2 to 6.

<sup>12</sup> *KD v A Borough Council* [2015] UKUT 0251 (ACC). See also *NM v Kent County Council* [2015] UKUT 125 (ACC).

<sup>13</sup> The role of the “nearest relative” is discussed in chapter 9.

between the two sets of assessors, and a potential gap in the law.

- 10.14 As set out above, the reason for the blanket non-availability of the DoLS in case E is the Department of Health's policy that objecting incapacitated people should generally be treated like objecting capacitated people and, therefore, where detention is necessary, the Mental Health Act should be used. However, an alternative policy position – that objecting incapacitated people should be treated in the same way as compliant incapacitated people – is not implausible. This would allow clinicians to pick and choose between the different regimes, based on the individual circumstances of the case and the least restrictive way of achieving the proposed assessment or treatment.<sup>14</sup> Notwithstanding the comments of Mr Justice Charles in *GJ v Foundation Trust* regarding the present position under the legislation, there is no obvious reason why the preservation or promotion of a therapeutic relationship should not be a relevant consideration.
- 10.15 However, such an approach would inevitably raise questions about which system provides greater safeguards and other advantages for the person deprived of liberty. For instance Mental Health Act patients are subject to protections concerning the provision of medical treatment, such as a requirement to obtain a second medical opinion from a doctor, and are protected by the powers given to their nearest relative, for example to discharge them or to block compulsory admission to hospital. Moreover, in some cases, Mental Health Act patients will be eligible for after-care services which must be provided free-of-charge (see chapter 15).
- 10.16 On the other hand, the use of the Mental Health Act can be perceived negatively and carry a stigma. This supports the view that generally the Act will be more “restrictive” than a DoLS authorisation.<sup>15</sup> We also consider that our proposed new scheme would offer many important safeguards for the person, including oversight of assessments and care planning (see chapter 6), rights to advocacy or an appropriate person (see chapter 9) and protections when restrictive care and treatment is being considered – including the use of conditions (see chapter 7).

### **Provisional view**

- 10.17 We have considered several options for the interface between our scheme and the Mental Health Act. First, we could retain and clarify the existing interface. In doing so, it is important to emphasise that we would not wish to preserve the current drafting of schedule 1A, which is widely viewed as impenetrable. We would also seek to codify elements of the interface and thereby reduce the need for case law in this area. We are concerned that the case-law has too often sought to impose additional, and sometimes unnecessary, check-lists for decision-makers which have complicated the interface further. Our intention would be to draft more straightforward and less elaborate statutory provisions which nevertheless do maintain the existing intended policy. However, we are concerned that, under this option, the interface would (at least in respect of case E) continue to be based on a speculative decision about the use of the Mental Health Act. We are also concerned that ruling out the DoLS for all people within the scope of the Mental Health Act may limit unnecessarily the available admission and treatment options.

<sup>14</sup> *AM v South London and Maudsley NHS Foundation Trust* [2013] UKUT 0365 (AAC).

<sup>15</sup> As above, at [65].

We have therefore provisionally discounted this option.

- 10.18 A second option would be to retain the existing interface but seek to establish a process for determining disputes over case E patients. For instance, the legislation could make clear that once a firm decision has been made that a person will not be detained under the Mental Health Act, they automatically become eligible for our new scheme.
- 10.19 Thirdly, we could provide that an objecting incapacitated person is in the same position as a compliant incapacitated person. In other words, decision-makers could choose whether to use the Mental Health Act or the new scheme, by considering the least restrictive way of achieving the proposed assessment or treatment. Arguably, this option would maximise clinical discretion and flexibility, and enable decisions to be tailored to the individual circumstances of the case. It would also mean that options are not closed off unnecessarily.
- 10.20 However, we have provisionally decided not to take forward these options. Under all of them, disputes could still arise between the two sets of assessors over which regime is most appropriate (although it might be possible to empower the same panel of assessors to carry out both assessments at the same time). Options two and three could lead to inconsistent outcomes – for example, two patients could be treated under different regimes even though their condition and circumstances are not objectively different. There may be a perception that decisions are being driven by non-clinical reasons, such as the rejection of the Mental Health Act to avoid the financial implications of free after-care services under section 117. Finally, in respect of option three, we are concerned that the choice between the two regimes could be settled by reference to the least restrictive way of achieving the proposed assessment or treatment. This does not appear to be a clear or meaningful test for choosing the appropriate scheme. It is difficult to see how, for instance, the Mental Health Act would offer a less restrictive alternative if the hospital care plan were the same as it would be under our new scheme (or vice versa). We would however welcome views on all these points.
- 10.21 Our provisionally preferred option would be to construct a solution based in the Mental Health Act. Since case E exclusively concerns mental health patients, and the Mental Health Act already provides a comprehensive scheme in this respect, we consider it would be more rational to extend the Act to enable all necessary deprivations of liberty for mental health patients for the purposes of mental health treatment. This would mean that our new scheme could not be used to authorise the detention in hospital of incapacitated people who require treatment for a mental disorder. Instead, there would be a new mechanism under the Mental Health Act to enable the admission to hospital of compliant incapacitated patients in circumstances that amount to deprivation of liberty, while those who are objecting could be detained under the existing provisions of the Mental Health Act. This would remove the issues of objection and treatment, and the purpose of the admission, and hopefully establish a clear-cut interface.
- 10.22 One of the main difficulties at present is that a person cannot be detained under the Mental Health Act without invoking the treatment powers and all the other safeguards, which clinicians are understandably reluctant to do if the patient is compliant. We therefore provisionally propose that the Mental Health Act be amended to include a lower-level power to deal with such cases. We envisage that

the safeguards would be similar to those provided to incapacitated compliant supervised community treatment patients who have not been recalled to hospital (Part 4A of the Mental Health Act), and would consist of:

- (1) the right to a Mental Health Act Advocate;
- (2) a power to provide treatment if a donee of a lasting power of attorney, a deputy, or the Court of Protection consents to the treatment on the person's behalf;<sup>16</sup>
- (3) a requirement that treatment cannot be given under this power if it is contrary to a valid advance decision or if force is needed to administer it;
- (4) a requirement that a second medical opinion is needed for certain treatments including medication;
- (5) rights for the patient and the nearest relative to seek a review of the treatment plan; and
- (6) rights to apply to the mental health tribunal for an order to discharge the patient.

10.23 This new provision could be achieved by introducing a new admission process under the Mental Health Act, or by amending the guardianship provisions to enable this to happen. However, it is likely that if guardianship were used for this purpose it would require substantial amendments in order to ensure it was compliant with the European Convention on Human Rights. We provisionally consider that a discrete admissions process would be preferable to the use of guardianship, but we welcome further views on this point.

10.24 Under our proposed approach it would be necessary to address the position of people with learning disabilities who require mental health treatment. Whereas section 2 of the Mental Health Act can be used to detain such people (assuming the other criteria are met), section 3 and guardianship cannot be used unless the learning disability is "associated with abnormally aggressive or seriously irresponsible conduct".<sup>17</sup> We would envisage that any new informal admission process (or the use of guardianship for this purpose) would be available for all people with learning disabilities who require mental health treatment. However, we would not propose to amend the section 3 or guardianship criteria. We welcome further views on this issue.

10.25 It is also necessary to consider the position of Mental Health Act patients outside hospital (cases A to D). One possibility would be to adopt a principle that all community powers under the Mental Health Act should be self-contained and article 5 compliant. This would entail amending, for example, conditional discharge and guardianship so that they can authorise deprivations of liberty. However, this may not be popular given that concern has been raised about the increasing numbers of patients being placed on community treatment orders and generally

<sup>16</sup> See the discussion of powers of attorney and deputies in chapter 13.

<sup>17</sup> Mental Health Act 1983, s 1(2A).

the “infiltration” of the Mental Health Act into the community.<sup>18</sup> Alternatively, community powers could be left as they are and the use of dual authorisation could continue. We would welcome further views on these options.

10.26 There is of course a further more radical option, which would be to fuse together mental health and mental capacity law into a single legislative framework. In effect, there would be no provision for the compulsory detention and treatment of those with mental health problems who have capacity to make the relevant decision, but refuse. The care and treatment of those with mental disorders will be on precisely the same best interests basis as all other forms of decision-making for those who have capacity. This approach has been proposed for Northern Ireland where the draft Mental Capacity Bill, if implemented, would mean that for the first time anywhere, there would be a single statute governing all decision-making in relation to the care, treatment (for a physical or mental illness) or personal welfare of a person aged 16 or over, who lacks capacity to make a specific decision.<sup>19</sup> The Northern Ireland Mental Health Order 1986 would no longer apply to those aged 16 or over. This model could clearly be seen as attractive in law reform terms, but as the Department of Health has no plans currently to pursue this option, we see no point in taking it forward.

10.27 **Provisional proposal 10-1: the Mental Health Act should be amended to establish a formal process for the admission of people who lack capacity and who are not objecting to their care and treatment. The safeguards provided would include an independent advocate, a requirement for a second medical opinion for certain treatments and rights to appeal to the mental health tribunal. The Mental Capacity Act (and our new scheme) could not be used to authorise the hospital admission of incapacitated people who require treatment for mental disorder.**

<sup>18</sup> See, for example, House of Commons Health Committee, *Post-legislative Scrutiny of the Mental Health Act 2007: First Report of the session 2013-14 (2013) HC 584*, paras 71 to 94.

<sup>19</sup> Department of Justice of Northern Ireland, *Consultation on the Proposals for New Mental Capacity Legislation for Northern Ireland*, see: <http://www.dojni.gov.uk/Consultation-on-proposals-for-new-Mental-Capacity-Legislation-for-Northern-Ireland> (last visited 22 June 2015).



# CHAPTER 11

## RIGHT TO APPEAL

11.1 We envisage that people subject to our new restrictive care and treatment scheme will have the right to challenge their care and treatment arrangements before a judicial body. This will include people who are deprived of liberty for the purposes of article 5 of the European Convention on Human Rights. Under the DoLS this role is performed by the Court of Protection. This chapter considers whether the Court should perform a similar role in relation to restrictive care and treatment, or whether there would be merit in establishing a system of appeal to a tribunal. In order to do this we compare the role of the Court of Protection with the Mental Health Tribunal that operates under the Mental Health Act. This chapter also considers a number of other issues relevant to the role of the court.

### THE COURT OF PROTECTION

11.2 Section 21A of the Mental Capacity Act gives the Court of Protection powers in relation to the DoLS. These powers are wide-ranging and not limited to reviewing whether the criteria for detention are satisfied. Once an urgent or standard authorisation has been granted, the Court may determine:

- (1) whether the urgent authorisation should have been given;
- (2) whether the person meets one or more of the qualifying requirements for a standard authorisation;
- (3) the period during which the authorisation is to be in force;
- (4) the purpose for which the authorisation is given; and
- (5) the conditions subject to which the standard authorisation is given.<sup>1</sup>

11.3 Having determined any of the above matters, the court may make an order varying or terminating the authorisation, or directing the supervisory body (for standard authorisations) or managing authority (for urgent authorisations) to do so.<sup>2</sup> Sir Nicholas Wall, a former President of the Family Division, has emphasised that in DoLS cases “the Court cannot simply act as a rubber stamp, however beneficial the arrangements may appear to be for the individual concerned”.<sup>3</sup>

11.4 Under its general powers, the Court may also make a declaration as to whether a person lacks or has capacity to make any decision. If the person lacks capacity, the Court can make decisions on the person’s behalf in relation to personal welfare, property and affairs.<sup>4</sup> For example, in *CC v KK*, the Court of Protection considered that, despite medical and psychiatric opinion that the relevant person lacked capacity, she had not been presented with “detailed options” so that her

<sup>1</sup> Mental Capacity Act 2005, ss 21A(1), (2) and (4).

<sup>2</sup> As above, s 21A(3) and (5).

<sup>3</sup> *A v A Local Authority* [2011] EWHC 727 (Fam), [2011] 2 FLR 459 at [15].

<sup>4</sup> Mental Capacity Act 2005, ss 15 and 16.

capacity to weigh up those options could be fairly assessed. On the facts, it was found that the local authority had failed to prove that she lacked capacity to make decisions as to where she should live.<sup>5</sup>

- 11.5 Whilst any person may apply to the Court of Protection, permission is required to initiate proceedings unless the applicant is the relevant person or their representative.<sup>6</sup> However, Mr Justice Mostyn has observed that the test for the grant of permission “does not appear unduly high in practice”.<sup>7</sup> The managing authority is required to take steps to ensure that the person understands his or her right to make an application under section 21A.<sup>8</sup> A similar duty is placed on any section 39D Independent Mental Capacity Advocate.<sup>9</sup> Legal aid for the person and their representative in proceedings under section 21A is not subject to a means test, but is subject to a merits test.<sup>10</sup>
- 11.6 Unlike under the Mental Health Act, there is no system of automatic referrals to the Court. However, in *London Borough of Hillingdon v Neary* it was held that “significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection”. Moreover, Strasbourg and domestic case law make it clear that there is a positive duty on public authorities to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of their detention reviewed speedily by a court.<sup>11</sup>
- 11.7 In order to ensure that a person’s article 5(4) rights are respected, the DoLS rely on the person themselves, their representative, or the section 39D Independent Mental Capacity Advocate to take steps to challenge the authorisation. Where the person objects to their continued deprivation of liberty, but is not assisted by the representative in exercising the right to challenge the authorisation, the local authority can appoint a different representative (including a paid representative). As a last resort, the supervisory body should consider bringing proceedings before the court itself.<sup>12</sup>

## **MENTAL HEALTH TRIBUNALS**

- 11.8 In England, the tribunal that hears applications and references in respect of patients who are subject to the powers of the Mental Health Act is now the First-tier Tribunal established under the Tribunals Courts and Enforcement Act 2007. The jurisdiction is located in the Health, Education and Social Care Chamber of the tribunal and is referred to as the First-tier Tribunal (Mental Health). There is a

<sup>5</sup> *CC v KK* [2012] EWHC 2136 (COP) at [68] and [74].

<sup>6</sup> Mental Capacity Act 2005, ss 50(1) and (1A).

<sup>7</sup> *AB v LCC* [2011] EWHC 3151 (Fam) at [30].

<sup>8</sup> Mental Capacity Act 2005, sch A1, paras 59 and 83.

<sup>9</sup> As above, ss 39D(7)(f) and (g).

<sup>10</sup> Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013, SI 2013 No 480, reg 5(1)(g), and Legal Aid, Sentencing and Punishment of Offenders Act 2012, sch 1, pt 1.

<sup>11</sup> *Hillingdon LBC v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [33] and [202].

<sup>12</sup> *AJ v A Local Authority* [2015] EWCOP 5, (2015) 18 CCLR 158 at [126].

separate Mental Health Review Tribunal for Wales. The Upper Tribunal, established under the 2007 Act, hears appeals against decisions made by the First-tier Tribunal or the Mental Health Review Tribunal for Wales on a point of law.

- 11.9 The main purpose of the tribunal is to review the cases of detained and conditionally discharged patients and patients subject to community treatment orders, and to direct the discharge of any patient where it thinks it appropriate. It also considers applications for discharge from guardianship. It cannot consider the validity of the original decision to bring the patient within the scope of the Act.<sup>13</sup> Nor can it assess or pass judgement on whether the patient is receiving appropriate treatment or care.<sup>14</sup> The tribunal decides simply whether, at the time of the hearing, the patient concerned should remain subject to the compulsory arrangement in question.
- 11.10 In some cases, if a tribunal decides not to discharge a patient from detention, it may make non-binding recommendations to facilitate the patient's discharge on a future occasion (for example, that the patient be granted a leave of absence or be transferred to another hospital). It can also recommend that the responsible clinician consider whether to discharge a patient onto supervised community treatment.<sup>15</sup>
- 11.11 In most cases, the patient and their nearest relative can make applications to the tribunal.<sup>16</sup> Hospital managers and Independent Mental Health Advocates are required to take steps to ensure that patients understand their rights to apply for a tribunal hearing.<sup>17</sup> However, in practice, many patients never apply and therefore the Act provides for a system of automatic references. For example, hospital managers must refer to the tribunal certain patients who have not had their detention reviewed within the last six months and patients who have had their detention renewed but have not appealed to the tribunal in the last three years (if aged 18 years or over) or the last year (if aged less than 18 years). Also, the Secretary of State and Welsh Ministers have powers to refer certain patients to the tribunal at any time.<sup>18</sup>
- 11.12 The relevant rules also set mandatory time limits for hearings. For example, patients detained under section 2 must have the hearing within seven days and patients detained under section 3 must have the hearing within eight weeks of receipt of the application by the tribunal administrators.<sup>19</sup> Legal aid is currently available to fund legal advice and representation before the tribunal, without requiring any assessment of the patient's means or the application of the merits

<sup>13</sup> *R v East London and the City Mental Health Trust ex p Brandenburg* [2003] UKHL 58, [2004] 1 All ER at [9].

<sup>14</sup> *R (B) v Dr SS* [2005] EWCA Civ 28, [2006] MHLR 131 at [65].

<sup>15</sup> Mental Health Act 1983, ss 72(3) and (3A).

<sup>16</sup> As above, s 66.

<sup>17</sup> As above, ss 132 and 132B.

<sup>18</sup> As above, ss 67 and 68.

<sup>19</sup> Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008, SI 2008 No 2699, r 37.

test.<sup>20</sup> Legal aid for appeals to the Upper Tribunal is means-tested and subject to a merits test.<sup>21</sup>

- 11.13 Tribunals are not as formal as court proceedings. Hearings in the First-tier Tribunal (Mental Health) are normally in private unless the patient requests a public hearing and the tribunal accepts the request.<sup>22</sup> For detained patients the hearing will usually take place in the hospital where the patient is detained. Each tribunal panel must consist of three members: a legal member (who is the judge), a medical specialist, and a third member (sometimes known as the “lay member”). The third member is intended to provide balance as a representative of the community outside the legal and medical professions. They will normally have a background of working in the health and social care sector; sometimes the lay member is a service user.<sup>23</sup>

## DISCUSSION

- 11.14 The Department of Health’s original consultation on how to respond to the *HL v United Kingdom* case considered the possible role of courts and tribunals in reviewing the deprivation of liberty of those who lack capacity.<sup>24</sup> The report on the consultation acknowledged that “many saw the [then Mental Health Review Tribunal] as the most appropriate body to take on this role”. However, the Department was “persuaded by the arguments put forward by the minority [of consultees] who considered the Court of Protection to be best placed to undertake this role”. This was because the legal framework for the DoLS would be provided by the Mental Capacity Act and therefore the Court of Protection was seen as best placed to take on this role “as part of its overall responsibility for the personal welfare of those who lack capacity”.<sup>25</sup>
- 11.15 More recently, the House of Lords committee considered the establishment of a system of appeal to the First-tier Tribunal, similar to that under the Mental Health Act, for the Mental Capacity Act as a whole but particularly in respect of the DoLS. However, while sympathetic to concerns raised regarding access and delay, it concluded that the replacement of the Court of Protection would “risk the loss of expertise and potentially increase costs in the system” and therefore a

<sup>20</sup> The Civil Legal Aid (Merits Criteria) Regulations 2013, SI 2013 No 104.

<sup>21</sup> Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013, SI 2013 No 480, reg 5(1)(f) and Legal Aid, Sentencing and Punishment of Offenders Act 2012, sch 1, pts 1 and 3.

<sup>22</sup> Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008, SI 2008 No 2699, r 38.

<sup>23</sup> Senior President of Tribunals, *Practice Statement: Composition of Tribunals in relation to matters that fall to be decided by the Health, Education and Social Care Chamber on or after 18 January 2010* (2014) para 4.

<sup>24</sup> Department of Health, “*Bournewood*” Consultation: *The approach to be taken in response to the judgment of the European Court of Human Rights in the “Bournewood” case* (2005) paras 5.10 to 5.13.

<sup>25</sup> Department of Health, *Protecting the Vulnerable: The “Bournewood” Consultation: Report of the public consultation on the Government’s proposed response to the “Bournewood” case (the judgment of the European Court of Human Rights in the case of HL v the UK)* (2006) paras 32 to 36.

new tribunal appeal system would not be the best way to address these concerns.<sup>26</sup>

- 11.16 We would normally be reluctant to re-open matters that have been the subject of recent and comprehensive reviews by the executive and legislative branches of Government. However, both reports pre-date the Supreme Court's decision in *Cheshire West* and were unable to take into account the significant impact it will have on judicial resources. We therefore consider that the issues deserve a fresh appraisal. In order to do this we have assessed the relative merits of the court and tribunal system against four key criteria: the relevant expertise, participation of the person, ability to access the court, and delays and resource considerations.

### **The relevant expertise**

- 11.17 Clearly, a major attraction of the Court of Protection is that it already operates under the Mental Capacity Act, and has built up a good deal of knowledge and expertise. Moreover, its powers are broad and not just concerned with the deprivation of liberty itself. For instance, it can make declarations on whether a person has been deprived of liberty unlawfully, and vary a standard authorisation by lifting restrictions or directing conditions. This would fit well with our new scheme, where the court would need broad powers concerning various aspects of the person's care and treatment plan. In contrast, the powers of the First-tier Tribunal (Mental Health) are generally limited to directing that the patient be discharged.
- 11.18 On the other hand, Lady Hale – amongst others – has voiced her support for giving the task of hearing DoLS cases to the Mental Health Tribunal, based in part on its knowledge of mental health and disability issues.<sup>27</sup> Certainly, most tribunal members will be mental health practitioners (including doctors, health and social care professionals and lawyers) who will already have a very great understanding of the relevant issues, and would only require limited retraining. Moreover, the concepts of mental capacity and best interests are not unfamiliar to the tribunal – for example, it will often need to consider if the patient lacks capacity to give instructions (and if so, appoint a representative), and be alert to the potential relevance of the DoLS to the issues it has to decide under the Mental Health Act. But these are not a major part of the tribunal's work currently, and any expansion of its role in this respect would obviously have resource implications.

### **Participation of the person**

- 11.19 The House of Lords committee heard evidence that, whilst the Court of Protection's expertise was valued, it was seen as "remote, inaccessible and not well understood".<sup>28</sup> The court is able to sit anywhere in England and Wales.

<sup>26</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 223.

<sup>27</sup> Lady Hale, *The Other Side of the Table?: Speech to the Mental Health Tribunal Members' Association* (17 October 2014) p 20.

<sup>28</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 202 to 203.

However, in most cases it sits in London, although cases can be heard in the regional court centres. It is unusual (but not unprecedented) for the Court of Protection to receive evidence, whether orally or in writing, from the person themselves.<sup>29</sup> Recent rule changes require the court, either on its own initiative or on the application of any person, to consider whether it should give directions relating to the relevant person's participation – including making the person a party, appointing a representative to relay information as to the person's wishes and feelings, and specific provision to enable the person to address the judge (directly or indirectly).<sup>30</sup>

- 11.20 In contrast, the Mental Health Tribunal generally sits wherever the person is detained and the hearing is almost always attended by the patient. A hearing may only proceed in the absence of the patient if it is satisfied that the patient has decided not to attend the hearing, or is unable to attend the hearing for reasons of ill-health, and a medical examination has been carried out or is impractical or unnecessary.<sup>31</sup> A further key advantage of the tribunal system is its relative lack of formality. Indeed the rules require tribunals to avoid “unnecessary formality” and “seek flexibility in the proceedings”.<sup>32</sup> Lady Hale has recognised that tribunals have the advantage of “dealing direct with people without the intervention of the Official Solicitor”.<sup>33</sup>

#### **Ability to access the court**

- 11.21 There is no system of automatic referrals to the Court of Protection. Instead, the DoLS secures article 5(4) compliance by relying upon the respective roles of the section 39A Independent Mental Capacity Advocate and the representative and, as a last resort, the local authority bringing proceedings before the Court.<sup>34</sup> Evidence shows, however, that cases rarely reach the Court of Protection. A review in Wales tracked 48 individual DoLS cases and found that none had resulted in an application to the Court of Protection.<sup>35</sup> In England, the Care Quality Commission reported finding roughly one application to the Court for every 40 cases.<sup>36</sup> Even accepting that many of these cases will not require a court hearing, this evidence suggests that access to the Court is still illusory for many.

<sup>29</sup> Notable exceptions, where the evidence of the person had a significant impact on the outcome of the case, include *KK v STCC* [2012] EWHC 2136 (COP) and *Re SB (A Patient; Capacity to Consent to Termination)* [2013] EWHC 1417 (COP), [2013] 3 FCR 384.

<sup>30</sup> Court of Protection (Amendment) Rules 2005, SI 2015 No 548.

<sup>31</sup> Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008, SI 2008 No 2699, r 39(2).

<sup>32</sup> Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008, SI 2008 No 2699, r 2(2)(b).

<sup>33</sup> Lady Hale, *The Other Side of the Table?: Speech to the Mental Health Tribunal Members' Association* (17 October 2014) p 20.

<sup>34</sup> *AJ v A Local Authority* [2015] EWCOP 5, (2015) 18 CCLR 158 at [126].

<sup>35</sup> Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *A National Review of the use of the Deprivation of Liberty Safeguards (DoLS) in Wales* (2014)

<sup>36</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13* (2014) p 31.

- 11.22 There are several possible reasons for this. For instance, it may be due to caution by representatives about “rocking the boat” with those whom they rely upon to commission or provide care for their loved ones, best interests assessors selecting representatives who are less likely to challenge the detention, low rates of referrals to section 39D Independent Mental Capacity Advocates or the misunderstanding that an appeal should only be enabled if this in the person’s best interests (see chapter 9). Particular difficulties arise when one or more of these persons support the deprivation of liberty and fail to initiate proceedings.<sup>37</sup> Furthermore, evidence suggests that authorities rarely refer cases to the Court of Protection, especially where, although the person objects, professionals and the family are in agreement about the person’s best interests. Additionally, in such cases, the person is unlikely to be eligible for an Independent Mental Capacity Advocate who may otherwise refer the case.<sup>38</sup>
- 11.23 In contrast, a patient’s case can come before a tribunal not only through applications by the patient or the nearest relative, but also through automatic referrals by the hospital managers or the Ministry of Justice, or discretionary referrals by the Secretary of State for Justice. The system of automatic reviews of detention is viewed as a particularly important safeguard where the patient lacks capacity to decide to appeal to the tribunal.

#### **Delays and resource considerations**

- 11.24 The Court of Protection process has been criticised widely – and even by its own judges – for being slow and expensive.<sup>39</sup> The House of Lords committee pointed to the “considerable strain” on the processing of applications and a “bottleneck” in the process, especially given that the workload of the Court has increased by 25% since 2009 but staffing has been cut by 30%.<sup>40</sup> One study of Court of Protection cases found that the median level of costs for local authorities in cases involving those deprived of liberty was over £11,000, and the median duration was 10 months, with a small number of cases lasting several years.<sup>41</sup> Jones has pointed to delays and expense arising from Court of Protection judges converting proceedings into a “Rolls Royce case conference service” which is concerned less with points of law than the determination of a person’s best interests.<sup>42</sup>
- 11.25 In contrast, Mental Health Tribunal hearings are subject to legislative time limits. We have been informed anecdotally by mental health lawyers that delays are no

<sup>37</sup> See, for example, *AJ v A Local Authority* [2015] EWCOP 5, (2015) 18 CCLR 158.

<sup>38</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 234 to 235.

<sup>39</sup> For example, see, *A Local Authority v ED* [2013] EWHC 3069 (COP) and *Re A (Court of Protection: Delay and Costs)* [2014] EWCOP 48. See Sir James Munby P’s comments in *Re MN* [2015] EWCA Civ 411 at [101], [104] and [107].

<sup>40</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 205 (evidence from Elizabeth Batten DJ) and 209.

<sup>41</sup> L Series and others, *Use of the Court of Protection’s Welfare Jurisdiction by Supervisory Bodies in England and Wales* (2015) pp 18 and 23.

<sup>42</sup> R Jones, *Mental Health Act Manual* (4th 2010) p v and R Jones, *Mental Health Act Manual* (5th 2012) p v.

longer a widespread problem for the tribunal. It is reported that the tribunal has met its target of listing 100% of section 2 cases within seven days of receipt.<sup>43</sup> But there is some evidence to suggest that patients continue to have negative experiences as a result of other delays in the process.<sup>44</sup> Nevertheless, it does appear that delay is less endemic in tribunals and that this, combined with their simplified processes, may currently place them in a good position to deal with any extension to their jurisdiction.

### **Provisional view**

- 11.26 We provisionally consider that the key advantages of the tribunal system are the diversity of training of its members, its ability to bring about the patient's participation, the flexibility and informality of its processes, and the capacity to deliver cost savings from these characteristics. In these respects, we consider that the introduction of a tribunal system would bring considerable practical benefits to our new system which could not be so easily replicated by the Court of Protection. However, this needs to be balanced against the considerable expertise that has been developed amongst Court of Protection judges and the wider jurisdiction of the court across all mental capacity issues.
- 11.27 However, some caution is required when comparing the relative accessibility and cost efficiencies of the two judicial systems. It may be argued that the additional costs and delays associated with the Court of Protection are due, predominantly, to the unique nature of its jurisdiction. The DoLS are highly complex and productive of protracted legal argument and time-consuming judicial determination. DoLS cases are not just concerned with determining whether the criteria for detention are satisfied; they also involve capacity assessments, best interests determinations and consideration of article 8 issues. This may generate, in turn, the need for more expert reports and evidence. Lord Justice Munby (as he was then) has described such cases as having "all the complexity of a heavy child care case" but having the additional elements of disputes about capacity and deprivation of liberty.<sup>45</sup>
- 11.28 The need for complex determinations would not disappear under our new system. Whilst we would seek to remove the complexity of the DoLS itself, decisions would still need to be made regarding capacity, best interests and deprivations of liberty. The relevant issue therefore is whether the Court or the tribunal system is better placed for dealing with such issues efficiently. Members of the judiciary have argued that access to justice would not necessarily improve with the establishment of tribunals:

Since tribunals were usually composed of panels of three people, the feasibility of reconvening the tribunal, as was often required in cases brought to the Court of Protection, would depend on the availability of all three panel members and would inevitably impact on the timetable. The alternative, for a case to be heard by a new tribunal with no

<sup>43</sup> Senior President of Tribunals, *Senior President of Tribunals' Annual Report* (2014) p 43.

<sup>44</sup> Administrative Justice and Tribunals Council and Care Quality Commission, *Patients' experiences of the First-tier Tribunal (Mental Health)* (2011).

<sup>45</sup> Munby LJ, "Dignity, Happiness and Human Rights" (2011) 1(1) *Elder Law Journal* 32, 34.



previous experience of the case, would impede continuity of oversight.<sup>46</sup>

- 11.29 We accept the general thrust of these concerns – although we do not think they are insurmountable; for instance they may be alleviated somewhat through effective case management. Moreover, these concerns are not confined to the tribunal system; the problems caused by lack of judicial continuity are a recognised feature of the Court of Protection.<sup>47</sup>
- 11.30 Caution is also required when comparing the relative cost efficiencies. It is reasonable to assume that the tribunal would attract a much higher volume of applications than the Court, because tribunals are generally perceived to be more user-friendly and less remote than courts. On the other hand, if the present problems regarding the lack of automatic referral to the Court of Protection were remedied, that Court would also expect a significant rise in the number of matters to be dealt with. Once it is accepted that the new system should provide for an effective right of access to review by an adjudicative body, we provisionally consider that a tribunal would be better placed to efficiently meet this demand efficiently. The unit costs of a First-tier tribunal should be very much lower than those of the Court of Protection. If we are correct, this could be of considerable additional benefit to local authorities and the legal aid budget.
- 11.31 It is also important to acknowledge that the introduction of a tribunal system under our scheme would create a difficult interface with the rest of the Mental Capacity Act. In effect, some Mental Capacity Act issues would fall under the jurisdiction of the Court of Protection, while others would come under the tribunal. This outcome looks vulnerable to the criticism that it would lead to confusion and inconsistency, and result in a significant group of people being treated disadvantageously (since their case would not receive attention from the tribunal). On the other hand, some of this criticism could be addressed by careful drafting, and by appointing judges simultaneously to both the Court of Protection and the tribunal.
- 11.32 On balance, we have provisionally concluded that a tribunal system should be established to review cases under the restrictive care and treatment scheme (and in respect of the hospital scheme – see chapter 8). We anticipate that this approach might save money, because the large majority of applications would be dealt with by a much cheaper, and probably quicker, tribunal hearing rather than a court hearing with all associated legal costs. The Court of Protection's resources would also be freed up for all its other work in relation to the Mental Capacity Act. The First-tier Tribunal already houses a large number of different jurisdictions, so there is considerable precedent for such an arrangement.
- 11.33 We also provisionally consider that there should be a right to appeal against a tribunal decision, either to the Court of Protection or to a chamber of the Upper Tribunal staffed by judges with similar expertise to those in the Court of Protection (and possibly appointed to sit in both places). We seek consultees'

<sup>46</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 222.

<sup>47</sup> See, for example, *Norfolk CC v PB* [2014] EWCOP 14, [2015] COPLR 118 at [128].

view on whether the Court of Protection or the Upper Tribunal would be the more appropriate forum for these appeals.

- 11.34 Currently, the Upper Tribunal considers mental health appeals on a point of law only. We are concerned that this would be too restrictive. On the other hand, a right to appeal any decision might be too permissive and lead to unmeritorious appeals clogging up access to the court. We have provisionally concluded that the best approach would be to establish a right of appeal for cases which raise points of law, and on law and fact in cases where the issues raised are of particular significance to the person concerned. We would welcome views on which cases should fall within the latter category.
- 11.35 We would also welcome views on how the First-tier Tribunal might introduce further efficiencies to deal with the increased number of cases following the *Cheshire West* judgment. For example, the Mental Health Tribunal has introduced a system of “paper reviews” for automatic referrals of cases where the patient is subject to a community treatment order. This means that the tribunal will not meet with the patient, but will carry out a review of the patient’s records and reports. Since it was introduced, the tribunal has reviewed 884 cases in this manner.<sup>48</sup> Patients are given the opportunity to object to having their case determined through a paper review, and will have a full hearing if they do so.
- 11.36 We would also welcome views on whether, in some relatively straightforward cases, it might be possible to have single member tribunals. It is likely that the single member would need to be a lawyer to ensure that proceedings follow correct procedure and take into account the legal issues that might arise. However, it may be open to doubt whether a lawyer constituting a single member tribunal will have sufficient knowledge (and confidence) to interrogate the medical evidence and witnesses and might be too deferential to medical experts. These problems might be reduced if the person subject to the proceedings were represented separately, and if the legal representative could obtain an independent medical expert’s report. However, this would require resources from the state, and might even cost more than running a three member tribunal. It would also spread the load of assessing the medical evidence across a wider range of medical experts, rather than concentrating it in the hands of medical tribunal members.
- 11.37 Whether or not a tribunal jurisdiction is introduced, we consider that there should be a system of automatic referrals. Case-law confirms that an applicant is not required, as a precondition to enjoying the protection of an appeal, to show on the facts that their case stands any particular chance of success, and “there is no place in article 5(4) for a best interests decision about the exercise of that right”.<sup>49</sup> We provisionally propose that local authorities should be required to refer people to the court or tribunal if there has been no application made within a specified period of time. We would welcome views on what this period of time should be.

<sup>48</sup> Care Quality Commission, *Monitoring the Mental Health Act in 2013/14* (2015) pp 41 to 42.

<sup>49</sup> *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [59] and [60], *Waite v United Kingdom* (2003) 36 EHRR 54 (App No 53236/99) at [59] and *AJ v A Local Authority* [2015] EWCOP 5, (2015) 18 CCLR 158 at [88].

- 11.38 In chapter 7, we also provisionally propose that all cases involving serious medical treatment should be decided by the Court of Protection, and seek views on whether all significant welfare issues where there is a major disagreement should be required to be decided by a court. We would welcome views on whether such cases should be considered by a tribunal.
- 11.39 **Provisional proposal 11-1: there should be a right to apply to the First-tier Tribunal to review cases under our restrictive care and treatment scheme (and in respect of the hospital scheme), with a further right of appeal.**
- 11.40 **Provisional proposal 11-2: an appeal against the decision of the First-tier Tribunal should lie on points of law in all cases and on law and fact where the issues raised are of particular significance to the person concerned.**
- 11.41 **Question 11-3: which types of cases might be considered generally to be of “particular significance to the person concerned” for the purposes of the right to appeal against the decision of the First-tier Tribunal?**
- 11.42 **Provisional proposal 11-4: local authorities should be required to refer people subject to the restrictive care and treatment scheme (or the hospital scheme) to the First-tier Tribunal if there has been no application made to the tribunal within a specified period of time.**
- 11.43 **Question 11-5: in cases where there has been no application made to the First-tier Tribunal, what should be the specified period of time after which an automatic referral should be made?**
- 11.44 **Question 11-6: how might the First-tier Tribunal secure greater efficiencies – for example, should paper reviews or single member tribunals be used for relatively straightforward cases?**

#### **OTHER ISSUES**

- 11.45 There are a number of related matters that we consider merit further consideration. These are considered below.

#### **Public law and the Mental Capacity Act**

- 11.46 A significant criticism of the current DoLS system is the lack of ability for people to challenge care planning and Mental Capacity Act decisions simultaneously. For example, it is argued that the right to challenge a DoLS authorisation in the Court of Protection is meaningless if, for example, the deprivation of liberty can only be ended through extra funding by a public authority (for example, the provision of more one-to-one support to enable a person to leave the care home when they wish to do so).
- 11.47 As noted in chapter 6, the courts have warned of the danger of blurring the distinction between statutory duties in a private law context (namely considering the best interests of a person lacking capacity), with public law challenges.<sup>50</sup> The role of the Court of Protection is to take, on behalf of adults who lack capacity,

<sup>50</sup> *ACCG v MN* [2013] EWHC 3859 (COP), [2014] COPLR 11 at [34].

decisions which if they had capacity, they would take themselves. It has no more powers to obtain resources or facilities (from a private individual or a public authority) than the adult, if they had capacity, would be able to obtain themselves. The decision of a public authority to provide a service, or not, is a public law decision, and judicial review remains the proper vehicle through which to challenge unreasonable or irrational decisions.<sup>51</sup>

11.48 Notwithstanding this distinction, there have been several cases where the Court of Protection has explored with public authorities the possibility of funding being made available for alternative packages of care, and they sometimes have been assertive in doing so. For example, the Court has directed a local authority to make a decision whether it is prepared to fund an alternative package of support, and placed a condition on a local authority and care provider to ensure that “within available resources” reasonable steps are taken to increase the number of visits to the marital home for a woman subject to the DoLS in a care home.<sup>52</sup>

11.49 But whilst “rigorous probing, searching questions and persuasion are permissible, pressure is not”.<sup>53</sup> The court cannot create options where none exist,<sup>54</sup> and any negotiations:

are however a far cry from the court embarking on a “best interests” trial with a view to determining whether or not an option which has been said by a care provider (in the exercise of their statutory duties) not to be available, is nevertheless in the patient’s best interest.<sup>55</sup>

11.50 The Court of Protection will however have a more direct role in cases where a public authority has assessed that a person who lacks capacity will be provided with services and has identified alternative packages of care that it is willing to fund. The Court can, in such cases, make a best interests decision in order to choose between the available options.<sup>56</sup> In effect, this would place the person in the same position as a person who had capacity who would normally participate in deciding which of the options should be provided.

11.51 In some cases the Court of Protection will be asked to approve the care plan put forward by the public authority. The only power of the court is to approve or refuse the care plan put forward, and it “cannot dictate to the public authority what the care plan should say”.<sup>57</sup> However, in rare cases an impasse may occur where the Court does not approve the care plan, for example on the basis that it

<sup>51</sup> *Re MN* [2015] EWCA Civ 411 at [80].

<sup>52</sup> *A Local Authority v PB* [2011] EWHC 2675 (Fam) at [21] to [22] and *Bedford BC v C* [2015] EWCOP 25 at [182].

<sup>53</sup> *Re MN* [2015] EWCA Civ 411 at [36] and [81].

<sup>54</sup> *Holmes-Moorhouse v Richmond-upon-Thames London Borough Council* [2009] 1 WLR 413, by Baroness Hale at [30].

<sup>55</sup> *ACCG v MN* [2013] EWHC 3859 (COP), [2014] COPLR 11 at [57]. Approved by Sir James Munby P in *Re MN* [2015] EWCA Civ 411 at [81].

<sup>56</sup> *ACCG v MN* [2013] EWHC 3859 (COP), [2014] COPLR 11.

<sup>57</sup> *Re MN* [2015] EWCA Civ 411 at [34].

would breach the person's article 8 rights. The Court must then "select the lesser of two evils", endorsing the plan or dismissing the proceedings.<sup>58</sup>

11.52 We would welcome further evidence on the difficulties that arise in cases that are close to the divide between public law and the Mental Capacity Act. We also welcome views on how the law might be able to address some of the difficulties that arise (while also maintaining the fundamental distinction between public law and the Mental Capacity Act).

11.53 **Question 11-7: what particular difficulties arise in court cases that raise both public and private law issues, and can changes to the law help to address these difficulties?**

#### **Mediation**

11.54 The House of Lords committee recommended the greater use of mediation and that consideration be given to making it a pre-requisite for launching proceedings – although this was particularly in the context of property and financial cases. Evidence suggested that this would encourage a less adversarial approach, which was seen as particularly important given the ongoing relationships between parties, and bring about savings.<sup>59</sup> The Government agreed to gather evidence on areas where mediation would be appropriate, but also to set out an initial view that mediation would be less appropriate for health and welfare cases. It also disagreed that mediation should be a pre-requisite for launching proceedings and argued it must be voluntary in order to be effective.<sup>60</sup> We would welcome further views on whether mediation would be appropriate under our new scheme and if so, how it could operate.

11.55 **Question 11-8: should protective care provide for greater use of mediation and, if so, at what stage?**

#### **Legal aid**

11.56 Non-means tested legal aid is provided for Mental Health Tribunal proceedings. Whilst non-means tested legal aid is also available for review of authorisations under DoLS, it is not available in proceedings in which the Court of Protection considers whether to authorise a deprivation of liberty. The House of Lords committee raised two particular concerns regarding this latter category of case: where the DoLS authorisation is not renewed by the local authority while appeal proceedings are under way, and in relation to those deprived of liberty in supported living accommodation. In both of these cases, the court may be called upon to authorise the deprivation of liberty itself, and non-means tested legal aid will not be available. Concerns were also raised in relation to cases where an unauthorised deprivation of liberty is alleged. Again, non-means tested legal aid

<sup>58</sup> As above, at [45] by Sir James Munby P referring to *Re MM* [2007] EWHC 2003 (Fam), [2009] 1 FLR 443.

<sup>59</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 224 to 232.

<sup>60</sup> HM Government, *Valuing Every Voice, Respecting Every Right: Making the Case for the Mental Capacity Act: The Government's Response to the House of Lords Select Committee Report on the Mental Capacity Act 2005* (2014) Cm 8884, paras 9.5 to 9.7.

may not be available in such cases. The House of Lords committee recommended that these gaps in protection be remedied as a matter of urgency.<sup>61</sup> In its response, the Government did not agree, stating instead that only cases involving a challenge to a DoLS authorisation should attract non-means tested legal aid. Other cases should be subject to the means test.<sup>62</sup>

11.57 The allocation of public resources is a political issue and properly a matter for Government. However, at the very least we would expect that under our new scheme the existing rules on legal aid (as outlined above) would be maintained. But we would welcome further views on the issues raised above. Legal aid is currently available for the relevant person's representative. It has been suggested to us that legal aid should also be available to close family members (either generally or through a defined list) so that, if a family member is overlooked as the relevant person's representative, he or she will have the means to challenge decision-makers. As described in chapter 9, this has been one of the difficulties associated with the role of the representative under the DoLS. It has also been pointed out that, currently, if the person or their representative is appealing their DoLS authorisation (rather than the supervisory body taking the appeal), then the person deprived of liberty will have to pay the application fee and the hearing fee (unless he or she qualifies for a fee exemption or remission). This is criticised in particular for requiring the person to have to pay in order to be released. We would welcome further evidence or views on any of these or related issues.

11.58 **Question 11-9: what are the key issues for legal aid as a result of our reforms?**

<sup>61</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 238 to 242, and 249.

<sup>62</sup> HM Government, Valuing Every Voice, Respecting Every Right: Making the Case for the Mental Capacity Act: The Government's Response to the House of Lords Select Committee Report on the Mental Capacity Act 2005 (2014) Cm 8884, paras 9.12 to 9.14

## CHAPTER 12

# SUPPORTED DECISION-MAKING AND BEST INTERESTS

12.1 In chapter 6 of this consultation paper, we highlighted a number of high-profile DoLS cases which have involved local authorities overriding the wishes of the person concerned (as well as their family or carers). This chapter considers how reform might help to ensure that the person who may lack capacity is placed at the heart of decision-making. First of all it considers supported decision-making and how a person could be assisted to make a decision before being assessed as lacking capacity to make the decision. Secondly, it looks at the extent to which best interests decision-making under the Mental Capacity Act recognises the person's wishes and feelings.

### SUPPORTED DECISION-MAKING

12.2 Supported decision-making refers to the process of providing support to people whose decision-making ability is impaired, to enable them to make their own decisions wherever possible. Supported decision-making therefore starts from the assumption that most people are capable of making decisions in all aspects of their life, if – where necessary – they are provided with appropriate support to do so.

12.3 Supported decision-making is often associated with a formal legal process in which a person is appointed to assist with decision-making. A number of common law jurisdictions have moved to or are moving to include this form of supported decision-making arrangement in law, significant amongst them being Alberta, British Columbia, Ireland, Ontario, Saskatchewan, South Australia and Victoria.<sup>1</sup> In addition, other forms of supported decision-making have been developed. These include the provision of clear information and simplification of decision-making tasks, the use of person-centred planning, independent advocacy and representation, and advance care planning.

12.4 In England and Wales, the Mental Capacity Act gives some recognition to supported decision-making. The second principle of the Act is that a person is not to be treated as unable to make a decision unless all practical steps to help them to do so have been taken without success.<sup>2</sup> The courts have required measures such as providing sex education, and presenting the person with “detailed

<sup>1</sup> Adult Guardianship and Trusteeship Act 2008 (Alberta); Representation Agreement Act 1996 (British Columbia); Assisted Decision-Making (Capacity) Bill (Ireland); Ontario Law Commission, *Legal Capacity, Decision-making and Guardianship* (May 2014); Adult Guardianship and Co-decision-making Act 2000 (Saskatchewan); Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Final Report (2014) para 3.4; Office of the Public Advocate (South Australia), *Annual Report 2012* (2013) pp 56 to 62; and Victorian Law Reform Commission, *Guardianship Final Report* (2012).

<sup>2</sup> Mental Capacity Act 2005, s 1(3).

options”, rather than starting with a “blank canvass”, to help a person attain the capacity to make a particular decision.<sup>3</sup>

- 12.5 Furthermore, in England there is a right to an independent advocate under the Care Act 2014, whose role is to represent and support the individual for the purpose of facilitating their involvement.<sup>4</sup> This right is triggered if the local authority considers that, if an independent advocate were not available, an individual would experience “substantial difficulty” in understanding relevant information, retaining that information, using or weighing that information, or communicating their views, wishes or feelings.<sup>5</sup> In other words, without an advocate, they would fail a functional test of mental capacity in relation to the decision at issue.

### Discussion

- 12.6 Proponents of supported decision-making argue that the state has a “primary role in protecting autonomy or the right of individuals to choose and pursue their own path” and therefore must consider what support is needed to ensure that a person can exercise his or her rights. Furthermore, it is argued that supported decision-making provides a clearer structure for individuals and families or carers negotiating and making decisions, secures societal benefits such as contributing towards greater inclusion of people with mental health problems, and generally enables better decisions to be made.<sup>6</sup>
- 12.7 One of the main drivers for supported decision-making has been the UN Disability Convention. In particular, article 12 (the right of disabled people to enjoy legal capacity on an equal basis with others) has been interpreted by the UN Disability Committee as indicating that national laws should provide support to disabled people to ensure that their will and preferences are respected, rather than overruled by action which is considered to be in the person’s objective best interests.<sup>7</sup>
- 12.8 A number of criticisms have been made of supported decision-making. It has been pointed out that some people, irrespective of the level of support given to them, will always be incapable of making certain decisions for themselves, such as a person in a coma. A related difficulty arises where a person’s preferences are inconsistent, for instance where a person with anorexia expresses preferences to live but not to eat.<sup>8</sup> Of course, the existence of difficult cases does not preclude a move towards supported decision-making. But it does suggest the

<sup>3</sup> *D Borough Council v AB* [2011] EWHC 101 (Fam), [2012] Fam 36 and *CC v KK* [2012] EWHC 2136 (COP).

<sup>4</sup> Care Act 2014, ss 67(2) and 68(2).

<sup>5</sup> As above, ss 67(4) and 68(3).

<sup>6</sup> G Davidson and others, “Supported Decision Making: A Review of the International Literature” (2015) 38 *International Journal of Law and Psychiatry* 61, 62.

<sup>7</sup> Committee on the Rights of Person with Disabilities, *General Comment No 1* (2014) para 20 to 21.

<sup>8</sup> P Gooding, “Navigating the “Flashing Amber Lights” of the Right to Legal Capacity in the United Nations Convention on the Rights of Persons with Disabilities: Responding to Major Concerns” (2015) 15 *Human Rights Law Review* 45, 58 and 62.



need for a flexible framework which can accommodate these situations. This could be achieved by retaining some form of substituted decision-making. Indeed, even the UN Disability Committee has moved towards an objective standard in certain cases, stating that:

where, after significant efforts have been made, it is not practicable to determine the will and preference of an individual, “best interpretation of will and preferences” must replace ‘best interests’ determinations.<sup>9</sup>

- 12.9 A further criticism, albeit one not confined to supported decision-making regimes, is the potential for abuse. For example, it is suggested that decision-making supporters may try to manipulate people to achieve their own ends.<sup>10</sup> Obviously, to counter this abusive potential, safeguards must be put in place, just as in substituted decision-making systems.
- 12.10 Arguably, the second principle of the Mental Capacity Act already makes adequate provision for supported decision-making. However, the evidence received by the House of Lords committee showed that the Mental Capacity Act principles were not working effectively, and that supported decision-making under the Act was “rare in practice”. As a result, it concluded that “supported decision-making, and the adjustments required to enable it, are not well embedded” and that “a fundamental change of attitudes among professionals is needed in order to move from protection and paternalism to enablement and empowerment”.<sup>11</sup>
- 12.11 Moreover, Series has argued that the Mental Capacity Act’s support principle is framed in the “passive voice”; it is not obvious “who must provide this support and what the support should look like”. This makes support “difficult to co-ordinate – it is atomised across decisions and dispersed over a large number of disparate actors who might rely on the general defence [under section 5 of the Mental Capacity Act]”.<sup>12</sup> In addition, the carrying out of the assessment or decision by a professional who has little knowledge of the individual (for example a DoLS assessor) may make it harder to support the person in making decisions.<sup>13</sup>

### **Provisional view**

- 12.12 We provisionally consider that there are a number of clear benefits in introducing a formal legal process in which a person (known as a “supporter”) is appointed to assist with decision-making. In particular, it would give greater certainty and

<sup>9</sup> Committee on the Rights of Person with Disabilities, *General Comment No 1* (2014) para 20 to 21.

<sup>10</sup> Office of the Public Advocate Systems Advocacy (Queensland), *A Journey towards autonomy? Supported decision making in theory and practice* (2014) p 6.

<sup>11</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 79, 104 and 108.

<sup>12</sup> L Series, “Relationships, Autonomy and Legal Capacity: Mental Capacity and Support Paradigms” (2015). This article is unpublished.

<sup>13</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 70.

transparency for individuals, families, carers, professionals and service providers, and could help to ensure that the Mental Capacity Act works as intended.

- 12.13 It is important to emphasise that in making this provisional proposal we are not seeking to abolish best-interests decision-making. Our intention is to bolster the existing provisions of the Mental Capacity Act. Thus, our proposed supported decision-making scheme would help to ensure that, in accordance with the Act, all practical steps have been taken to help the person make a decision, and to permit and encourage the person to participate as fully as possible. We are also not seeking to replace the role of the Care Act advocate which in many ways is intended to ensure that a supported decision can be made. However, we provisionally consider that it is also important for the person to be able to appoint a supporter rather than this being undertaken only by a professional.
- 12.14 It is also noteworthy that a number of other comparable common law jurisdictions have decided to make specific provision for supported decision-making. Our proposed scheme, set out below, is based on our analysis of the systems established in these jurisdictions.
- 12.15 First, we provisionally propose that impaired capacity should not be a pre-requisite to qualify for supported decision-making assistance. We think there will be many people who retain formal capacity, who may nevertheless benefit from supported decision-making. Such people, if provided with support prior to or at a time when their capacity is beginning to falter, may be able to delay or avoid the need for substituted best-interests decision making. We also consider that a lack of capacity to make the relevant decision should not necessarily disqualify a person from appointing a supporter, or from having a supporter otherwise appointed, unless the person also lacks the capacity to understand the nature of the support relationship or lacks the capacity, even with support, to make the relevant decision. We provisionally consider that a person should be entitled to supported decision-making assistance if the person:
- (1) expresses a wish to receive support;
  - (2) has formed a trusting relationship with the supporter;
  - (3) indicates which decisions they wish to be supported in; and
  - (4) consents to the proposed supporter.
- 12.16 In addition, the supporter must agree to provide the support. There may also be a need to set some parameters for who can act as a supporter. There are obvious benefits where a family member or friend acts as a supporter, as a high degree of trust may already exist. For instance, some evidence suggests that supported decision-making works best when the person is already trusted.<sup>14</sup> Some systems, but not all, prohibit professionals and/or volunteers from being supporters. The Swedish “personal ombudsman” system permits only professional supporters. Under this system the professional (usually a social worker or lawyer with expert training) builds up a relationship of trust and confidence over a long period of time

<sup>14</sup> Law Commission of Ontario, *Understanding the Lived Experience of Supported Decision Making* (2014) p 78.

with the person before commencing the support role.<sup>15</sup> We would welcome further views on whether professionals or, alternatively, non-professionals should be able to act as supporters. A further consideration may be that the provision of support has the potential to require significant time and energy, and it may be unrealistic to expect that family and volunteers can be relied upon in all circumstances to perform this role. There may therefore be other practical benefits to professional involvement.

- 12.17 As an additional safeguard, some systems require that the proposed supporter demonstrate certain values (such as a respect for personal dignity), that certain circumstances apply (such as that the supporter have the time required to support the person), and that the supporter be of *good standing* (for example that they have not been convicted of certain offences). We would welcome views on whether any additional requirements are necessary.
- 12.18 Some jurisdictions create a fiduciary relationship between the supporter and the person. On one view this may be a sensible approach, given the possibility of abuse and the inherent difficulties of monitoring the situation. On another view, strict application of fiduciary law may be misplaced as the harsh remedies which operate for breach of fiduciary duty may be inappropriate, particularly where the supporter is unpaid and acts in good faith. In response to these complexities, the Victorian Law Reform Commission recommended that supported decision-making arrangements should give rise to fiduciary duties, but that decision-makers be given immunity from breach where they act in good faith within the terms of their appointment and other duties.<sup>16</sup> We would welcome views on this approach.
- 12.19 There are a number of different possible options for how a supporter might be appointed. For example, a supporter could be appointed by the person under a contractual or agreement model, a court or tribunal process, through an administrative process such as approval by a local government officer, or by a combination of these.
- 12.20 We provisionally consider that a person should be able to appoint a supporter, at least in circumstances where they retain capacity to understand the nature of the support offered, and to enter into such an agreement. This person would be appointed as the supporter unless they are unable, unwilling or unsuitable to perform this role. The best interests assessor (which will be known as the Approved Mental Capacity Professional under our proposals – see chapter 7) would be given the power to displace the person if necessary.
- 12.21 We also consider that it may be useful to set out the over-arching objective of the supported decision-making process which, in line with the UN Disability Convention, would be to provide people with access to the supports they require in order to exercise their legal capacity. This purpose would then inform the functions of the supporter which would be to:

- (1) access, collect and obtain information relevant to the decision, or assist

<sup>15</sup> M Jespersen, *PO-Skane – A Concrete Example of Supported Decision Making* (2014).

<sup>16</sup> Victorian Law Reform Commission, *Guardianship Final Report* (2012) para 8.130.

the person to do so;

- (2) explain the relevant information and considerations relating to a decision;
- (3) ascertain the will and preferences of the person and assist in communicating them;
- (4) assist the person to make and express a decision; and
- (5) endeavour to ensure that the person's decision is implemented.

12.22 In broad terms we do not want to limit unnecessarily the kinds of decisions that may be subject to a supported decision-making arrangement. Some jurisdictions do contain restrictions; such as the exclusion of financial decisions or certain personal welfare decisions (such as withdrawal of life sustaining treatment). We would welcome views on which, if any, decisions should be excluded.

12.23 We also provisionally propose that the support relationship be capable of being terminated by the supporter or by the person at any time, or by the Approved Mental Capacity Professional (on the basis that the criteria for initial entry into the arrangement no longer applies). This would be subject to a right of appeal. The relationship should also be capable of being amended or terminated by a court or tribunal on the application of any interested person.

12.24 In some cases a person may have appointed a supporter and also potentially be eligible for a Care Act advocate whose role (as noted above) includes supported decision-making. The right to an independent advocate arises if the local authority considers that, if an advocate were not available, an individual would experience "substantial difficulty" in understanding relevant information, retaining that information, using or weighing that information, or communicating their views, wishes or feelings. In such cases the local authority may consider that the appointment of an advocate (in addition to a supporter) is not necessary.

#### ***A co-decision-making scheme***

12.25 We have also considered whether a co-decision-making scheme could be introduced. These schemes involve the formal appointment of a co-decision-maker, usually by a court authorisation. For instance, in Saskatchewan, where a person's capacity is impaired to such an extent that they require support to make reasonable decisions, a co-decision-maker may be appointed.<sup>17</sup> Following the appointment, only acts that are agreed by the person and their co-decision-maker have legal force. These appointments are said to be useful for people who sometimes make impulsive decisions which they later regret. However, because of the potential for co-decision-makers to veto a person's choice, they have been characterised as leaning towards substituted decision-making.<sup>18</sup> We have therefore not made any provisional proposals in this respect.

<sup>17</sup> Adult Guardianship and Co-decision-making Act SS 2000 (Saskatchewan), s 14.

<sup>18</sup> See, L Series, "Relationships, Autonomy and Legal Capacity: Mental Capacity and Support Paradigms" (2015). This article is unpublished.

- 12.26 Similarly, we do not make any proposals in respect of self-binding directives or “Ulysses agreements” (see chapter 13).
- 12.27 **Provisional proposal 12-1: a new legal process should be established under which a person can appoint a supporter in order to assist them with decision-making. The supporter must be able, willing and suitable to perform this role. The Approved Mental Capacity Professional (currently best interests assessor) would be given the power to displace the supporter if necessary (subject to a right of appeal).**

### **BEST INTERESTS**

- 12.28 The Mental Capacity Act introduced a statutory best interests test for actions or decisions taken for or on behalf of a person who lacks capacity.<sup>19</sup> Although the concept of a person’s “best interests” is not defined, the Act sets out a number of rules which must be followed. These require that a decision-maker must consider all relevant circumstances and in particular:
- (1) must not make their determination merely on the basis of the age or the appearance of the person, or on the basis of unjustified assumptions from the person’s condition or behaviour;
  - (2) must consider whether the patient is likely to regain capacity and, if so, when that is likely to occur;
  - (3) must encourage the person to participate as fully as possible in the decision before making it for the person;
  - (4) in making best interests decisions in relation to life-sustaining treatment must not be motivated by a desire to bring about the person’s death;
  - (5) must consider the person’s past and present wishes and feelings (including written statements), the person’s beliefs and values, and any other factors that the person would be likely to consider if they were able; and
  - (6) must consult a number of people including carers, holders of lasting powers of attorney, deputies and anyone else named by the person.<sup>20</sup>
- 12.29 Neither the legislation, nor the *Mental Capacity Act Code of Practice*, provides an indication of the relative weight to be given to the various factors.<sup>21</sup> This approach reflects a deliberate policy decision that a prioritisation of the factors would unnecessarily fetter their operation in the many and varied circumstances in which they might fall to be applied.<sup>22</sup>

<sup>19</sup> Mental Capacity Act 2005, s 1(5).

<sup>20</sup> As above, s 4.

<sup>21</sup> See, for example, Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) paras 5.5 to 5.7.

<sup>22</sup> The Government Response to the Scrutiny Committee’s Report on the Draft Mental Incapacity Bill (2004) Cm 6121.

12.30 Instead, in weighing these factors, the courts have endorsed a “balance sheet” approach whereby the relevant benefits and burdens of a particular course of action are to be listed and, only where the “account” can be said to be in “significant credit”, can a decision be said to be in a person’s best interests.<sup>23</sup> Whilst case law has confirmed that there is no hierarchy as between these factors, and that the weight attached to each will vary in the circumstances of each case, certain factors can become “magnetic” and so tilt the balance towards a certain resolution.<sup>24</sup> For instance, a “magnetic” factor arose in the case of *W v M* where, in considering the withdrawal of artificial nutrition and hydration from a patient in a minimally conscious state, the sanctity of life was considered sufficient to pull decisively against the other factors to be weighed.<sup>25</sup>

### **The person’s wishes and feelings**

12.31 As noted above, the Mental Capacity Act requires expressly that a person’s wishes and feelings be considered when making a best interests decision. In *Re M*, Mr Justice Munby (as he was then) observed that the person’s “wishes and feelings will always be a significant factor to which [the decision-maker] must pay close regard”. Nevertheless, he went on to note that the weight attached to the person’s wishes and feelings “will always be case-specific and fact-specific”. As a result, in some cases the person’s wishes and feelings may be “preponderant” whereas in others they will carry “little weight”. Additionally, the weight to be accorded will be “issue-specific”, so that they may carry more or less weight for the same individual in relation to different decisions. He noted that, in considering this question, all relevant circumstances must be taken into account. He then gave a number of examples of relevant matters:

- (1) the degree of the person’s incapacity, such that where a person’s incapacity falls close to the border of capacity, greater weight should be accorded to their wishes and feelings;
- (2) the strength and consistency of the views expressed by the person;
- (3) the possible impact on the person if they became aware that their preferences were not being followed;
- (4) the extent to which the person’s preferences are not rational or capable of being sensibly followed in the circumstances; and
- (5) “crucially”, the extent to which the person’s wishes and feelings can be accommodated with what is assessed to be in their best interests.<sup>26</sup>

12.32 This final factor clearly reinforces the notion that, although the preferences of the person are an important consideration, a best interests decision may ultimately depart from them.

<sup>23</sup> *Re A (Mental Patient: Male Sterilisation)* [2000] 1 FCR 193, 206 by Thorpe LJ. This was endorsed in *Ealing LBC v KS* [2008] EWHC 636 (Fam), [2008] MHLR 256 at [71].

<sup>24</sup> *Re M* [2009] EWHC 2525 (Fam), [2009] 12 CCLR 635 at [29].

<sup>25</sup> *W v M* [2011] EWHC 2443 (Fam), (2011) 14 CCLR 689 at [249].

<sup>26</sup> *Re M* [2009] EWHC 2525 (Fam), [2009] 12 CCLR 635 at [35].

12.33 Some subsequent cases have suggested that, in certain circumstances, the person's wishes and feelings will be determinative.<sup>27</sup> In particular, in *Re S* the court accepted that the person's views are not ordinarily paramount, but went on to say that where a person's wish is:

not irrational (in the sense of being a wish which a person with full capacity might reasonably have), is not impracticable as far as its physical implementation is concerned, and is not irresponsible having regard to the extent of [the person's] resources (ie whether a responsible person of full capacity who had such resources might reasonably consider it worth using the necessary resources to implement his wish) then that situation carries great weight, and effectively gives rise to a presumption in favour of implementing those wishes, unless there is some potential sufficiently detrimental effect for [the person] of doing so which outweighs this.<sup>28</sup>

12.34 However, some doubt has been cast on the validity of this statement on the basis that it overstates the importance to be given to the person's wishes and feelings.<sup>29</sup>

12.35 It has been argued that the Supreme Court judgment in *Aintree University Hospitals NHS Foundation Trust v James* has given a new impetus to the centrality of the person at the heart of the best interests process.<sup>30</sup> In that case Lady Hale confirmed that "the preferences of the person concerned are an important component in deciding where his best interests lie". Importantly, she went on to state that:

The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. ... But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.<sup>31</sup>

<sup>27</sup> See, for example, *Newcastle upon Tyne Hospitals Foundation Trust v LM* [2014] EWHC 454 (COP), [2015] 1 FCR 373 at [23].

<sup>28</sup> *Re S* [2008] EWHC B16 (Fam), [2010] WLR 1082 at [57].

<sup>29</sup> *Re P* [2009] EWHC 163 (Ch), [2010] Ch 33 at [41].

<sup>30</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 99.

<sup>31</sup> *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591 at [24] and [45].

## Discussion

- 12.36 The House of Lords committee found that “the best interests principle is widely praised but its implementation is problematic”.<sup>32</sup> This was on the basis of evidence that the wishes and feelings of the person lacking capacity are not routinely prioritised in best interests decision-making, and instead “clinical judgments or resource-led decision-making predominate”.<sup>33</sup> This conclusion has been echoed by a Department of Health Green Paper on the care and treatment provided to people with learning disabilities, autism and mental health needs.<sup>34</sup> In both instances the underlying theme is that, although the present law should result in the person’s thoughts and feelings being given effect, this is not in practice occurring. This may be because, as simply one of a number of factors to be weighed, thoughts and feelings often yield to other considerations.
- 12.37 A number of law reform proposals have been put forward to address this issue. For example, the draft Disabled People (Community Inclusion) Bill 2015 (commonly referred to as the “LB Bill”) proposes to amend section 4 of the Mental Capacity Act by introducing a requirement to treat the disabled person’s wishes, feelings and preferences as a primary consideration in best interests decisions.<sup>35</sup> In Ireland, the Assisted Decision-Making (Capacity) Bill 2013 provides that when making an “intervention” (a concept deliberately distinguished from a best interests decision) the intervener must:

give effect, in so far as is practicable, to the past and present will and preferences of the relevant person, in so far as that will and those preferences are reasonably ascertainable.<sup>36</sup>

- 12.38 This does not simply render a person’s preferences a “primary consideration” in best interests decisions, but goes further to require that they be given “effect in so far as is practicable”.
- 12.39 However, certain important issues are left unresolved under the LB Bill and the Assisted Decision-Making (Capacity) Bill. For example, it is not indicated how decision-makers are to deal with cases where a person’s present preferences cannot be determined, may need to yield to other considerations (such as their safety or public law considerations, including resources), or are in conflict with their past wishes. Such dilemmas may in practice need to be left to professional discretion, case-law and guidance.
- 12.40 To a large degree, these various reforms are intended to align the law, as far as possible, with the UN Disability Convention. As noted above, the UN Disability Committee’s general comment on article 12 indicates that national laws should provide supports to the person to ensure that their will and preferences are

<sup>32</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 90.

<sup>33</sup> As above, para 104.

<sup>34</sup> No Voice Unheard, No Right Ignored – A Consultation for People with Learning Disabilities, Autism and Mental Health Conditions (2015) Cm 9007, pp 13 and 33 to 34.

<sup>35</sup> Justice for LB Campaign, “Disabled People (Community Inclusion) Bill 2015 (the “LB Bill”)” (2015) cl 7(2).

<sup>36</sup> Assisted Decision-Making (Capacity) Bill 2013, cl 3.



respected, rather than substituted decision-making based on a person's objective best interests. Where a person's will and preferences cannot be determined, support must be provided in accordance with the best interpretation of their will and preferences, rather than their best interests.<sup>37</sup> This moves in the direction of the removal of best interests decision-making, rather than a recalibration of the weight to be accorded to a person's preferences in the determination of their best interests.

### **Provisional view**

- 12.41 The fundamental importance of a person's wishes and feelings (including where the person lacks capacity) is widely recognised. For example, it has been stated that:

The desire to determine one's own interests is common to almost all human beings. Society is made up of individuals, and each individual wills certain ends for themselves and their loved ones, and not others, and has distinctive feelings, personal goals, traits, habits and experiences. Because this is so, most individuals wish to determine and develop their own interests and course in life, and their happiness often depends on this. The existence of a private sphere of action, free from public coercion or restraint, is indispensable to that independence which everyone needs to develop their individuality, even where their individuality is diminished, but not extinguished, by illness. It is for this reason that people place such weight on their liberty and right to choose.<sup>38</sup>

- 12.42 However, we are concerned that the law fails to give sufficient certainty for best interest decision-makers on how much emphasis should be given to the person's wishes and feelings. On the one hand, it can be said that there is no hierarchy between the various factors listed in section 4. This was clearly the policy intention behind the legislation. On the other hand, the Supreme Court has clarified in the *Aintree* case that best interests requires consideration of matters from the person's point of view and that the person's wishes and feelings are an important factor, arguably attaching some level of primacy to this factor. Similarly, in some cases the Court of Protection has gone to great lengths to make the decision the person would have wanted.<sup>39</sup> But equally, in other cases, the outcomes have been expressly inconsistent with what the person wants or would have wanted.<sup>40</sup>

- 12.43 It is also the case that circumstances have changed greatly since the introduction of the Mental Capacity Act: much of the Act was based on the work of the Law

<sup>37</sup> Committee on the Rights of Person with Disabilities, *General Comment No 1* (2014) paras 20 to 21.

<sup>38</sup> A Ruck Keene and others, *Court of Protection Handbook: A User's Guide* (2014) para 3.79.

<sup>39</sup> See, for example, *Westminster CC v Sykes* [2014] EWCOP B9, (2014) 17 CCLR 139.

<sup>40</sup> See, for example, *GW v A Local Authority* [2014] EWCOP 20 and *D v JC* (2012) MHLO 35 (COP). Cited by L Series, "Relationships, Autonomy and Legal Capacity: Mental Capacity and Support Paradigms" (2015). This article is unpublished.

Commission in the 1990s and predates more recent developments such as the Human Rights Act 1998 and the ratification of the UN Disability Convention.<sup>41</sup> In addition, the Mental Capacity Act has now been in force for over eight years, and there is growing evidence about how best interests decisions are taken in practice. In this respect, we share the concerns of the House of Lords committee that, too often, insufficient recognition is given to the person's wishes and feelings when making a best interests decision. Cases outlined elsewhere in this paper – such as *London Borough of Hillingdon v Neary* and *G v E* – illustrate the consequences of such failures.

- 12.44 The views of the UN Disability Committee are considered in chapter 3. For present purposes, it is sufficient to note that we consider that abandonment of best interest decision-making would raise many unresolved issues, and would be highly politically and ethically contentious at this stage. It is also not within the remit of our review to initiate a complete reconfiguration of decision-making under the Mental Capacity Act. Such a radical reform is properly a policy matter for Government.
- 12.45 Nevertheless, we are sympathetic to the broad aim of prioritising a person's wishes and feelings. This is something we consider to be consistent with the aims and aspirations of the UN Disability Convention. Whilst the Mental Capacity Act refers to "wishes and feelings" in this context, the UN Disability Convention adopts the term "will and preferences". However, we do not consider that there is any substantial difference between these phrases (although clearly they are deployed for different purposes). We therefore provisionally propose that section 4 of the Mental Capacity Act should be amended to attach a level of primacy to a person's wishes and feelings. Their precise legal status might range from making them a "primary consideration" for decision-makers, to simply directing that they be given effect to, unless impractical. We provisionally consider that an intermediate option would be appropriate. Under this approach there would be an assumption that the person's wishes and feelings are determinative as to their best interests, although this assumption could be overridden where there are good reasons to do so.
- 12.46 Currently, the Mental Capacity Act does not expressly indicate whether the present or past wishes and feelings of a person are to be given greater priority. However, it has been held that both the previously expressed wishes of the person, as well as the hypothetical wishes and feelings that they would express if they were able, must be considered.<sup>42</sup> This gives rise to a potentially difficult question where these diverge. Although this issue has not yet been determined by courts, other parts of the Mental Capacity Act do give a preference to present wishes. For instance, advance decisions cannot be acted upon where the person has subsequently done anything clearly inconsistent with the advance decision (although the Act is silent on what doing something inconsistent means).<sup>43</sup> As a result, it has been argued that a preference for present wishes should also apply

<sup>41</sup> Law Commission: Report on Mental Incapacity (1995) Law Commission Report No 231.

<sup>42</sup> *Re G* [2010] EWHC 3005 (Fam), [2011] Med LR 89 at [37].

<sup>43</sup> Mental Capacity Act 2005, s 25(2).

when weighing preferences for the purposes of a best interest decision.<sup>44</sup> We consider that a similar approach should be adopted for the purposes of the best interests checklist. However, we think this matter could be left to guidance.

- 12.47 **Provisional proposal 12-2: section 4 of the Mental Capacity Act should be amended to establish that decision-makers should begin with the assumption that the person's past and present wishes and feelings should be determinative of the best interests decision.**

<sup>44</sup> Mary Donnelly, "Determining Best Interests Under the Mental Capacity Act 2005" (2011) 19 *Medical Law Review* 304, 311 to 312.

## CHAPTER 13

# ADVANCE DECISION-MAKING

- 13.1 Consent is of central importance in health and social care law. The legality of an intervention will largely turn on whether the person has given valid consent to it. Once a person has been assessed as lacking capacity to consent, some legal justification is required before the proposed action is taken. Normally it will be necessary to make a best interests decision. But it may also be the case that the person has indicated previously which care or treatment they would or would not be prepared to accept in these circumstances. This part considers the existing legal framework for advance decision-making and how it might be reflected under our new scheme.

### CURRENT LEGAL FRAMEWORK

#### Lasting Powers of Attorney

- 13.2 A lasting power of attorney enables a person (the donor) to confer authority on another person (the donee) to make certain decisions on their behalf, and continues to operate after a donor no longer has capacity. They can cover property and affairs decisions (such as managing the person's financial affairs, and buying or selling property) and personal welfare decisions (such as consenting to medical treatment). Unless expressed to the contrary, donees of a property and affairs power can make all decisions, whether or not the donor lacks capacity. A personal welfare power can be used only when the donor no longer has capacity to make the particular decision.
- 13.3 An act carried out by the donee is treated in law as an act carried out by the donor. Under the law of agency, the donor has certain duties towards the donee, including duties of care, to carry out the donor's instructions, not to take advantage of the position of the donee, of good faith, of confidentiality and to comply with directions of the Court of Protection.<sup>1</sup> Attorneys who undertake their duties in the course of their professional work (such as solicitors or corporate trustees) must display professional competence and follow their profession's rules and standards.
- 13.4 The donee must also act within the scope of their powers set out in the instrument. The donor may limit the authority of the donee so that the power relates only to specified matters, or operates in certain circumstances, or gives blanket permission to act in relation to all relevant issues. The authority conferred is also subject to the provisions of the Mental Capacity Act, in particular the section 1 principles and the best interests decision-making process in section 4. In addition, donees have a specific obligation to have regard to the *Mental Capacity Act Code of Practice*.<sup>2</sup>

<sup>1</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) paras 7.58 to 7.68.

<sup>2</sup> Mental Capacity Act 2005, s 42(4).

13.5 The Mental Capacity Act and the common law contain certain restrictions on decisions that can be made by donees.<sup>3</sup> The donee has the power to give or refuse consent for medical treatment for the donor. But this does not extend to:

- (1) requiring that a particular medical treatment be given to the donor;<sup>4</sup>
- (2) giving or refusing consent to life sustaining treatment unless the instrument contains express provision to that effect;<sup>5</sup>
- (3) the refusal of basic care, such as the provision of hydration and nutrition by non-artificial means;
- (4) decisions about treatment for mental disorder which are regulated by Part 4 of the Mental Health Act,<sup>6</sup> and
- (5) consenting to a deprivation of liberty in the absence of a court order or the DoLS procedures.<sup>7</sup>

13.6 Whilst a donee cannot authorise a deprivation of liberty, they have an important role to play in the DoLS process. For instance, a standard authorisation cannot be issued if the decision to place a person in a hospital or care home conflicts with a valid decision of a donee.<sup>8</sup> The Court of Protection has wide powers under the Mental Capacity Act to determine questions and give directions as to the meaning and effect of a lasting power of attorney. It can also remove donees who act improperly.<sup>9</sup>

#### **Advance decisions to refuse treatment**

13.7 Advance decisions (sometimes referred to as advance directives) allow people with capacity to refuse in advance specified medical treatment that might be given at a point in the future when they lack the capacity to consent or refuse consent to that treatment. Only people aged 18 and over who have the capacity to do so can make an advance decision. It is necessary to specify the treatment which is to be refused, although this does not have to be done in medical terms, and can be expressed in layperson's language.<sup>10</sup>

13.8 If an advance decision is both valid and applicable in the particular circumstances, it has the same effect as a contemporaneous refusal of treatment by a person with capacity. This means that the treatment specified in the decision cannot lawfully be given.<sup>11</sup> Proceeding to treat a patient in the face of an advance

<sup>3</sup> As above, ss 11 and 27 to 29.

<sup>4</sup> *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273.

<sup>5</sup> Mental Capacity Act 2005, s 11(8).

<sup>6</sup> As above, s 28.

<sup>7</sup> *Re Stewart* (COP) November 9, 2011 (unreported).

<sup>8</sup> Mental Capacity Act 2005, sch A1, para 20.

<sup>9</sup> As above, ss 15 and 22.

<sup>10</sup> As above, s 24.

<sup>11</sup> As above, s 26(1).

decision could amount to tortious battery, and potentially result in criminal prosecution.<sup>12</sup> However, an advance decision will cease to have effect if the person is detained under the Mental Health Act and the treatment comes within scope of Part 4 of that Act.<sup>13</sup> Advance decisions can play an important role in the DoLS decision-making process. For instance, a standard authorisation cannot be issued if it is sought for the purposes of treatment which is covered, either wholly or partially, by a valid and applicable advance decision.<sup>14</sup>

- 13.9 The Mental Capacity Act does not impose any particular formalities concerning the format of an advance decision or the procedures involved in making one. The sole exception is an advance decision to refuse life-sustaining treatment, which must be in writing, signed and witnessed, and state clearly that the decision applies even if life is at risk.<sup>15</sup> Advance decisions concerning the refusal of other types of treatment may be written or oral. The *Mental Capacity Act Code of Practice* contains suggestions about what to include in a written advance decision, and how to record verbal advance decisions.<sup>16</sup>
- 13.10 There are no formal requirements for the revocation of an advance decision. An advance decision is “inherently revocable”. In other words, any purported stipulation that the advance decision is irrevocable, or which imposes conditions upon its revocation, is contrary to public policy and void.<sup>17</sup> The Court of Protection has the power to make declarations as to the existence, validity and applicability of an advance decision.<sup>18</sup> The Court, however, has no power to overturn a valid and applicable advance decision.

### **Advance Statements**

- 13.11 An advance statement is made when a person has capacity and sets out his or her wishes and feelings in respect of a matter, including positive preferences. It might include requests for specific forms of medical treatment or placement in a named care home in the event of future incapacity. However, the legal principle that a person has the right to refuse treatment does not carry with it as a corollary that the person has a right to demand particular treatment, whether at the time or in advance.<sup>19</sup> Unlike advance decisions, an advance statement is not legally binding, but should be taken into account by decision-makers when making best interests determinations.<sup>20</sup>
- 13.12 However, this does not mean that advance statements have no force. In *RGB v Cwm Taf Health Board*, Mr Justice Moor stated that a “clearly articulated”

<sup>12</sup> *Collins v Wilcock* [1984] 1 WLR 1172, 1177.

<sup>13</sup> Mental Capacity Act 2005, s 28.

<sup>14</sup> As above, sch A1, para 20.

<sup>15</sup> As above, ss 25(5) and (6).

<sup>16</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) paras 9.10 to 9.23.

<sup>17</sup> *HE v A Hospital NHS Trust* [2003] EWHC 1017 (Fam), [2003] 2 FLR 408 at [46].

<sup>18</sup> Mental Capacity Act 2005, s 26(4).

<sup>19</sup> *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 at [55].

<sup>20</sup> Mental Capacity Act 2005, s 4(6).

advance statement setting out the person's strong wish not to have any contact with her husband was "absolutely central to the matter" and that there "would have to be some extremely compelling reason to go against such clearly expressed wishes".<sup>21</sup> If an advance statement is not followed, the *Mental Capacity Act Code of Practice* provides that the decision-maker should record their reasons and be able to justify their reasons if challenged.<sup>22</sup>

### **"Ordinary" Power of Attorney**

- 13.13 Section 10 of the Powers of Attorney Act 1971 provides for the giving of an ordinary power of attorney to manage the donor's property and finances. It is usually made when it is difficult for the donor to manage their affairs, for example, because of a physical disability or when the donor is travelling abroad. An ordinary power of attorney ceases to have effect if the donor loses capacity.

### **Advance consent**

- 13.14 Case law on advance decision-making focuses on advance refusals of consent. But consent may also be given in advance of medical treatment, particularly major surgical operations which will be performed under general anaesthetic. Such consent is documented routinely by consent forms. Consent and refusal of consent are both expressions of the patient's right to self-determination.
- 13.15 In order to be valid, advance consent would normally need to be treatment-specific: consent to one particular treatment does not legitimise, for example, a surgeon performing another treatment for the sake of convenience.<sup>23</sup> Not every agreement to undergo treatment is, in law, a valid consent because it may be based on inadequate information or undue influence.

### **Self-binding directives**

- 13.16 Recent years have seen the increased use of self-binding directives (commonly referred to as "Ulysses agreements").<sup>24</sup> These are not recognised in law and their use has developed informally. A self-binding directive purports to bind the individual in the future in relation to refusals of (non-medical) care and treatment and consent to care and treatment. They can be constructed to apply both if the person lacks capacity or to override capable refusal and consent.
- 13.17 They are said to be useful for people with fluctuating conditions who have a level of insight and awareness when well, which they know they will lack when unwell, and want to be able to control their unwell self as far as possible. Examples include a crisis plan which has been agreed between a person with mental health

<sup>21</sup> *RGB v CWM Taf Health Board* [2013] EWHC 23 (COP), [2014] COPLR 83 at [39] by Moor J.

<sup>22</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) para 5.43.

<sup>23</sup> A Grubb and others (eds), *Principles of Medical Law* (3rd ed 2010) para 8.56.

<sup>24</sup> The term refers to the ancient Greek hero Ulysses who wanted to hear the song of the sirens but knew it would render him incapable of resisting them, resulting in him being lured to his death. He therefore asked his crew to tie him to the mast of his ship and not to untie him, whatever he said.

problems and the treatment team which will be put into operation when the person starts to relapse.

### **Do not resuscitate orders**

- 13.18 A “do not resuscitate order” is a statement to the effect that cardiopulmonary resuscitation should not be administered if the person has a cardiac arrest. Patients can decline cardiopulmonary resuscitation but cannot require clinicians to perform such treatment which is not clinically indicated.<sup>25</sup>
- 13.19 It follows that the Mental Capacity Act cannot be used to require cardiopulmonary resuscitation (for instance through a best interests decision) in such circumstances. But the person could make an advance statement to request this treatment, and this must be taken into account by the decision-maker (see above). The Mental Capacity Act can be used to determine that cardiopulmonary resuscitation should not be given to a person who lacks capacity to consent if this is his or her best interests or in accordance with a valid advance decision.
- 13.20 Thus a “do not resuscitate order” may have been triggered by an advance decision by the person to refuse this treatment. Alternatively, the clinical team may have taken a decision that cardiopulmonary resuscitation is not clinically indicated because it will not be successful.

### **PROVISIONAL VIEW**

- 13.21 Advance decision-making can have a number of important benefits. For instance, it gives a person greater control over his or her circumstances and so reduces the chances of potentially distressing situations, and it gives health and social care professionals greater clarity over treatment options. Research has shown that advance care planning can be used to establish a person’s wishes regarding care at the end of life and this increases the likelihood of their wishes being met.<sup>26</sup> But there are also risks. It may be difficult, for example, for a person with capacity to contemplate how they would respond to the reality of living with a condition and losing their ability to make decisions.
- 13.22 As a matter of law, advance decision-making is well-established. For example, advance decisions to refuse medical treatment were placed on a statutory footing recently by the Mental Capacity Act, but were recognised 17 years earlier by Lord Goff in *F v West Berkshire Health Authority*.<sup>27</sup> As noted earlier, the DoLS give some recognition to advance decision-making.<sup>28</sup> We want to consider whether its role might be expanded under our new scheme.

<sup>25</sup> *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591.

<sup>26</sup> J Abel and others, “The impact of advance care planning of place of death, a hospice retrospective cohort study” [2013] 3 *BMJ Supportive & Palliative Care* 2, 168 and NHS Improving Quality, *Capacity, care planning and advance care planning in life limiting illness: A Guide for Health and Social Care Staff* (2014).

<sup>27</sup> *F v West Berkshire Health Authority* [1990] 2 AC 1, 75 to 76.

<sup>28</sup> See the discussion above in chapter 2.



- 13.23 One possible role for advance-decision making would be to enable people with capacity to consent to future care and treatment which amounts to a deprivation of liberty. The Law Commission considered anticipatory decisions to consent to treatment in our 1995 report *Mental Incapacity*. We argued that formal recognition was not necessary because the decision-maker would always be required to exercise clinical judgement about appropriate treatment, and then decide what is necessary in the patient's best interests. Whether or not the patient had consented in advance, the outcome would always be the same.<sup>29</sup>
- 13.24 This is of course correct. But in the context of deprivation of liberty the effect of valid consent has significant implications. Even if a person is objectively confined, their circumstances will not fall within the scope of article 5 if they have validly consented to the confinement.<sup>30</sup> If this principle were applied to anticipatory decisions to consent to treatment, it would mean that a person could consent in advance to what would otherwise amount to a deprivation of liberty. In this precise scenario, therefore, the outcome would be the same (a best interests decision would still need to be made) but the legal implications would be very different (the article 5 protections would not apply).
- 13.25 The Department of Health has argued in the context of palliative care that if a person has capacity to consent to the arrangements for their care at the time of their admission, or at a time before losing capacity, and does consent, this consent would cover the period until death; hence there is no deprivation of liberty. The main exception would be if "significant extra restrictions" were subsequently imposed or the care was contrary to the previously expressed wishes, in which case a DoLS authorisation or Court of Protection order may be required.<sup>31</sup>
- 13.26 We agree that this is likely to be the correct position in law. We also consider that the underlying legal principle has a wider application beyond palliative care to other settings, such as accident and emergency departments, and circumstances, such as where a person agrees to an elective operation. Our provisional view is that this position should be reflected in the new scheme. However, the ability to approve a future deprivation of liberty also needs to be carefully circumscribed. We are conscious that the Strasbourg court has recalled on several occasions that:

The right to liberty is too important in a democratic society within the meaning of the Convention for a person to lose the benefit of the protection of the Convention for the single reason that he gives himself up to be taken into detention.<sup>32</sup>

<sup>29</sup> *Mental Incapacity* (1995) Law Com No 231, para 5.12.

<sup>30</sup> *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision) at [117].

<sup>31</sup> Department of Health, *Update on the Mental Capacity Act and Following the 19 March 2014 Supreme Court Judgment: Letter from Mr Niall Fry to MCA-DoLS Leads in Authorities and the NHS* (14 January 2014) p 4.

<sup>32</sup> *De Wilde v Belgium* (1979-80) 373 (App No 2832/66) at [65]. See also *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99) at [90].

13.27 We therefore think that the ability to consent to a future deprivation of liberty should be restricted to a defined event of relatively limited duration. Thus, where a person agrees to an elective operation or enters palliative care, they should be able to consent, as part of that process, to a deprivation of liberty should they later lose capacity, as long as they made an informed decision and the circumstances do not then change materially. In other words, the consent must be valid and applicable to the relevant care and treatment.

13.28 However, the position of a person who has made a lasting power of attorney is less straightforward. The Scottish Law Commission has recommended that donees should have powers to authorise, rather than consent to, “significant restrictions of liberty” which are being proposed by clinicians. Therefore the person would still be entitled to article 5(4) safeguards.<sup>33</sup> The Commission also considered if the consent of a donee could be constructed in such a way which would prevent a set of restrictions from amounting in law to a deprivation of liberty. In other words, the subjective requirement would not be met. However, it decided not to take this idea forward, because:

The idea of taking people whose circumstances would otherwise amount to deprivation of liberty out of all independent authorisation and monitoring arrangements is not immediately attractive. It is also debatable that the European Court would sanction such an approach, even if based on its own dicta.<sup>34</sup>

13.29 Provisionally, we have a number of concerns about giving donees powers to authorise deprivations of liberty and consent to what would otherwise be a deprivation of liberty. For example, donees must make best interests decisions. These are not coterminous with decisions which give effect to the person’s wishes and feelings (although in chapter 12, we discuss provisional proposals to require greater emphasis on wishes and feelings). Even if donees attempted to give effect to the person’s wishes and feelings, research indicates that people routinely get things wrong in this respect.<sup>35</sup> The donee may fall out with the person, or just make poor best interests decisions. Finally, lasting powers of attorney, like advance decisions, value a person’s decisions at one point in time over another. This assumption is increasingly being questioned.<sup>36</sup>

13.30 On the other hand, certain safeguards are in place to address poor decision-making by donees. For example, the Court of Protection can revoke a lasting power of attorney in certain circumstances.<sup>37</sup> The Court may also give directions

<sup>33</sup> Report on Adults with Incapacity (2014) Scot Law Com No 240, paras 4.57 to 4.60.

<sup>34</sup> As above, para 3.60. The reference to the dicta of the European Court was a reference to *Stanev v Bulgaria* (2012) 55 EHRR 22 at [130].

<sup>35</sup> V Williams and others, *Making Best Interests Decisions: People and Processes* (2012).

<sup>36</sup> See, for example, R Dresser, “Advance Directives, Self determination, and Personal Identity” in C Hackler and others (eds), *Advance Directives in Medicine* (1989).

<sup>37</sup> Mental Capacity Act 2005, s 22(3)(b).

with respect to decisions which the donee has authority to make.<sup>38</sup> This means there are certain safeguards in place for poor decision making by donees.

- 13.31 On balance, we provisionally consider that a donee should not have powers to consent in advance to what would otherwise be a deprivation of liberty. We do not think that lasting powers of attorney are sufficiently analogous to an advance decision to justify such an approach.
- 13.32 As noted above, lasting powers of attorney and advance decisions play an important role in the DoLS decision-making process. A standard authorisation cannot proceed if it conflicts with a decision of a donee or advance decision. We provisionally propose to maintain similar provisions in our new scheme. Thus, restrictive care and treatment (or the hospital scheme in chapter 8) would not apply if it conflicts with a valid decision of a donee or an advance decision.
- 13.33 We do not make any proposals in respect of self-binding directives or “Ulysses agreements”. These involve a person purporting to irrevocably bind themselves regarding their future decision-making (for example, a set of agreed actions that can be taken by the treatment team if a person with mental health problems starts to relapse). In effect, the person’s present wishes and feelings can be overruled.
- 13.34 Finally, we would like to explore ways in which advance decision-making, in general, could become more central to health and social care. For example, some stakeholders have suggested that practitioners should be required to discuss the options with patients and service users, while others have suggested the use of statutory forms for this purpose. There may also be a need to require decision-makers to record in the care plan that a person has made a form of advance decision. We welcome further views on whether legal solutions would be appropriate and useful in this context.
- 13.35 **Provisional proposal 13-1: the ability to consent to a future deprivation of liberty should be given statutory recognition. The advance consent would apply as long as the person has made an informed decision and the circumstances do not then change materially.**
- 13.36 **Provisional proposal 13-2: the restrictive care and treatment scheme and the hospital scheme would not apply in cases where they would conflict with a valid decision of a donee or advance decision.**
- 13.37 **Question 13-3: how (if at all) should the law promote greater use of advance decision-making?**

<sup>38</sup> As above, s 23(2)(a)(i).

## CHAPTER 14

# REGULATION AND MONITORING

- 14.1 This chapter considers the regulatory and oversight arrangements that should apply under our proposed protective care scheme. It includes the current arrangements under the DoLS and the requirements imposed by the Optional Protocol to the Convention against Torture.

### REGULATION OF THE DOLS

- 14.2 The Mental Capacity Act makes provision for one or more prescribed bodies to be appointed to monitor and report on the operation of the DoLS in England.<sup>1</sup> The Care Quality Commission has been appointed to undertake these functions.<sup>2</sup> The Mental Capacity Act also provides that regulations may make provision enabling the Welsh Ministers to monitor and report on the operation of the DoLS in relation to Wales, and direct one or more persons or bodies to carry out these functions.<sup>3</sup> The relevant bodies are the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales.<sup>4</sup>
- 14.3 Health and social care regulation is often associated with two broad approaches: the “discrete case approach” which identifies individuals or “bad apples” responsible for poor performance and enforces individual responsibility, and the “systemic approach” where emphasis is placed on systemic failures as well as individual responsibility.<sup>5</sup> The DoLS regulators operate under a hybrid model which utilises aspects of both approaches. In broad terms, the regulators’ functions include the registration of service providers, inspection and monitoring of compliance, enforcement, publication of information about health and social care, and additional powers and responsibilities in relation to the protection of rights and interests of patients detained under the Mental Health Act.
- 14.4 In relation to the DoLS, the regulators have specific powers to visit hospitals and care homes, to interview residents, and to require the production of records related to the care or treatment of persons who are, or should be, subject to the DoLS.<sup>6</sup> Providers must notify the regulator of DoLS requests and authorisations, and of any direct application to the Court of Protection to authorise a deprivation of liberty.<sup>7</sup> Despite this legal requirement, the Care Quality Commission reports

<sup>1</sup> Mental Capacity Act 2005, sch A1, para 162(1).

<sup>2</sup> The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments - Amendment) Regulations 2009, SI 2009 No 827, reg 2.

<sup>3</sup> Mental Capacity Act 2005, sch A1, para 163.

<sup>4</sup> *Memorandum of Understanding between the Welsh Ministers and the Chief Inspector of the Care and Social Services Inspectorate Wales and the Chief Executive of Healthcare Inspectorate Wales* (December 2014) p 4.

<sup>5</sup> See, for example, L Mulcahy, “Health Care Professions: A Case Study in Regulatory Dilemmas” (2011) [unpublished paper].

<sup>6</sup> See, for example: the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments - Amendment) Regulations 2009, SI 2009 No 827, reg 4.

<sup>7</sup> Care Quality Commission (Registration) Regulations 2009, SI 2009 No 3112, reg 18. In Wales this is done under the powers delegated by the Welsh Government to the Care and Social Services Inspectorate Wales under the Care Standards Act 2000, ss 5 and 31(1).

that it has been notified of just over a third of applications to supervisory bodies since the provision came into force in 2011.<sup>8</sup> Whilst there are no specific powers to enforce compliance with the DoLS, the regulators can potentially rely on their general enforcement powers in such cases. For instance, action may be taken on the basis that the provider's non-compliance with the DoLS amounts to non-compliance with broader regulatory standards (for example those relating to person-centred care or dignity).<sup>9</sup>

- 14.5 The DoLS are expressly limited in application to care homes and hospitals. It follows that the regulators' regulatory functions in relation to the DoLS have no application in supported living and shared lives accommodation. Moreover the regulators have no general powers to regulate such accommodation.<sup>10</sup> Nevertheless, they do regulate domiciliary care providers who are providing "personal care" separately in supported living and shared lives accommodation.
- 14.6 The Care Quality Commission is a non-departmental statutory body. Although it enjoys a certain level of independence from Government, the Commission is ultimately accountable to the Secretary of State who may, for instance, direct it to carry out any of its functions where it is considered that it has significantly failed to do so properly.<sup>11</sup> Nevertheless, recent legislative changes have increased the Commission's independence in various ways, including by removing the Secretary of State's power to regulate the manner in which its inspection function is to be carried out.<sup>12</sup> The Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales are both part of the Welsh Government, but a memorandum of understanding grants them a level of operational independence in carrying out their inspection and regulatory functions.<sup>13</sup>
- 14.7 It should be noted that a recent Bill, introduced into the Welsh Assembly in February 2015, proposes a number of reforms to the regulatory and inspection regime for social care services.<sup>14</sup>

### **The Optional Protocol to the Convention against Torture**

- 14.8 The Optional Protocol to the Convention against Torture<sup>15</sup> is an international

<sup>8</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards 2013/14* (January 2015) p 14.

<sup>9</sup> See, for example, The Care Quality Commission, *The Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Guidance for Providers* (2011) p 10, and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014 No 2936.

<sup>10</sup> Supported living schemes can be distinguished from care homes on the basis that any care requirements are dealt with separately to the provision of accommodation, rather than being bundled together. See, generally, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014 No 2936, sch 1.

<sup>11</sup> Health and Social Care Act 2008, s 82.

<sup>12</sup> Care Act 2014, s 90(7), amending the Health and Social Care Act 2008, s 61(1) and (4).

<sup>13</sup> *Memorandum of Understanding between the Welsh Ministers and the Chief Inspector of the Care and Social Services Inspectorate Wales and the Chief Executive of Healthcare Inspectorate Wales* (December 2014) p 1.

<sup>14</sup> Regulation and Inspection of Social Care (Wales) Bill GB/28/15.

<sup>15</sup> Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (18 December 2002) A/RES/57/199.

human rights treaty designed to strengthen protections against the abuse of people deprived of liberty. The United Kingdom ratified the protocol in December 2003, and it came into force in June 2006.

- 14.9 Essentially, the protocol provides for a system of unannounced and unrestricted visits by both national and international bodies to places of detention. At the international level, this role is undertaken by the Subcommittee on Prevention.<sup>16</sup> The inspection of a wide range of places must be allowed by states, extending to any place under a state's jurisdiction and control where people are, or may be, deprived of their liberty either by an order given by a public authority or "at its instigation or with its consent or acquiescence".<sup>17</sup> The notion of a deprivation of liberty is also defined broadly to mean:

any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.<sup>18</sup>

- 14.10 Inspection must be allowed not only in places like prisons or police cells, but also in hospitals and care homes. Ultimately, the wide notion of a deprivation of liberty may also potentially suggest that inspection must be allowed within supported living and shared lives accommodation, and domestic settings where deprivations of liberty are occurring with state acquiescence. Up to this point, however, the Subcommittee on Prevention has not attempted to exercise this potentially extremely wide jurisdiction.

- 14.11 At the national level, the protocol requires that state parties set up or designate one or more "national preventive mechanisms" to conduct visits to places of detention.<sup>19</sup> These mechanisms must be guaranteed functional independence from the state and, at a minimum, have powers to examine regularly the treatment of people deprived of liberty in places of detention. These mechanisms may also make recommendations to the relevant authorities to improve the treatment and conditions of those deprived of their liberty to prevent torture and other ill-treatment.<sup>20</sup> In the United Kingdom, rather than creating a new single body to act as the national preventive mechanism, the Government collectively designated 18 existing bodies. The designated bodies in relation to England and Wales, as relevant to detention for treatment and care of adults who lack capacity, are the Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales.<sup>21</sup>

<sup>16</sup> Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (18 December 2002) A/RES/57/199, art 2(1).

<sup>17</sup> As above, art 4(1). Although there is some inconsistency between article 4(1) and the language used in article 4(2), which appears to set out a narrower definition, the broader definition is more widely accepted, see University of Bristol Human Rights Implementation Centre, *'Deprivation of Liberty' as per Article 4 of OPCAT: The Scope* (October 2011).

<sup>18</sup> As above, art 4(2).

<sup>19</sup> As above, arts 3 and 17.

<sup>20</sup> As above, arts 18(1) and 19.

<sup>21</sup> UK Government, *Fifth Annual Report of the United Kingdom's National Preventive Mechanism* (2014) Cm 8964, p 10.

- 14.12 Compliance with the Convention against Torture and the Optional Protocol is overseen by the Committee against Torture.<sup>22</sup> In 2013 the Committee raised a concern regarding the practice in the United Kingdom of seconding state officials working in places where deprivations of liberty occur to the regulators, on the basis that this may serve to compromise the guarantee of full independence expected from such bodies.<sup>23</sup> In response, the United Kingdom Government agreed to work to strengthen the actual and perceived independence of the mechanisms. It noted, however, that the functions carried out by some regulators are broader than merely ensuring compliance with the protocol.<sup>24</sup>

### **PROVISIONAL VIEW**

- 14.13 It is essential that our proposed protective care scheme provides for a regulatory system that complies with the Optional Protocol to the Convention against Torture. Research shows that different countries achieve compliance through different mechanisms. In England and Wales, the existing powers of the DoLS regulators would appear to satisfy the protocol's requirements at a national level, and we envisage that they will continue to play a key role under protective care. But we would welcome views on whether any aspects of the current regulatory arrangements do not comply with the Optional Protocol.
- 14.14 Given the broad definition of a deprivation of liberty adopted in the Optional Protocol, we consider it an open question whether it requires inspection of deprivations of liberty in supported living and shared lives accommodation and other domestic settings. As has been seen, the present regulatory oversight does not extend to these settings (albeit that it does extend to the care provided in such settings). Although the most recent report on the United Kingdom by the Committee against Torture did not raise this as a compliance issue, these aspects of the protocol have not yet been definitively tested.
- 14.15 In any event, our proposed restrictive care and treatment scheme will enable the authorisation of deprivations of liberty by the state in such settings and, whether or not the protocol applies, some form of oversight is needed. We provisionally propose that the DoLS regulators should be responsible for monitoring and reporting on the operation of restrictive care and treatment and the hospital scheme. In effect, their regulatory remit would be extended to include supported living and shared lives accommodation and other domestic settings (when restrictive care and treatment, including a deprivation of liberty, is in place). Given the regulators' present role in inspecting care provided in supported living settings, we expect the resource implications of this change to be minimised. Nevertheless, there may be resource implications. We do not think the regulators should be given specific responsibility for supportive care since this would be overseen by the relevant local authority.

<sup>22</sup> Subcommittee on Prevention of Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment of the Committee against Torture, established by Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (18 December 2002) A/RES/57/199, art 2(1).

<sup>23</sup> Committee against Torture, *Concluding Observations on the Fifth Periodic Report of the United Kingdom of Great Britain and Northern Ireland, Adopted by the Committee at its Fiftieth Session* (24 June 2013) CAT/C/GBR/CO/5, par 14.

<sup>24</sup> UK Government, *Fifth Annual Report of the United Kingdom's National Preventive Mechanism* (2014) Cm 8964, pp 60 to 61.

- 14.16 We have heard from service providers, and from the regulators themselves, that responding to the increased regulatory inspection demand resulting from the higher numbers of DoLS applications in the wake of *Cheshire West* has been highly challenging.<sup>25</sup> To the extent that an expanded remit may also allow inspection of supported living and other domestic homes, there may also be privacy issues to consider.
- 14.17 One way of minimising the resource implications might be to explore the potential for greater joint working and sharing of intelligence amongst the various health and social care actors. Advocates and individual practitioners may offer valuable insights and useful information about the day-to-day experiences of patients and service users who are deprived of liberty. Local authorities and the NHS may have useful information about providers through their commissioning role. Health and Wellbeing Boards, Healthwatch England and local Healthwatch bodies may also be important sources of information about health and social care providers, and might be well placed to gather local views and information about the effectiveness of the new scheme. Finally, various regulatory bodies may provide information about individual providers, units or sites, or individuals where there may be potential concerns. For instance individual professionals are regulated by bodies such as the General Medical Council, Nursing and Midwifery Council and Health and Care Professional Council. The Health Service Ombudsman and Local Government Ombudsman deal with individual complaints, as well as publish reports and good practice guides which draw attention to poor performance trends across the sectors. Poor professional service standards may also give rise to a serious untoward incident, a safeguarding investigation, a serious case review or a criminal prosecution. Finally, housing providers may also be regulated by the Homes and Communities Agency.
- 14.18 Some of these various actors already have ways of encouraging more effective interfaces, such as through a memorandum of understanding.<sup>26</sup> It may be that greater joint working between these different bodies and the DoLS regulators may help to relieve the burdens placed upon them. We would welcome views on whether there is scope for greater co-operation, and if the law is the most appropriate way of facilitating this.
- 14.19 We would also be interested in exploring whether the increased demands post *Cheshire West* might be reduced through alternative forms of regulation. For example, the concept of “right-touch regulation” encourages proportionate and targeted forms of regulatory intervention, as well as finding ways other than regulation to promote good practice and high quality care. In other words, it promotes the “minimum regulatory force required to achieve the desired result”.<sup>27</sup> It has been suggested to us that the DoLS regulators will need to develop more proportionate forms of regulation in the future as an alternative to the inspection model; such as undertaking a “meta-regulation” role in settings which are already subject to extensive forms of regulation, or encouraging a system of lay or community visitors. The use of community visitors in mental health institutions

<sup>25</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896.

<sup>26</sup> The General Dental Council, the General Medical Council, General Social Council and the Nursing and Midwifery Council.



has already been developed in the Australian state of Victoria.<sup>28</sup> The need for proportionate and tailored forms of regulation may be particularly important in respect of supported living and other domestic and family homes. We would be interested in further views on the different regulatory approaches that might be adopted in this context.

- 14.20 Finally, we are aware that some have criticised the DoLS for its failure to regulate directly the actions of the supervisory body. For instance it is claimed that cases such as *London Borough of Hillingdon v Neary* point to the dangers that arise as a result of poor decision-making by assessors and the lack of internal arrangements to mitigate against conflicts of interest.<sup>29</sup> These concerns have been heightened in England as a result of the Care Act 2014 which removed the role of the Care Quality Commission in routinely assessing the quality of local authority commissioning – although it can undertake a special review in cases of systematic failure.<sup>30</sup> Under our provisional proposals the role of the local authority and the NHS would alter, and there would be greater emphasis on individual decision-making by Best Interest Assessors (who will be known as Approved Mental Capacity Professionals). We have proposed in chapter 7 that separate regulatory arrangements should be introduced for these professionals. We consider this would provide adequate regulatory and oversight arrangements in this respect, but we would welcome further views on this point.
- 14.21 **Provisional proposal 14-1: the Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales should be required to monitor and report on compliance with the restrictive care and treatment scheme and the hospital scheme.**
- 14.22 **Question 14-2: how might the new legal framework encourage greater joint working between the various health and social care bodies and regulatory schemes and alternative forms of regulation?**
- 14.23 **Question 14-3: is greater regulatory oversight needed of individual decision-makers and local authorities and the NHS for the purposes of protective care?**

<sup>27</sup> Professional Standards Authority, *Right-touch Regulation* (2010) para 2.6.

<sup>28</sup> Care Quality Commission, *A Comparative Review of International Monitoring Mechanisms for Mental Health Legislation* (2013).

<sup>29</sup> See chapter 6.

<sup>30</sup> Care Act 2014, s 91.

## CHAPTER 15

### OTHER ISSUES

- 15.1 This chapter considers certain matters which are relevant to our proposed protective care scheme. Specifically it considers the position of children and young people, ordinary residence, criminal offences and civil remedies, coroners, paying for care, and foreign detaining orders.

#### CHILDREN AND YOUNG PEOPLE

- 15.2 A child or young person's ability to consent to care and treatment depends on their capacity or competence to do so. The Mental Capacity Act applies to people aged 16 and over, and therefore will determine whether a young person (aged 16 or 17) has capacity to consent. The competence of a child under 16 to consent will be determined by the principles set out in *Gillick v West Norfolk and Wisbech Area Health Authority*.<sup>1</sup> However, the DoLS only apply to adults aged 18 and over. Therefore, different legal frameworks must be used to authorise deprivations of liberty for children and young people.

#### Parental authority

- 15.3 Case law recognises the right of parents – in certain cases – to place constraints on children and young people which can authorise what would otherwise amount to a deprivation of liberty. In *Neilsen v Denmark* the Strasbourg court found that the hospitalisation of a 12 year old boy in a psychiatric unit for five months was not a deprivation of liberty. It was instead the responsible exercise by the child's mother of her custodial rights in the interests of the child.<sup>2</sup> This decision was described as "controversial" by Lord Neuberger in *Cheshire West* and has also been doubted by Mr Justice Munby (as he was then).<sup>3</sup>
- 15.4 In *RK v BCC* the Court of Appeal accepted that "detention engages the article 5 rights of the child and a parent may not lawfully detain or authorise the detention of a child".<sup>4</sup> However, Mr Justice Keehan in *Trust A v X* doubted whether this correctly stated the legal position.<sup>5</sup> It was held that a child's parents are capable of authorising what would otherwise be a deprivation of liberty where this is within the "zone of parental responsibility".<sup>6</sup> Mr Justice Keehan emphasised that whether care or treatment falls within the zone of parental responsibility will

<sup>1</sup> *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

<sup>2</sup> *Neilsen v Denmark* (1988) 11 EHRR 175 (App No 10929/84). But note the many dissenting opinions. The decision was also been doubted by Munby J in *Re A* [2010] EWHC 978 (Fam) at [161].

<sup>3</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [72] and *Re A* [2010] EWHC 978 (Fam) at [161].

<sup>4</sup> *RK v BCC* [2011] EWCA Civ 1305 at [14].

<sup>5</sup> *Trust A v X* [2015] EWHC 922 (Fam) at [29]. We understand that this case will be considered by the Court of Protection as the person concerned has now turned 16.

<sup>6</sup> As above, at [55].

depend on the facts, but it is “inevitable and necessary” to take into account the child or young person’s diagnosed conditions.<sup>7</sup>

- 15.5 In *Cheshire West* one of the appellants was 17 years old. Lady Hale stated that constraints would not amount to deprivation of liberty for the purpose of article 5 “if imposed by parents in the exercise of ordinary parental responsibilities” and “outside the legal framework governing state intervention in the lives of children or people who lack the capacity to make their own decisions”.<sup>8</sup> Lord Kerr suggested that since restriction of liberty is a common condition for all children, a comparison should be made with a child of the same age and relative maturity of the child.<sup>9</sup>

### **State detention**

- 15.6 Secure accommodation can be provided under the Children Act 1989 for the purpose of restricting liberty.<sup>10</sup> This applies to children accommodated by the NHS or local authority in children’s homes, residential care homes, nursing homes or mental nursing homes (but not to children over the age of 16 who are accommodated in community homes).<sup>11</sup> Regulations provide that children can be kept in secure accommodation without the authorisation of the court for up to 72 hours in a period of 28 days. The court has power under the regulations to authorise the use of such accommodation for up to three months initially, with extensions of up to six months on a renewal of application.<sup>12</sup> The Court of Appeal has held that an order under section 25 authorising deprivation of liberty in secure accommodation is compatible with article 5.<sup>13</sup>
- 15.7 The Mental Health Act can be used to provide compulsory medical treatment for a mental disorder, and is available for people of all ages. Section 131 provides that a young person who has capacity to consent cannot have his or her decision on whether or not to be admitted to hospital overridden by a person with parental responsibility.
- 15.8 Outside these cases, a public authority can make an application to the Court of Protection for a declaration as to the legality of depriving a young person of liberty.<sup>14</sup> It has also been confirmed that the Court of Protection has the power to make an order which authorises a person who has attained the age of 18 being deprived of liberty in premises which are a children’s home.<sup>15</sup>

<sup>7</sup> *Trust A v X* [2015] EWHC 922 (Fam) at [55] to [57].

<sup>8</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [54].

<sup>9</sup> As above, at [79].

<sup>10</sup> Children Act 1989, s 25(1).

<sup>11</sup> Children (Secure Accommodation) Regulations 1991, SI 1991 No 1505, regs 7 and 5(2)(b).

<sup>12</sup> As above, regs 11 and 12.

<sup>13</sup> *Re K* [2001] Fam 377.

<sup>14</sup> *Barnsley MBC v GS* [2014] EWCOP 46, [2015] COPLR 51.

<sup>15</sup> *Liverpool City Council v SG* [2014] EWCOP 10, [2014] COPLR 585.

### **Provisional view**

- 15.9 The remit of our review extends to considering whether young people (not children aged 15 or younger) should fall within our proposed protective care scheme. This would enable deprivations of liberty to be authorised for such people, as well as provide oversight arrangements for their care and treatment. Arguably, the present law introduces unjustifiable inequalities amongst age groups, and potentially places young people at a distinct disadvantage compared to those over 18. The development of human rights law has contributed to the increasing recognition of the need to give greater weight to the views of young people. This is beginning to be reflected in law in relation to the admission of young people under the Mental Health Act. We provisionally consider that the deprivation of liberty of those aged 16 and 17 should come under our scheme. We do not consider that the alternative provisions, such as section 25 of the Children Act, provide an adequate basis for dealing with 16 and 17 year olds who satisfy the “acid test”. In effect, young people who lack capacity under the Mental Capacity Act could be eligible for supportive care (see chapter 6), restrictive care and treatment scheme (see chapter 7) and the hospital scheme (see chapter 8).
- 15.10 It is also a matter of concern that judicial confidence is being placed in the “zone of parental control” which remains a poorly understood and ill-defined concept.<sup>16</sup> It is a concept introduced in the 2008 version of the *Mental Health Act Code of Practice* and was renamed the “scope of parental responsibility” in the current version. It is emphasised that whether a particular intervention can be undertaken on the basis of parental consent will need to be assessed in the light of the particular circumstances of the case, and practitioners will need to consider a range of factors. These include the age, maturity and understanding of the child or young person.<sup>17</sup> The implication of the case law is that a young person who lacks capacity may be left without the protections guaranteed by article 5 as a result of this concept. We would welcome further views on the appropriateness of the concept of parental control in relation to young people, and evidence of how it is being used.
- 15.11 **Provisional proposal 15-1: protective care should apply to persons aged 16 and over.**
- 15.12 **Question 15-2: is the concept of the zone of parental responsibility appropriate in practice when applied to 16 and 17 year olds who lack capacity?**

### **ORDINARY RESIDENCE**

- 15.13 Where a person needs to be deprived of liberty in a care home in England or Wales, the DoLS provide that the supervisory body is always the local authority in whose area the person is ordinarily resident.<sup>18</sup> This remains the case regardless of whether the person has been placed in the care home in another authority’s area by the local authority or the NHS. If the person is a self-funder (and for instance a deputy has entered into a tenancy with the care home on behalf of the

<sup>16</sup> See, for example, J Watts and R Mackenzie, “The Zone of Parental Control: A reasonable Idea or an Unusable Concept?” 18(1) *Tizard Learning Disability Review* 38.

<sup>17</sup> Department of Health, *Mental Health Act 1983: Code of Practice* (2015) chap 19.

<sup>18</sup> Mental Capacity Act 2005, sch A1, para 182(1) and (2).

person) or is not ordinarily resident in any local authority (for example a person of “no settled residence”) they usually acquire ordinary residence in the area in which their care home is located.<sup>19</sup> The “deeming” provisions in the Care Act 2014 and (in Wales) the National Assistance Act 1948 apply for the purposes of determining where a person is ordinarily resident.<sup>20</sup> This means that if a local authority places the person in a care home in a different local authority area, their ordinary residence remains with the first local authority.

- 15.14 Where a hospital patient in England is subject to the DoLS, the supervisory body is the local authority where the person is ordinarily resident. This means that in England the supervisory body for a person deprived of their liberty in a hospital is not determined by the way the person’s treatment is commissioned. Following the Health and Social Care Act 2012, the patient’s treatment is commissioned by the relevant Clinical Commissioning Group – which is identified by reference to the patient’s registered GP practice or the area in which the patient is “usually resident”. Where a hospital patient in Wales is subject to the DoLS, the managing authority is the NHS body that commissioned care.
- 15.15 If a person needs to be deprived of liberty in a care home upon discharge from hospital, and the care home applies for a standard authorisation in advance whilst the person is still in hospital, it is the local authority in whose area the person was ordinarily resident before their admission to hospital which is responsible for acting as the supervisory body. This remains the case even where it is planned that the person will be discharged from hospital to a care home located in another local authority area. If a person in receipt of NHS continuing health care becomes subject to the DoLS, the responsible supervisory body is the local authority in which he or she was ordinarily resident immediately before being provided with NHS continuing health care.<sup>21</sup>
- 15.16 Where two or more local authorities dispute the person’s ordinary residence for the purpose of identifying which authority is the supervisory body, disputes may be determined by the Secretary of State or appointed person, or by the Welsh Ministers where they cannot be resolved locally. Disputes between a local authority in England and a local authority in Wales are determined by the Secretary of State or Welsh Ministers.<sup>22</sup> In the event of a dispute occurring, the local authority which receives the request for a standard authorisation must act as the supervisory body until the dispute is resolved, unless another local authority agrees to perform this role.<sup>23</sup>

<sup>19</sup> As above, sch A1, para 182(3).

<sup>20</sup> As above, sch A1, para 183.

<sup>21</sup> Section 39(5) of the Care Act applies to all NHS accommodation and not just hospitals.

<sup>22</sup> Mental Capacity Act 2005, sch A1, para 183(4) and Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858.

<sup>23</sup> Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, regs 17 to 18.

### Provisional view

- 15.17 The remit of our review does not extend to considering the meaning of ordinary residence or whether the concept of ordinary residence is the most effective way of determining which body is responsible for an individual. We envisage that – in broad terms – the principles set out above would continue to apply under our scheme. However, there would need to be some changes in order to accommodate our provisional proposals.
- 15.18 In chapters 6 and 7, we set out our proposed protective care scheme for care home, supported living and shared lives accommodation. Section 39 of the Care Act and regulations made under it extend the “deeming” principle in England to all of these forms of accommodation.<sup>24</sup> It therefore follows that under the proposed protective care scheme, if a local authority in England places the person in care home, supported living or shared lives accommodation in a different local authority area, responsibility would remain with the first local authority. In Wales the deeming provisions currently apply only to care homes, but there is a proposal to extend them to shared lives accommodation.<sup>25</sup> Therefore the effect would be the same as in England, except in respect of supported living, where the person would usually acquire ordinary residence in the area in which their accommodation is located.<sup>26</sup> We do not provisionally propose to change this under our scheme since it is linked to funding responsibilities.
- 15.19 In chapter 8, we set out our proposed scheme for deprivations of liberty in hospitals where the person is not receiving mental health treatment. For up to 28 days the detention would be authorised by the hospital managers, and therefore the responsible body would be the NHS body (for instance the Clinical Commissioning Group or Local Health Board) responsible for running the hospital in which the relevant person is, or is to be, resident. This would represent a change in England where currently the relevant local authority is responsible for such cases.
- 15.20 We have proposed above that our scheme should apply to young people aged 16 and 17. The Children Act 1989 provides that where a young person moves to certain accommodation which is out of the area where they were receiving children’s services (for example, to move to a higher or further education institution) they will normally remain ordinarily resident in the area where their parents live or the area of the local authority which had responsibility for them as a child.<sup>27</sup> If our scheme were extended to 16 and 17 year olds, the supervisory body would be the authority in which the person lived before they moved.

<sup>24</sup> Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014, SI 2014 No 2828.

<sup>25</sup> The draft Care and Support (Ordinary Residence) (Specified Accommodation) (Wales) Regulations 2015, see Welsh Government, *Consultation Document: Implementation of the Social Services and Well-being (Wales) Act 2014* (2014), annex B.

<sup>26</sup> Similarly, if the Welsh Government decides not to change its ordinary residence rules, people in supported living and shared lives accommodation would be the responsibility of the local authority area in which their accommodation is located.

<sup>27</sup> Children Act 1989, s 105(6).

- 15.21 We would welcome views on whether these cases would cause any difficulties in practice, and more broadly on how the rules currently operate and whether it might be helpful to clarify any particular elements.
- 15.22 It has also been reported to us that the lack of a fast track determination system for ordinary residence disputes can cause problems in respect of the DoLS. For instance, there have been cases where a local authority has granted a standard authorisation for someone not in fact ordinarily resident in its area, and has incurred costs as a result of section 21A proceedings and in paying for the DoLS assessments and other assessments (for example, a care and support assessment). We would welcome further evidence on whether a fast track procedure would assist.
- 15.23 **Question 15-3: what are the current difficulties that arise when identifying the supervisory body for the purposes of the DoLS? Are there any current areas that could be usefully clarified under the new scheme?**
- 15.24 **Question 15-4: is a fast track determination scheme needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence?**

#### **CRIMINAL OFFENCES AND CIVIL REMEDIES**

- 15.25 This following discussion sets out the criminal sanctions and civil remedies that may apply when a person lacking capacity is deprived of liberty unlawfully, followed by a discussion of whether the law sufficiently protects this group of people. The Mental Capacity Act sets out circumstances where deprivation of liberty is lawful: namely, where it is pursuant to a decision made by the Court of Protection or an urgent or standard authorisation given under the DoLS, or is necessary for life-sustaining treatment or doing any "vital act".<sup>28</sup>

#### **False imprisonment**

- 15.26 In civil law, establishing the tort of false imprisonment gives rise to a right to compensation for loss of liberty and "damage to reputation, humiliation, shock, injury to feelings and so on which can result from the loss of liberty". The tort is one of strict liability, meaning that it is not necessary to establish a state of mind.<sup>29</sup> The criminal offence of false imprisonment mirrors the tort, except the crime is not of strict liability, meaning it can only be committed where the defendant knew that his or her actions would detain the claimant, or was aware of a risk that this would happen and it was unreasonable to take that risk, or knew the person was not consenting or was reckless as to that fact.<sup>30</sup>
- 15.27 False imprisonment has two elements: the fact of imprisonment and the absence of lawful authority to justify it. The first is "a question of fact"; the second is "a

<sup>28</sup> Mental Capacity Act 2005, ss 4A and 4B.

<sup>29</sup> *R v Governor of Brockhill Prison, ex parte Evans (No 2)* [1999] QB 1043, 1060, by Lord Wolf..

<sup>30</sup> *R v Rahman* (1985) 81 Cr App R 349, 353; *R v Hutchins* [1988] Criminal Law Review 379.

matter of pure law”.<sup>31</sup> However, the first element of imprisonment is narrower than the concept of deprivation of liberty as it requires a degree of compulsion. Thus the Court of Appeal has held that “there may be a deprivation of liberty without false imprisonment and vice versa”.<sup>32</sup> False imprisonment can be committed without physical intervention, such as by persuading someone to remain in a confined area.<sup>33</sup> However, a person who has no desire to leave or does not appreciate that they would be stopped if they attempted to leave is not being compelled to remain, so they are not falsely imprisoned.<sup>34</sup> In contrast, deprivation of liberty does not require physical restraint or a locked ward, and can occur where the person is compliant and never attempts, or expresses the wish, to leave.<sup>35</sup>

### **Kidnapping**

- 15.28 The criminal offence of kidnapping is defined as the taking or carrying away of one person by another by force or fraud, without consent and lawful excuse and which amounts to an attack on and infringement of personal liberty.<sup>36</sup> It is punishable on indictment by a fine or imprisonment, or both. It can be committed either intentionally or recklessly. Some degree of moving is necessary to constitute kidnapping and the offence is committed during the taking or the carrying away. To establish kidnapping it is necessary to show that the victim did not consent to being taken or carried away. This can be established by proving that the person lacked the capacity to consent to being taken or carried away.<sup>37</sup> But, significantly, kidnapping only applies where there is “an attack on and infringement of the personal liberty of an individual” and force or fraud was used on them.<sup>38</sup> This creates potential difficulties establishing the offence of kidnapping in the mental health context because someone who lacks capacity may be inclined to accompany another person without any force or fraud being used against them.<sup>39</sup>

### **Regulatory offences**

- 15.29 The Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales have powers to take regulatory action against care providers that unlawfully deprive someone of liberty, or where they fail to protect users from unnecessary or disproportionate acts intended to control or

<sup>31</sup> *R (Sessay) v South London & Maudsley NHS Foundation Trust* [2011] EWHC 2617 (QB), [2012] QB 760 at [47], by Supperstone J.

<sup>32</sup> *Walker v Commissioner of Police for the Metropolis* [2014] EWCA Civ 897, [2015] 1 WLR 312 at [31], by Sir Bernard Rix.

<sup>33</sup> *Harnett v Bond* [1925] AC 669.

<sup>34</sup> *R v Bournemouth Community Mental Health NHS Trust* [1999] 1 AC 458.

<sup>35</sup> *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99) at [90].

<sup>36</sup> *R v D* [1984] AC 778, 800 by Lord Brandon.

<sup>37</sup> Simplification of Criminal Law: Kidnapping and Related Offences Law Com No 355 at paras 2.29 to 2.32 and 2.46 to 2.47.

<sup>38</sup> *Hendy-Freegard* [2007] EWCA Crim 1236, [2008] QB 57 at [41].

<sup>39</sup> Simplification of Criminal Law: Kidnapping and Related Offences Law Com No 355 at paras 2.37 to 2.42.



restrain them.<sup>40</sup> The Care Quality Commission can also take regulatory action where a patient is abused or ill-treated.<sup>41</sup> The regulators have powers to prosecute the provider for an offence, or take other regulatory action such as cancelling registration. But there are limits to the ability to regulate deprivations of liberty in some settings such as supported living placements and private homes.

- 15.30 Also, professional regulatory bodies such as the General Medical Council, Nursing and Midwifery Council and Health and Care Professions Council may take disciplinary action against individual professionals where there has been an unlawful deprivation of liberty. This would normally be on the basis that the incident demonstrates impaired fitness to practise on the basis of deficient professional performance or misconduct.

### **Proceedings under the Human Rights Act**

- 15.31 The Human Rights Act created rights to bring proceedings against public authorities for breaching human rights and to claim a remedy where this is “just and appropriate”.<sup>42</sup> Damages may be available where someone is unlawfully deprived of their liberty, but only where they can establish that they should not have suffered deprivation of liberty.<sup>43</sup> The remedy under the Human Rights Act is limited to public authorities. But someone deprived of their liberty in accommodation managed by private providers or in their family home may be able to claim against the relevant local authority for failing to take steps to protect them from interferences with their liberty.

### **Assault and battery**

- 15.32 A person may be liable in tort and criminal law for assault and/or battery. “An assault is an act which causes another person to apprehend the infliction of immediate, unlawful, force on his person”.<sup>44</sup> And there is no requirement to prove that the contact caused or threatened any physical injury or harm.<sup>45</sup> Battery is committed by touching someone in excess of what is “generally acceptable in everyday life”.<sup>46</sup> For example, taking hold of someone’s arm to require them to listen to you is a battery.<sup>47</sup> However, shaking someone’s hand would be generally acceptable. Assault and battery can be committed either intentionally or recklessly. The defendant must have intentionally or recklessly applied unlawful force on the claimant to commit battery, or caused the claimant to apprehend unlawful force on his person to commit assault. Battery and assault can be committed even where the defendant had a “laudable intention”.<sup>48</sup>

<sup>40</sup> See, for example, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014 No 2936, regs 13(4)(b) and (5).

<sup>41</sup> As above, reg 13.

<sup>42</sup> Human Rights Act 1998, ss 7 and 8.

<sup>43</sup> *Essex County Council v RF* [2015] EWCOP 1 at [72] and [73].

<sup>44</sup> *Collins v Wilcock* [1984] 1 WLR 1172, 1177.

<sup>45</sup> *Wilson v Pringle* [1987] QB 237, 249.

<sup>46</sup> *F v West Berkshire HA* [1990] 2 AC 1, 73, by Lord Goff.

<sup>47</sup> *Collins v Wilcock* [1984] 1 WLR 1172.

<sup>48</sup> As above, 1180, by Goff LJ.

- 15.33 Committing the torts of assault or battery will give rise to liability for nominal damages at least, and will also cover any physical and psychiatric injury caused.<sup>49</sup> Damages are additionally available for “humiliation and injury to pride and dignity”.<sup>50</sup> Common assault and battery are summary only offences, with a penalty of a fine, or imprisonment for a term not exceeding six months.<sup>51</sup>
- 15.34 Someone providing care to an individual unlawfully deprived of their liberty will not be committing assault or battery if they comply with section 5 of the Mental Capacity Act. This provides that where a person does an act in connection with the care or treatment of a person who lacks capacity, they will not incur liability so long as there is a reasonable belief that the person lacks capacity and it will be in their best interests for the act to be done. Section 5 does not authorise restraint unless it is necessary to prevent harm and is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.<sup>52</sup>

### **Ill-treatment and wilful neglect**

- 15.35 The Mental Health Act and the Mental Capacity Act establish criminal offences of ill-treatment and wilful neglect in relation to mental health patients and those who lack capacity respectively.<sup>53</sup> These offences apply to a “person”, which can include an individual, corporate body or partnership. An organisation can only be found guilty of wilful neglect, if a “directing mind” of that organisation was also guilty of the offence, such as where the organisation as a whole was guilty of the offence. A person is a directing mind if they are sufficiently senior to be considered the embodiment of the company.<sup>54</sup> An individual convicted of these offences faces a maximum of five years’ imprisonment or an unlimited fine.
- 15.36 Ill-treatment and wilful neglect are separate concepts and it is not necessary to prove that both took place. The courts have confirmed that to be guilty of ill treatment, the person does not necessarily need to cause physical harm, and this may include the emotional and psychological damage that the actions have caused or have the potential to cause, both to the patient and to their family. For example, it can include failing to protect the privacy and dignity of a vulnerable patient (even where the victim is not aware that they have been ill-treated).<sup>55</sup> The meaning of “wilful neglect” has also been developed through case law. The leading case is *R v Sheppard*, in which the majority held that someone “wilfully” fails to provide adequate medical attention if he or she deliberately does so, knowing that there is some risk that the person’s health may suffer unless they receive such attention, or does so because they do not care whether the person

<sup>49</sup> *Wilson v Pringle* [1987] QB 237, 247.

<sup>50</sup> *Rowlands v Chief Constable of Merseyside* [2006] EWCA Civ 1773; [2007] 1 WLR 1065 at [28].

<sup>51</sup> Criminal Justice Act 1988, s 39.

<sup>52</sup> Mental Capacity Act 2005, s 6.

<sup>53</sup> Mental Health Act 1983, s 27 and Mental Capacity Act 2005, s 44.

<sup>54</sup> *Tesco Supermarkets Ltd v Natrass* [1972] AC 153.

<sup>55</sup> *R v Newington* (1990) 91 Cr App R 247, and *Dublas v Nursing and Midwifery Council* [2011] EWHC 4214 (Admin).

may be in need of medical treatment or not.<sup>56</sup> In the most recent case, *R v Turbill*, the Court of Appeal emphasised the subjective nature of the test, holding that the term wilful “means something more is required than a duty and what a reasonable person would regard as a reckless breach of that duty”.<sup>57</sup>

- 15.37 The Criminal Justice and Courts Act 2015 introduced new offences involving ill-treatment and wilful neglect. Section 20 makes it an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or willfully neglect that individual. “Care worker” is defined widely to include any individual who is paid to give care, supervise or manage individuals providing care, and directors and similar officers of an organisation that provides such care. But the offence does not apply to family members or other individuals providing care free of charge. Where an offence under section 20 is committed, relevant care providers may be criminally liable under section 21 for any failures in management or organisation linked to the individual’s ill-treatment or wilful neglect. To be liable under section 21, the care provider’s failure must amount to a gross breach of a duty of care. A care provider found guilty of the corporate offence will be liable to pay a fine.<sup>58</sup>
- 15.38 These offences protect an individual in paid care who is unlawfully deprived of liberty where they suffer ill-treatment or wilful neglect. But they do not offer protection to individuals who receive good standards of care whilst being deprived of their liberty.

#### **Negligence and breach of statutory duty**

- 15.39 Someone deprived of liberty unlawfully may be entitled to a remedy in the law of negligence. For a claim in negligence to be successful it would have to be shown that the defendant owed the claimant a duty of care. For example, it might be possible to argue that there is a duty of care to obtain authorisation for a deprivation of liberty. But liability in negligence does not usually extend to omissions unless the defendant assumed responsibility to take some action. It is also conceivable that a claim could be brought in tort for breach of statutory duty, if it could be established that the provisions in the Mental Capacity Act about deprivation of liberty were intended to create a private action.<sup>59</sup>

#### **Unlawful detention**

- 15.40 The Northern Ireland Mental Health Order 1986 includes a specific criminal offence of knowingly detaining a person suffering from a mental disorder otherwise than in accordance with statutory procedures or detaining someone after gaining knowledge that the power authorising their detention has expired.<sup>60</sup> Furthermore, immunity is provided from criminal and civil liability in respect of any act purporting to be done in pursuance of the Order, unless the act was done in

<sup>56</sup> *R v Sheppard* [1981] AC 394. Also, see Archbold, Criminal Pleading, Evidence and Practice 2015 (Sweet & Maxwell), para 17-47.

<sup>57</sup> *R v Turbill* [2013] EWCA Crim 1422, [2014] 1 Cr App R 7 at [19].

<sup>58</sup> Criminal Justice and Courts Act 2015, s 23.

<sup>59</sup> Mental Capacity Act 2005, s 4A.

<sup>60</sup> Northern Ireland Mental Health Order 1986, No 595 (NI 4) art 120.

bad faith or without reasonable care.<sup>61</sup> This offence is triable either way and is punishable through a fine or imprisonment, or both. The Northern Ireland Assembly has proposed the introduction of new mental capacity legislation that retains this offence.<sup>62</sup>

### **Provisional view**

15.41 There is a small category of cases where criminal offences do not apply to unlawful deprivations of liberty. These are the cases of people who do not wish to leave their accommodation or are not aware that they would be prevented from leaving if they attempted to do so, or are taken from places of safety without the need for force or fraud, or for restraint, so that false imprisonment and kidnapping do not apply to them.<sup>63</sup> This is limited to people living in ordinary family homes or supported living placements, as in other settings the Care Quality Commission, Care, Social Services Inspectorate Wales and Healthcare Inspectorate Wales have regulatory jurisdiction over the care provider and can take action against them for unlawful deprivation of liberty. Moreover, these are people receiving acceptable standards of care, as the criminal law would otherwise apply through the offences of ill-treatment and wilful neglect, battery and assault. It is therefore our provisional opinion that it is legitimate in this small category of cases for criminal sanctions to not apply. This group of people would still have a civil remedy under the Human Rights Act against public authorities which have failed to protect their human rights.

15.42 **Question 15-5: should a new criminal offence of unlawful deprivation of liberty be introduced?**

### **CORONERS**

15.43 The purpose of this section is to discuss the role of coroners in investigating deaths of people who die while being subject to the deprivation of liberty safeguards. Coroners are independent judicial office holders who carry out investigations into the cause of a person's death. They are appointed by a local authority, although some will cover more than one authority area. The cost of coronial investigations is generally met by the local authority for the relevant area.<sup>64</sup> Coroners are usually lawyers but sometimes doctors, and their duties are prescribed by the Coroners and Justice Act 2009. The Chief Coroner heads the coroner service and gives guidance on standards and practice.

<sup>61</sup> Northern Ireland Mental Health Order 1986, No 595 (NI 4) art 133.

<sup>62</sup> Department of Social Services and Public Safety, *Draft Mental Capacity Bill* (May 2014), cl 135.

<sup>63</sup> In our report on kidnapping we recommend that the element of force or fraud in the offence be replaced by an element of force or threats of force. This would still leave uncriminalised the luring away of compliant people who lack mental capacity. We have recommended no change to the offence of false imprisonment in our recommended statutory offence of unlawful detention, see, *Simplification of Criminal Law: Kidnapping and Related Offences* Law Com No 355.

<sup>64</sup> Ministry of Justice, *Guide to Coroner Services* (2014), para 2.5.

### **The duty to carry out an investigation**

- 15.44 Once the coroner has reason to suspect that the criteria in section 1(2) of the 2009 Act are satisfied, there is a duty to conduct an investigation into the death, which may lead to an inquest in due course. Where the coroner has reason to suspect that the deceased died while in “state custody or otherwise in state detention”, there must be an investigation with an inquest, which must be held as soon as practicable after the coroner is satisfied that the duty to hold an inquest applies.<sup>65</sup>
- 15.45 The purpose of the inquest is to ascertain who the deceased was, how they came by their death, when they came by their death, where they were at the time of death and (where article 2 of the European Convention on Human Rights applies – see below) in what circumstances the deceased came by their death.<sup>66</sup>

### **Meaning of state detention**

- 15.46 State detention is defined in the Coroners and Justice Act to include persons “compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998”.<sup>67</sup> The explanatory notes explain that state detention includes persons detained in “prison, in police custody or in an immigration detention centre or held under mental health legislation”.<sup>68</sup>
- 15.47 There has been some debate about whether persons who die while deprived of their liberty under the DoLS are covered by this provision. The Chief Coroner issued guidance (which is not binding on coroners) on 5 December 2014 concerning those who die when subject to a DoLS authorisation or a judicial authorisation of the deprivation of their liberty under the Mental Capacity Act. Whilst it is acknowledged that there are opposing views, the guidance advises that:

on the law as it now stands, the death of a person subject to a DoL should be the subject of a coroner investigation because that person was in state detention within the meaning of the Coroners and Justice Act 2009.<sup>69</sup>

- 15.48 We consider that the Chief Coroner’s guidance represents the correct legal interpretation. This appears to have been the Government’s intention when it passed the legislation as evidenced in a written response to the Joint Committee

<sup>65</sup> Coroners and Justice Act 2009, ss 1(2), 4(2)(b) and 6 and Coroners (Inquests) Rules 2013, SI 2013 No 1616, r 5.

<sup>66</sup> Coroners and Justice Act 2009, s 5.

<sup>67</sup> Coroners and Justice Act 2009, s 48(2).

<sup>68</sup> Explanatory notes to the Coroners and Justice Act 2009, para 61.

<sup>69</sup> Chief Coroner, *Chief Coroner’s Guidance No 16: Deprivation of Liberty Safeguards* (December 2014).

of Human Rights during the Parliamentary debates (although the point is not made expressly).<sup>70</sup>

### **Type of inquest**

- 15.49 After it is decided that an inquest will be carried out the coroner will consider whether to hold the inquest with a jury. Where the person died whilst in state custody or otherwise in state detention it will be necessary to hold the inquest with a jury where there is reason to suspect that the death was a violent or unnatural one or the cause of death is unknown.<sup>71</sup> The coroner may order that a post mortem examination be conducted to examine the cause of death prior to deciding whether there is a duty to hold the inquest with a jury.<sup>72</sup> The Court of Appeal has held that “unnatural circumstances” means the death was unexpected and would not have occurred but for some culpable human failing. In particular, unnatural circumstances include a negligent failure to monitor the deceased.<sup>73</sup>
- 15.50 Where there is no reason to suspect either that “the death was a violent or unnatural one” or “the cause of the death is unknown”, it is permissible to hold an inquest on the papers.<sup>74</sup> The coroner will make their findings on the basis of written evidence and announce their decision at a public hearing, after reading out the relevant evidence. We have heard evidence that the vast majority of DoLS inquests are conducted in this format. It is possible that the family of the deceased might insist that the coroner calls witnesses at the inquest, which they are entitled to do as an “interested person”.<sup>75</sup>

### **Article 2 investigatory obligations**

- 15.51 Article 2 requires a proactive investigation into “the circumstances” whereby the person came by their death where “the evidence suggests a possible breach of the state's substantive duty to protect the life of those in its direct care”.<sup>76</sup> Lady Justice Hallett has held that there is little practical difference between the scope of an inquest where article 2 is engaged and one where it is not.<sup>77</sup> However, where article 2 is engaged the coroner may be obliged to exercise the power

<sup>70</sup> Government replies to the Second, Fourth, Eighth, Ninth and Twelfth reports of session 2008-09, Report of the Joint Committee on Human Rights (2008-09) HL 104/HC 592, p 15 and *Hansard*, HL Debate 9 June 2009, col 564.

<sup>71</sup> Coroners and Justice Act 2009, s 7(2)(a).

<sup>72</sup> As above, s 14(1)(a).

<sup>73</sup> *R (Touche) v HM Coroner for Inner North London District* [2001] EWCA Civ 383, [2001] QB 1206.

<sup>74</sup> Coroners and Justice Act 2009, s 7(2)(a).

<sup>75</sup> Coroners (Inquests) Rules 2013, SI 2013 No 1616, r 19.

<sup>76</sup> *R (Humberstone) v Legal Services Commission* [2010] EWCA Civ 1479, [2011] 1 WLR 1460 at [52].

<sup>77</sup> *R (Sreedharan) v HM Coroner for the County of Greater Manchester* [2013] EWCA 181, [2013] Med LR 89 at [18].

under section 32 of the Coroners and Justice Act to report matters to some person believed to have power to take action to prevent future deaths.<sup>78</sup>

- 15.52 The Strasbourg court has not considered whether the investigatory duty applies to people lacking mental capacity who are deprived of their liberty in hospital, care homes or domestic settings. But the domestic courts have confirmed that people detained in hospital under the Mental Health Act and informal mental health patients (in cases where they are not in fact free to leave) are under the control of the state and therefore the article 2 investigatory duty can apply to them.<sup>79</sup> It has been held that certain types of death where the individual was under the control of the state trigger the investigatory duty automatically – for example a formal or informal mental health patient who commits suicide in a hospital which they were not free to leave.<sup>80</sup>
- 15.53 We consider it likely that the courts would consider that the article 2 substantive duty applies to people deprived of their liberty in hospitals and care homes under DoLS (or a relevant Court of Protection order). And therefore the investigatory duty may apply where an individual under the DoLS dies, for example where they commit suicide. This is likely to be the case notwithstanding the fact that some individuals under the DoLS are self-funders in private institutions. This is because, first, the fact that a public authority has to authorise their detention suggests that deprivation of liberty is a public function.<sup>81</sup> Secondly, Lady Hale has stated in argument that the exercise of a statutory power to deprive someone of their liberty is of the nature of a public power.<sup>82</sup> Thirdly, as noted above, the Government intended all cases under the DoLS to fall within the definition of a state detention. Finally, it is likely to be relevant that the Care Quality Commission, Care, Social Services Inspectorate Wales or Healthcare Inspectorate Wales maintains a regulatory role over all care homes, including private ones.<sup>83</sup>

### **Provisional view**

- 15.54 With the increase in DoLS authorisations following *Cheshire West* there will inevitably be a corresponding rise in the number of coroner's inquests. The exact size of the increase remains to be seen. It has been suggested to us that the number of DoLS inquests is currently ranging from two per month in some coroner areas to as many as 30 in others. This may be an underestimate given the backlog of cases local authorities are facing and underreporting of deaths.

<sup>78</sup> *R (Lewis) v Mid and North Shropshire Coroner* [2009] EWCA Civ 1403, [2010] 1 WLR 1836 at [11] and [35].

<sup>79</sup> *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, [2012] 2 AC 72 at [34]. This case involved the state's substantive duty, but it also provides an indication of when the investigatory duty is triggered as well. See *R (Letts) v The Lord Chancellor* [2015] EWHC 402 (Admin) at [88].

<sup>80</sup> *R (Letts) v The Lord Chancellor* [2015] EWHC 402 (Admin), [2015] 2 Costs LR 217 at [92].

<sup>81</sup> See also: *Poplar Housing and Regeneration Community Association Ltd v Donoghue* [2001] EWCA Civ 595, [2002] QB 48 at [65] by Lord Woolf.

<sup>82</sup> *YL v Birmingham CC* [2007] UKHL 27, [2008] 1 AC 95 at [70].

<sup>83</sup> *Storck v Germany* (2006) 43 EHRR 6 (App No 61603/00).

- 15.55 We have been told that the requirement to hold an inquest in the case of any death of a person subject to a DoLS authorisation goes wider than is required for the purposes of public protection and is problematic both for coroners and for relatives of the deceased. In particular, the problems revolve around additional workload for coroners and, for relatives, their subjection to an intrusive-seeming process and delay caused to funeral arrangements. The Care Quality Commission has reported that families are experiencing distress when delays occur following someone's death, in particular in cases where a swift burial following death is a cultural norm.<sup>84</sup> It has also been suggested that the requirement to hold an inquest will potentially effect organ donation – especially in certain hospital settings, such as intensive care, where the potential for high levels of DoLS authorisations will increase the demand for coroners investigations, thus blocking organ donations. On the other hand, we have heard of coroners who have devised methods of working that enable them to complete inquests “on the papers” within a very short time of the death of a person subject to a DoLS authorisation. Any further evidence on these issues would be very valuable to us.
- 15.56 The Department of Health has also argued that while the death of an individual who is subject to the DoLS (or a relevant Court of Protection order) may in legal terms be a death in state detention and a robust investigation is needed in cases involving untoward factors – “it is important to recognise that on the ground and for the family, in the great majority of cases, the death has occurred in a ‘normal’ care environment”.<sup>85</sup>
- 15.57 As regards solutions, we have considered whether there should be amendment of the Coroners and Justice Act 2009. A number of approaches could be taken, singly or in combination. It may be possible for example to introduce into the legislation an additional criterion for compulsory inquests into deaths of those deprived of liberty under restrictive care and treatment, to the effect that the state has a duty under article 2 to investigate the circumstances of the person's death. Another is to rely on a different investigatory authority to carry out an article 2 investigation into deaths of people subject to protective care, such as the appropriate services regulator where the deceased died in the care of a regulated institution. This however would have significant resource implications for the regulators and would depart from the principle that the coroner is the official charged with investigating deaths.
- 15.58 There may be other potential modifications of the 2009 Act that could be beneficial. Possibilities might include a coronial “article 2 investigation”, meeting the requirements of article 2 without the formality of an inquest, or relaxation in some cases of the duty to hold an inquest with a jury. On the other hand, we have heard evidence from coroners that inquests are capable of being conducted with minimal formality and expense. This is consistent with the Chief Coroner's guidance which suggests that cases where there are no controversial issues can be dealt with on the papers only, decided in open court and without witnesses

<sup>84</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013/14* (2015) p 23.

<sup>85</sup> Department of Health, *Update on the Mental Capacity Act and Following the 19 March 2014 Supreme Court Judgment: Letter from Mr Niall Fry to MCA-DoLS Leads in Authorities and the NHS* (14 January 2014) p 4.



having to attend.<sup>86</sup> This leads us to believe that the problem is caused by the large number of inquests involved, rather than the formality and expense of holding each individual inquest.

- 15.59 It is our provisional opinion that the mandatory duty to carry out an inquest into deaths of people subject to the DoLS should be amended in its application to our restrictive care and treatment scheme, so that an inquest is only necessary where the coroner is satisfied that the state's investigatory duty applies. This should mean that inquests are avoided in a vast number of cases which do not engage the state's investigatory duty under article 2, and thereby reduce the number of burials and cremations being disrupted by inquests. It is important that any amendment, whilst relieving pressure on coroners, does not render the United Kingdom in breach of article 2 and we would be interested in the views of stakeholders on how this can be achieved.
- 15.60 The amendment that we currently favour would empower a coroner to discontinue an investigation where the coroner is satisfied that a deceased person who was subject to the restrictive care and treatment scheme was not deprived of their liberty at the time of their death, or that the circumstances of the death were not such as to trigger the article 2 duty. We welcome views on this. In addition there might also be scope for introducing a power for coroners to release the deceased's body for burial or cremation before the conclusion of an investigation or inquest. We would value stakeholders' views on whether this is necessary in addition to our provisional proposal.
- 15.61 It should be borne in mind that our proposed scheme of protective care applies to a wider cohort of people than the DoLS, and includes people who are not deprived of liberty. Only those under the restrictive care and treatment scheme or subject to the hospital scheme could be deprived of liberty. It is axiomatic that under our proposals the duty to undertake inquests would apply only where the person subject to restrictive care and treatment is deprived of liberty.
- 15.62 We are assuming that the coroner is made aware of all cases of deaths where he or she has a duty to conduct an investigation. No particular person or office is recognised as having responsibility for referring cases of deaths under the DoLS to the coroner. We have been told that in practice coroners are made aware of these cases, for example following a report from a local registrar.<sup>87</sup> However, we have heard that there may be cases where they are not referred as a result of resource pressure on local authorities. We would welcome views on whether the current law on referrals to coroners causes problems in practice and risks non-compliance with article 2.
- 15.63 **Provisional proposal 15-6: the Criminal Justice Act 2009 should be amended to provide that inquests are only necessary into deaths of people subject to the restrictive care and treatment scheme where the coroner is satisfied that they were deprived of their liberty at the time of their death and that there is a duty under article 2 to investigate the circumstances of that individual's death.**

<sup>86</sup> Chief Coroner, *Chief Coroner's Guidance No 16: Deprivation of Liberty Safeguards* (December 2014) at para 71.

<sup>87</sup> Registration of Birth and Death Regulations 1987, SI 1987 No 2088, reg 41.

- 15.64 **Question 15-7: should coroners have a power to release the deceased's body for burial or cremation before the conclusion of an investigation or inquest?**
- 15.65 **Question 15-8: is the current law on the reporting of deaths to the coroners satisfactory?**

#### **PAYING FOR CARE AND TREATMENT**

- 15.66 When a person is detained under the Mental Health Act or the DoLS in hospital their care and stay is free. If a person has been detained under section 3 of the Mental Health Act they are also eligible for free-after care services.<sup>88</sup> In contrast, social care is means tested and therefore people living in care homes subject to the DoLS may be charged (and may potentially face the need to sell their home as a result). The Joint Committee on Human Rights has argued:

This gives rise to potential issues under article 14 of the Convention if there are arbitrary bases for charging for deprivations of liberty, such as might arise if a person could be shown to have been charged for residential accommodation primarily on the basis that they lack capacity.<sup>89</sup>

- 15.67 The Government has argued that to provide free personal care for all people deprived of liberty in care homes would create new, unacceptable inequities and potential discrimination between those care home residents who are deprived of liberty and those who are not. During the Parliamentary debates in the House of Lords on the Mental Health Act 2007, Baroness Ashton, the then Parliamentary Under-Secretary of State, argued that:

The whole basis of the Bournemouth principle is that people are deprived of their liberty because they need to be made safe and secure and given high-quality care. I see no reason to suggest that the means-testing element should be disapplied.<sup>90</sup>

- 15.68 In the House of Commons, Rosie Winterton MP, the then Minister of State argued that:

We must consider the views of residents in circumstances when care for another resident suddenly becomes free because restrictions have been put in place for that person's best interests, but their care does not.<sup>91</sup>

<sup>88</sup> *R (Stennett) v Manchester CC* [2002] UKHL 34, [2002] 2 AC 1127.

<sup>89</sup> House of Lords House of Commons Joint Committee on Human Rights: Legislative Scrutiny Seventh Progress Report: Fifteenth Report of Session 2006-07: Drawing Special Attention to the Mental Health Bill (2007) HL Paper 112, HC 555 para 1.31.

<sup>90</sup> House of Lords Committee stage, 17 Jan 2007, vol 688, col 764, Baroness Ashton.

<sup>91</sup> *Hansard* (HC), Public Bill Committee, Tuesday 15 May 2007 (PM) col 404, by Rosie Winterton MP.

- 15.69 It was also suggested that there might be a perverse incentive for people to be deprived of liberty because that would be the cheaper option for them.<sup>92</sup>
- 15.70 The issue was considered by the Administrative Court in *DM v Doncaster Borough Council*. It was held that the Mental Capacity Act does not provide an express power to accommodate, and therefore accommodation is provided through some other power or duty (in this case the National Assistance Act 1948 which at the time required local authorities to charge for accommodation). The court saw the Mental Capacity Act as designed to ensure that those implementing a care regime in a person's best interests which involves deprivation of liberty are free from liability for doing so. It was also held that the element of compulsion involved does not automatically take the person's needs out of social care and into NHS continuing health care (which must be provided free of charge). The court also rejected arguments that the requirement to pay was discriminatory within the meaning of the European Convention on Human Rights and could not be justified. Those subject to the DoLs were not materially in the same position as those who receive aftercare under section 117 of the Mental Health Act; the correct comparison was with those who did not lack capacity and were being accommodated.<sup>93</sup>

#### **Provisional view**

- 15.71 In our view, as a matter of principle it seems unfair that a person who lacks capacity who is being deprived of liberty by the state is also charged for that accommodation, particularly where the decision to place them in that accommodation is being taken for them by the state. But as a matter of law, local authorities can charge for residential accommodation and *DM v Doncaster Borough Council* confirms that there is no alternative legislative route for the provision of such accommodation. In that case the court held that the correct comparator for people subject to the DoLS was those who had capacity and who had been placed by the local authority, but this may be questionable. Arguably the more appropriate comparators are patients detained under the Mental Health Act; like people placed in accommodation under the DoLS, they have not consented to the situation but, unlike those people, they will not be charged the cost of that detention. On the other hand, the position regarding psychiatric patients may reflect the fact that NHS treatment, whether physical or psychiatric, is generally free of charge, whereas accommodation with care is generally not.
- 15.72 Of course, any suggestion that the state should pay for care and treatment when a person is deprived of liberty would have significant resources implications. It is highly unlikely that in the current economic climate the Government could fund such a commitment. We would nevertheless be interested in consultees' views on the issues of principle and the possible existence of practical solutions
- 15.73 **Question 15-9: should people be charged for their accommodation when they are being deprived of liberty in their best interests – and are there any realistic ways of dealing with the resource consequences if they are not charged?**

<sup>92</sup> As above.

<sup>93</sup> *DM v Doncaster MBC* [2011] EWHC 3652 (Admin), (2012) 15 CCLR 128.

## CROSS-BORDER ISSUES

- 15.74 Section 63 of, and schedule 3 to, the Mental Capacity Act gives effect in England and Wales to the Hague Convention on the International Protection of Adults.<sup>94</sup> In particular this provides for mutual recognition of “protection measures” imposed by a foreign court regardless of whether the country has ratified the Convention.
- 15.75 Mr Justice Baker in *Health Service Executive of Ireland v PA* held that by including schedule 3 in the Mental Capacity Act, Parliament must be assumed to have permitted foreign orders to be recognised notwithstanding that they may be inconsistent with the law and procedures in England and Wales. As the definition of “adult” in schedule “plainly extends to persons who may not be incapacitated”, it follows that the court must recognise and enforce orders of a foreign court in terms that could not be included in an order made under the domestic jurisdiction under the Mental Capacity Act. It is only where the court concludes that recognition of the foreign measure would be manifestly contrary to public policy that the discretionary ground to refuse recognition will arise.<sup>95</sup>
- 15.76 It has been reported to us by legal practitioners that there has been a steady increase in court cases recognising and enforcing detention in England and Wales on the basis of foreign orders which authorise deprivation of liberty on mental health grounds. However, as noted above, such people fall outside the scope of the Mental Capacity Act and the Mental Health Act and it may sometimes not be clear if the foreign orders can be applied in this country (particular if there are doubts over whether foreign order complies with article 5). In effect, they form a separate category of people deprived of liberty. We would welcome further evidence on whether the law is sufficiently clear and effective in this area.
- 15.77 Further issues potentially arise when a person needs to be deprived of liberty and has been placed by a local authority in England or Wales into residential care in a different UK country. As a general rule, responsibility for individuals who are placed by a local authority (in England, Scotland, and Wales) and a Health and Social Care Trust (in Northern Ireland) in cross-border UK residential care remains with the first authority.<sup>96</sup> If the person subsequently needed to be deprived of liberty (and lacked capacity), it is possible that schedule 3 would still be relevant but on the basis of habitual residence rather than ordinary residence. In broad terms this would mean that any deprivation of liberty would be under the law of the county in which the person has been placed. However, a question might arise as to whether a local authority in England and Wales can place a person in a different country in the UK in the event that there were inadequate safeguards to protect his or her article 5 rights. We would be pleased to hear from consultees with experience of such issues and whether further clarity is needed.
- 15.78 **Question 15-10: does the law concerning foreign detention orders cause difficulties in practice?**

<sup>94</sup> Hague Convention on the International Protection of Adults (13 January 2000).

<sup>95</sup> *Health Service Executive of Ireland v PA* [2015] EWCOP 38 at [93] and [98].

<sup>96</sup> Care Act 2015, sch 1.

15.79 **Question 15-11: what difficulties arise when a person needs to be deprived of liberty and has been placed by a local authority in England or Wales into residential care in a different UK country?**

# APPENDIX A

## PROVISIONAL PROPOSALS AND QUESTIONS

### CHAPTER 2: ANALYSIS OF THE DEPRIVATION OF LIBERTY SAFEGUARDS

**Provisional proposal 2-1:** the Deprivation of Liberty Safeguards should be replaced by a new system called “protective care”.

**Provisional proposal 2-2:** the introduction of protective care should be accompanied by a code of practice, and the UK and Welsh Government should also review the existing *Mental Capacity Act Code of Practice*.

### CHAPTER 3: PRINCIPLES OF PROTECTIVE CARE

**Question 3-1:** have we identified the correct principles to underpin protective care, namely that the scheme should deliver improved outcomes, and be based in the Mental Capacity Act, non-elaborate, compliant with the European Convention on Human Rights, supportive of the UN Disability Convention, and tailored according to setting?

### CHAPTER 4: THE SCOPE OF THE NEW SCHEME

**Provisional proposal 4-1:** the scope of protective care should include hospital, care home, supported living, shared lives and domestic accommodation.

**Question 4-2:** is the definition of supported living provided under the Care Act 2015 appropriate for our scheme?

### CHAPTER 6: SUPPORTIVE CARE

**Provisional proposal 6-1:** supportive care should apply where a person is living in care home, supported living or shared lives accommodation, or if a move into such accommodation is being considered.

**Provisional proposal 6-2:** supportive care should cover people who may lack capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain, in relation to the question whether or not they should be accommodated in particular care home, supported living or shared lives accommodation for the purpose of being given particular care or treatment.

**Provisional proposal 6-3:** a local authority should be required to undertake or arrange an assessment, or ensure that an appropriate assessment has taken place, where it appears that a person may be eligible for supportive care in care home, supported living or shared lives accommodation.

**Provisional proposal 6-4:** the local authority must ensure that the assessor has the skills, knowledge and competence to carry out the assessment and is appropriately trained. The assessor must consult a person with expertise in relation to the condition or circumstances of the individual, where the assessor considers that the needs of the individual require them to do so.

**Provisional proposal 6-5:** local authorities should be required to keep under review the health and care arrangements for any person who falls within supportive care. This would include ensuring that a care plan and proper capacity assessments have been undertaken.

**Provisional proposal 6-6:** local authorities should be required to ensure that assessments and care plans record, where appropriate, what options have been considered and the reasons for the decisions reached.

**Provisional proposal 6-7:** under supportive care, a person's care plan must make clear the basis on which their accommodation has been arranged.

**Question 6-8:** are any changes needed to provide greater protection and certainty for people who lack capacity and their landlords in relation to tenancies?

**Question 6-9:** what difficulties arise when landlords require tenancies to be signed by a donee or deputy, and how might these be addressed?

**Question 6-10:** should local authorities and the NHS in England ever set personal budgets for disabled people living at home by reference to the cost of meeting the person's needs in residential care?

**Question 6-11:** should there be a duty on local authorities and the NHS, when arranging care home, supported living or shared lives accommodation for a person who lacks capacity to decide where to live:

- (1) to secure the most appropriate living arrangement for that person, which as far as possible reflects the person's wishes and feelings; and
- (2) to seek the agreement of any donee of a Lasting Power of Attorney or deputy, or a declaration from the Court of Protection.

**Question 6-12:** should local authorities and the NHS be required to report annually on issues relating to living arrangements and community support, such as the number of living arrangements made and how often these arrangements were inconsistent with the person's wishes and feelings?

**Provisional proposal 6-13:** all registered care providers should be required to refer an individual for an assessment under the relevant protective care scheme if that person appears to meet the relevant criteria.

**Question 6-14:** should the duty to make referrals for protective care be a regulatory requirement which is enforced by the Care Quality Commission, Care and Social Services Inspectorate Wales, or Healthcare Inspectorate Wales?

## **CHAPTER 7: RESTRICTIVE CARE AND TREATMENT**

**Provisional Proposal 7-1:** the restrictive care and treatment scheme should apply to people who lack decision-making capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain.

**Provisional proposal 7-2:** a person would be eligible for safeguards if: they are moving into, or living in, care home, supported living or shared lives accommodation; some form of “restrictive care and treatment” is being proposed; and the person lacks capacity to consent to the care and treatment.

**Provisional proposal 7-3:** restrictive care and treatment should include, but should not be limited to, any one of the following:

- (1) continuous or complete supervision and control;
- (2) the person is not free to leave;
- (3) the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted;
- (4) barriers are used to limit the person to particular areas of the premises;
- (5) the person’s actions are controlled, whether or not within the premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication – other than in emergency situations;
- (6) any care and treatment that the person objects to (verbally or physically);
- (7) significant restrictions over the person’s diet, clothing, or contact with and access to the community and individual relatives, carers or friends (including having to ask permission from staff to visit – other than generally applied rules on matters such as visiting hours).

The Secretary of State and Welsh Ministers could add to and amend this list by secondary legislation.

**Question 7-4:** should the restrictive care and treatment safeguards be available to people who lack capacity to consent to their care plan, in any of the following cases:

- (1) the person is unable, by reason of physical or mental disability, to leave the premises, including:
  - (a) unable to leave without assistance;
  - (b) able to leave without assistance but doing so causes the adult significant pain, distress or anxiety;
  - (c) able to leave without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or
  - (d) able to leave without assistance but takes significantly longer than would normally be expected;
- (2) the person has high care needs and consequently is dependent on paid carers; and



- (3) the person has limited ability to direct their own care or to access existing safeguards?

**Question 7-5:** are there any specific forms of care and treatment that should automatically mean that the person is eligible for the restrictive care and treatment safeguards?

**Provisional proposal 7-6:** the local authority should be required to ensure that an assessment for restrictive care and treatment takes place, and confirm that the restrictive care and treatment is in the person's best interests.

**Question 7-7:** should the restrictive care and treatment assessment require a best interests assessment to determine whether receiving the proposed care or treatment is in a person's best interests, before deciding whether it is necessary to authorise restrictive care and treatment?

**Question 7-8:** should a person be eligible for the restrictive care and treatment scheme if restrictive care and treatment is necessary in their best interests – taking into account not just the prevention of harm to the person but also the risks to others?

**Provisional proposal 7-9:** cases involving serious medical treatment should be decided by the Court of Protection.

**Question 7-10:** should all significant welfare issues where there is a major disagreement be required to be decided by the Court of Protection?

**Provisional proposal 7-11:** restrictive care and treatment assessments should be referred to an "Approved Mental Capacity Professional" (currently, the best interests assessor) who would be required to arrange for the assessment to be undertaken by a person already involved in the person's care (eg the person's social worker or nurse) and quality assure the outcome of that assessment or oversee or facilitate the assessment; or undertake the assessment themselves.

**Provisional proposal 7-12:** the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) would be required to specify the duration of restrictive care and treatment, which may not exceed 12 months.

**Provisional proposal 7-13:** the Secretary of State and Welsh Ministers should have powers in secondary legislation to provide for equivalent assessments, timescales for the completion of assessments and records of assessments.

**Question 7-14:** what should the timescales be for the assessments under protective care and what records should be contained in the assessment?

**Provisional proposal 7-15:** restrictive care and treatment should enable Approved Mental Capacity Professionals (currently, Best Interests Assessors) to use equivalent assessments where this is necessary.

**Provisional proposal 7-16:** the new scheme should establish that the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) acts on behalf of the local authority but as an independent decision-maker. The local authority would be required to ensure that applications for protective care appear to be duly made and founded on the necessary assessment.

**Provisional proposal 7-17:** the Health and Care Professions Council and Care Council for Wales should be required to set the standards for, and approve, the education, training and experience of “Approved Mental Capacity Professionals” (currently, Best Interests Assessors).

**Provisional proposal 7-18:** the ability to practise as an “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) or Approved Mental Health Professional should be indicated on the relevant register for the health or social care professional.

**Question 7-19:** should there be additional oversight of the role of the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) and a right to request an alternative assessment?

**Provisional proposal 7-20:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be responsible for setting conditions and making recommendations in respect of the person’s care and treatment.

**Provisional proposal 7-21:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be given responsibility for monitoring compliance with conditions. This could be delegated to health and social care professionals who are allocated to the case, and advocates and the appropriate person would be required to report any concerns about non-compliance with conditions.

**Question 7-22:** should the new scheme allow for conditions or recommendations to be made that are more restrictive of liberty than the application is asking for?

**Question 7-23:** should there be specific sanctions for a failure to comply with a condition, and if so, what should they be?

**Provisional proposal 7-24:** an “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be allocated to every person subject to the restrictive care and treatment scheme. This should not be the same professional who authorised the restrictive care and treatment.

**Provisional proposal 7-25:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be required to keep under review generally the person’s care and treatment, and given discretion to discharge the person from the restrictive care and treatment scheme.

**Provisional proposal 7-26:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be able to review and vary conditions without necessarily holding a full reassessment of best interests.

**Provisional proposal 7-27:** the local authority should be given general discretion to discharge the person from the restrictive care and treatment scheme. Local authorities could consider discharge themselves, or arrange for their power to be exercised by a panel or other person.

**Provisional proposal 7-28:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) and local authority must review the care and treatment following a reasonable request by the person, a family member or carer, or an advocate or appropriate person.

**Provisional proposal 7-29:** if a person who is eligible for the restrictive care and treatment scheme needs to be deprived of liberty in his or her best interests, this must be expressly authorised by the care plan.

**Provisional proposal 7-30:** cases of deprivation of liberty concerning those living in a family or domestic setting must be authorised by the Approved Mental Capacity Professional and subject to the same safeguards as those provided under the restrictive care and treatment scheme.

**Provisional proposal 7-31:** the Approved Mental Capacity Professional (currently the Best Interests Assessor) should ensure that before a deprivation of liberty is authorised, objective medical evidence be provided by a doctor or psychologist who is independent of the detaining institution. If appropriate evidence already exists, a fresh assessment should not be required.

**Provisional proposal 7-32:** the medical assessment should confirm that the person is suffering from a disability or disorder of mind or brain and lacks capacity to consent to the proposed care and treatment.

**Question 7-33:** should the medical assessment address other matters such as providing a second opinion on treatment already being provided or proposed?

**Question 7-34:** should doctors be eligible to act as Approved Mental Capacity Assessors (currently Best Interests Assessors)?

**Provisional proposal 7-35:** an Approved Mental Capacity Professional (currently Best Interests Assessor) should be able to authorise restrictive care and treatment in urgent cases for up to 7 days, and to extend this period once for a further 7 days, pending a full assessment.

**Provisional proposal 7-36:** the restrictive care and treatment scheme should include powers to authorise transportation, leave, suspension and transfers. It should also enable care and treatment to be authorised in multiple settings.

## **CHAPTER 8: PROTECTIVE CARE IN HOSPITAL SETTINGS AND PALLIATIVE CARE**

**Provisional proposal 8-1:** a separate scheme should be established for hospitals and palliative care settings.

**Provisional proposal 8-2:** a person may be deprived of liberty for up to 28 days in a hospital setting based on the report of a registered medical practitioner. A responsible clinician must be appointed and a care plan produced. Further authorisations for a deprivation of liberty would require the agreement of an Approved Mental Capacity Professional (currently a Best Interests Assessor).

**Question 8-3:** is the appointment of an advocate always appropriate in all hospital cases, or is there a need for an alternative safeguard (such as a second medical opinion)?

## **CHAPTER 9: ADVOCACY AND THE RELEVANT PERSON'S REPRESENTATIVE**

**Provisional proposal 9-1:** an independent advocate or an appropriate person must be appointed for any individual subject to protective care. The individual must consent to such support or if the individual lacks capacity to consent, it must be in their best interests to receive such support.

**Provisional proposal 9-2:** the provision of advocacy should be streamlined and consolidated across the Care Act and Mental Capacity Act (in its entirety), so that Independent Mental Capacity Advocates would be replaced by a system of Care Act advocacy and appropriate persons.

**Question 9-3:** should the appropriate person have similar rights to advocates under the Care Act to access a person's medical records?

**Question 9-4:** should Independent Mental Health Advocacy be replaced by a system of Care Act advocacy and appropriate persons?

**Provisional proposal 9-5:** a "relevant person's representative" should be appointed for any person subject to the restrictive care and treatment scheme (or the hospital scheme) and who is being represented by an advocate. The person must consent to being represented by the representative, or if they lack capacity to consent, it must be in the person's best interests to be represented by the representative.

**Provisional proposal 9-6:** where there is no suitable person to be appointed as the representative, the person should be supported by an advocate or appropriate person.

**Provisional proposal 9-7:** the Approved Mental Capacity Professional (currently Best Interests Assessor) should have discretion to appoint a representative where the person is being supported by an appropriate person.

**Provisional proposal 9-8:** the Approved Mental Capacity Professional (currently best interests assessor) should be required to monitor the relevant person's representative and ensure they are maintaining contact with the person.

**Question 9-9:** does the role of relevant person's representative need any additional powers?

**Consultation question 9-10:** should people always where possible be provided with an advocate and a relevant person’s representative, and could these roles be streamlined?

## **CHAPTER 10: THE MENTAL HEALTH ACT INTERFACE**

**Provisional proposal 10-1:** the Mental Health Act should be amended to establish a formal process for the admission of people who lack capacity and who are not objecting to their care and treatment. The safeguards provided would include an independent advocate, a requirement for a second medical opinion for certain treatments and rights to appeal to the mental health tribunal. The Mental Capacity Act (and our new scheme) could not be used to authorise the hospital admission of incapacitated people who require treatment for mental disorder.

## **CHAPTER 11: RIGHT TO APPEAL**

**Provisional proposal 11-1:** there should be a right to apply to the First-tier Tribunal to review cases under our restrictive care and treatment scheme (and in respect of the hospital scheme), with a further right of appeal.

**Provisional proposal 11-2:** an appeal against the decision of the First-tier Tribunal should lie on points of law in all cases and on law and fact where the issues raised are of particular significance to the person concerned.

**Question 11-3:** which types of cases might be considered generally to be of “particular significance to the person concerned” for the purposes of the right to appeal against the decision of the First-tier Tribunal?

**Provisional proposal 11-4:** local authorities should be required to refer people subject to the restrictive care and treatment scheme (or the hospital scheme) to the First-tier Tribunal if there has been no application made to the tribunal within a specified period of time.

**Question 11-5:** in cases where there has been no application made to the First-tier Tribunal, what should be the specified period of time after which an automatic referral should be made?

**Question 11-6:** how might the First-tier Tribunal secure greater efficiencies – for example, should paper reviews or single member tribunals be used for relatively straightforward cases?

**Question 11-7:** what particular difficulties arise in court cases that raise both public and private law issues, and can changes to the law help to address these difficulties?

**Question 11-8:** should protective care provide for greater use of mediation and, if so, at what stage?

**Question 11-9:** what are the key issues for legal aid as a result of our reforms?

## **CHAPTER 12: SUPPORTED DECISION-MAKING AND BEST INTERESTS**

**Provisional proposal 12-1:** a new legal process should be established under which a person can appoint a supporter in order to assist them with decision-making. The supporter must be able, willing and suitable to perform this role. The Approved Mental Capacity Professional (currently best interests assessor) would be given the power to displace the supporter if necessary (subject to a right of appeal).

**Provisional proposal 12-2:** section 4 of the Mental Capacity Act should be amended to establish that decision-makers should begin with the assumption that the person's past and present wishes and feelings should be determinative of the best interests decision.

## **CHAPTER 13: ADVANCE DECISION-MAKING**

**Provisional proposal 13-1:** the ability to consent to a future deprivation of liberty should be given statutory recognition. The advance consent would apply as long as the person has made an informed decision and the circumstances do not then change materially.

**Provisional proposal 13-2:** the restrictive care and treatment scheme and the hospital scheme would not apply in cases where they would conflict with a valid decision of a donee or advance decision.

**Question 13-3:** how (if at all) should the law promote greater use of advance decision-making?

## **CHAPTER 14: REGULATION AND MONITORING**

**Provisional proposal 14-1:** the Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales should be required to monitor and report on compliance with the restrictive care and treatment scheme and the hospital scheme.

**Question 14-2:** how might the new legal framework encourage greater joint working between the various health and social care bodies and regulatory schemes and alternative forms of regulation?

**Question 14-3:** is greater regulatory oversight needed of individual decision-makers and local authorities and the NHS for the purposes of protective care?

## **CHAPTER 15: OTHER ISSUES**

**Provisional proposal 15-1:** protective care should apply to persons aged 16 and over.

**Question 15-2:** is the concept of the zone of parental responsibility appropriate in practice when applied to 16 and 17 year olds who lack capacity?

**Question 15-3:** what are the current difficulties that arise when identifying the supervisory body for the purposes of the DoLS? Are there any current areas that could be usefully clarified under the new scheme?

**Question 15-4:** is a fast track determination scheme needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence?

**Question 15-5:** should a new criminal offence of unlawful deprivation of liberty be introduced?

**Provisional proposal 15-6:** the Criminal Justice Act 2009 should be amended to provide that inquests are only necessary into deaths of people subject to the restrictive care and treatment scheme where the coroner is satisfied that they were deprived of their liberty at the time of their death and that there is a duty under article 2 to investigate the circumstances of that individual's death.

**Question 15-7:** should coroners have a power to release the deceased's body for burial or cremation before the conclusion of an investigation or inquest?

**Question 15-8:** is the current law on the reporting of deaths to the coroners satisfactory?

**Question 15-9:** should people be charged for their accommodation when they are being deprived of liberty in their best interests – and are there any realistic ways of dealing with the resource consequences if they are not charged?

**Question 15-10:** does the law concerning foreign detention orders cause difficulties in practice?

**Question 15-11:** what difficulties arise when a person needs to be deprived of liberty and has been placed by a local authority in England or Wales into residential care in a different UK country?

## APPENDIX B PRE-CONSULTATION MEETINGS

Care Providers Alliance, London	July 2014
MIND, London	July 2014
Association of the Directors of Adults Social Services DoLS Taskforce, Birmingham	July 2014
University of Nottingham, London	August 2014
Community Care Conference, London	August 2014
Anchor Trust, London	August 2014
Plymouth and Cornwall Best Interest Assessors and DoLS Leads, Exeter	September 2014
Pan-London DoLS Forum, London	September 2014
VoiceAbility, London	September 2014
South East Best Interest Assessors and DoLS Leads, Chertsey	September 2014
Law Society Mental Health and Disability Committee, London	September 2014
Association of the Directors of Adults Social Services DoLS Taskforce, Birmingham	September 2014
Northern Ireland Department of Health, Social Services and Public Safety, London	September 2014
Tri-borough BIAs Forum, London	September 2014
NHS Safeguarding Conference, Midlands	October 2014
Community Care DoLS Conference, London	October 2014
Browne Jacobson Solicitors, London	October 2014
DoLS Conference, Manchester	October 2014
University of Nottingham, London	October 2014
National Housing Federation, Chartered Institute of Housing, SITRA and Housing and Support Alliance, London	October 2014
Association of the Directors of Adults Social Services DoLS Taskforce, Birmingham	October 2014
Adult Safeguarding Conference, London	October 2014



Care Providers Alliance, London	October 2014
Law Review Committee of the Coroners Society, London	October 2014
Hertfordshire DoLS professionals, London	November 2014
West Midlands DoLS Forum, Birmingham	November 2014
Safeguarding and DoLS Conference, Cardiff	November 2014
National Advocacy Steering Group Meeting, London	November 2014
Eastern Region Mental Capacity Act and DoLS Meeting, Cambridge	November 2014
Association of the Directors of Adults Social Services DoLS Taskforce, Birmingham	November 2014
DoLS and Safeguarding Conference, Leeds	December 2014
Legal Action Group Community Care Conference, London	December 2014
University of Manchester, London	December 2014
Best Interest Assessors and DoLS Leads in Wales , Cardiff	December 2014
Supported Living Visit, Milton Keynes and Bletchley	December 2014
Tri-borough Best Interests Assessors forum, London	December 2014
Supported Living Visit, Bromley	December 2014
Coroners Policy Leads, London	January 2015
Care Quality Commission, London	January 2015
Hospice and Palliative Care Stakeholders, London	January 2015
South West MCA and DoLS Forum, Exeter	January 2015
Supported Living Visit, Peterborough	January 2015
Learning Disability Conference, London	January 2015
Safeguarding and DoLS Conference, Bristol	January 2015
Mental Capacity Act and DoLS Forum, Nottingham	January 2015
North East Best Interest Assessors and DoLS Leads, Newcastle	February 2015
NHS Best Interest Assessors and DoLS Leads, Newcastle	February 2015
Justice for LB, London	February 2015
West Yorkshire Mental Capacity Act and DoLS Forum,	February 2015

Leeds	
Bradford and Airedale Mental Health Advocacy Group, Bradford	February 2015
Chief Social Worker, London	February 2015
Housing and Safeguarding Conference, London	February 2015
Safeguarding and Mental Capacity Act Seminar, Manchester	February 2015
Mental Capacity Act Pan-London Forum, London	March 2015
Human Rights Implementation Centre University of Bristol, London	March 2015
Housing and Support Alliance, London	March 2015
King's College London, London	March 2015
Safeguarding Conference, London	March 2015
Department of Health and Chief Social Worker Mental Capacity Act sSeminar, London	March 2015
Law Society Stakeholder Seminar, London	March 2015
Nuffield Foundation and Cardiff University Roundtable, London	March 2015
Learning Disabilities and Autism Groups, London	March 2015
Intensive Care and Rehabilitation Specialists, London	March 2015
Intensive Care Clinicians, London	April 2015
Japanese Bar Association, London	April 2015
Visit to Hammersmith Hospital Intensive Care Unit, London	May 2015
Safeguarding Adults Conference, Birmingham	June 2015

# APPENDIX C

## KEY LEGAL PROVISIONS

### EUROPEAN CONVENTION ON HUMAN RIGHTS

#### Article 2: Right to life

- (1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
- (2) Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
  - (a) in defence of any person from unlawful violence;
  - (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
  - (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

#### Article 5: Right to liberty and security

- (1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
  - ...
  - (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
  - ...
- (2) Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.
- (3) Everyone arrested or detained in accordance with the provisions of paragraph 1 (c) of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.
- (4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

- (5) Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

**Article 8: Right to respect for private and family life**

- (1) Everyone has the right to respect for his private and family life, his home and his correspondence.
- (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

**Article 14: Prohibition of discrimination**

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

**MENTAL CAPACITY ACT 2005**

**Section 1: The principles**

The following principles apply for the purposes of this Act.

- (1) A person must be assumed to have capacity unless it is established that he lacks capacity.
- (2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- (3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- (4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- (5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

**THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES**

**Article 12: Equal recognition before the law**

- (1) States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law

- (2) States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
- (3) States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
- (4) States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
- (5) Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

**Article 14: Liberty and security of the person**

- (1) States Parties shall ensure that persons with disabilities, on an equal basis with others:
  - (a) Enjoy the right to liberty and security of person;
  - (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
- (2) States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

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