Law
Commission
Reforming the law

Mental Capacity and Deprivation of Liberty - Consultation Analysis

Contents

Glossary

ADASS	Association of Directors of Adult Social Services
ADSS Cymru	Association of Directors of Social Services Cymru
ARCO	Associated Retirement Community Operators
BABICM	British Association of Brian Injury Case Managers
BIA	Best interests assessor
Buckinghamshire multi-agency response	Local authorities, CCGs, IMCA providers and healthcare staff and the Service User and Carer Organisation (SUCO)
CCG	Clinical Commissioning Group
Cheshire West	*P v Cheshire West and Chester Council* and *P v Surrey County Council* [2014] UKSC 19, [2014] AC 896.
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
DoLS Code of Practice	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).
EACH	East Anglia’s Children’s Hospice
ECHR	European Convention on Human Rights
EKHUFT	East Kent Hospital University NHS Foundation Trust
GP	General Practitioner
Housing LIN	Housing Learning and Improvement Network
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
LGA	Local Government Association
MCA	Mental Capacity Act 2005
MDDUS	Medical and Dental Defence Union of Scotland

Mental Capacity Act Project	The Mental Capacity Act Project is an initiative to support health teams within the NHS to implement the Mental Capacity Act.
Mental Capacity Act Code of Practice	Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007).
MHA	Mental Health Act
Mental Health Act Code of Practice	Department of Health, *Mental Health Act 1983: Code of Practice* (2015).
NASS	National Association of Independent Schools and Non-Maintained Special Schools
National Panel for Registration	The National Panel for Registration is the local authorities' forum to enable strategic dialogue between central and local government on issues that impact on local authority registration (births, deaths, marriages and civil partnerships), celebratory and nationality functions.
NELFT	North East London NHS Foundation Trust
NUTHFT	Newcastle upon Tyne Hospitals NHS Foundation Trust
OPCAT	Optional Protocol to the United Nationals Convention Against Torture
SAB	Safeguarding Adults Board
SARCP	Staffordshire Association of Registered Care Providers
SEND	Special Educational Needs and Disability
Sitra	A membership organisation for supported housing providers.
Tri-Borough Councils	London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council
UHL	University Hospitals of Leicester
UN Disability Convention	Convention on the Rights of Persons with Disabilities, adopted by the United Nations General Assembly on 13 December 2006 (Resolution A/RES/61/106).
WLGA	Welsh Local Government Association

Chapter 1: Introduction

1.1 This document sets out the responses to the Law Commission's consultation paper, Mental Capacity and Deprivation of Liberty.[1] It describes the views of consultees to each of the 55 provisional proposals and 42 consultation questions.

THE CONSULTATION PROCESS

1.2 The consultation paper was published on 7 July 2015. The publication of the consultation paper received coverage in the general media (including BBC news, the Guardian and "You and Yours" on Radio 4) and was covered widely in specialist publications, such as the British Medical Journal, Community Care, the Elder Law Journal, Learning Disability Today, the Journal of Adult Protection, and Family Law.

1.3 The public consultation period ran from publication until 2 November 2015. During this period, we attended 83 events across England and Wales. These events covered a wide audience, including service users, patients, family members and other unpaid carers, health and social care professionals, academics, lawyers, service providers, regulatory bodies, and voluntary, charitable and campaigning organisations. Some examples of the events are listed below:

(1) two webinars organised by Community Care – 2057 people signed up for the first webinar which launched the consultation and 807 signed up for the second;

(2) two all day conferences in Sheffield and London – organised by Hospice UK and St Luke's Hospice, Sheffield – attended by over 160 people overall;

(3) discussions with individuals involved in deprivation of liberty litigation, including Mark Neary (who successfully challenged his autistic son's deprivation of liberty in 2011),[2] Mr and Mrs "E" (HL's carers who brought the legal challenge which resulted in the "Bournewood case"[3]) and the Justice for LB Campaign group, including Connor Sparrowhawk's parents, Sara Ryan and Richard Huggins;[4]

(4) a half-day workshop in Bristol with family carers who provide support to people with learning disabilities;

(5) two regional half-day conferences for social housing providers, jointly organised by the National Housing Federation, Sitra, the Associated Retirement Community Operators and Housing LIN;

(6) an all-day event in Lancashire – split into two sessions: the first was attended by 25 service users and family members and other unpaid carers and the second

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[1] Mental Capacity and Deprivation of Liberty (2015) Law Commission Consultation Paper No 222.

[2] *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584.

[3] *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99).

[4] The LB campaign was set up 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.

by over 100 professionals from the social care, health, voluntary and independent sectors;

(7) a half-day workshop event - organised by the Mental Capacity Project in the Midlands - which presented our proposals to members of the public and service users via interactive theatre;

(8) a Parliamentary seminar – hosted by the social care minister Alistair Burt MP – and attended by over 15 members of the House of Commons and the House of Lords (and staff);

(9) meetings with best interests assessors, DoLS regional networks and local Mental Capacity Act forums throughout England and Wales;

(10) formal presentations at national conferences – including the Mental Health Tribunal Members Association and Court of Protection Practitioners Association annual conferences; and

(11) seminars organised by firms of solicitors or barristers' chambers, including Bevan Brittan, Browne Jacobson, Clarke Wilmott, DAC Beachcroft, 39 Essex Chambers and RadcliffesLeBrasseur.

1.4 At each of the consultation events we attended, we received a wide range of views on various different aspects of our proposals. As a general observation, we were struck by the widespread support for our project and the need to reform this area of law as a matter of priority. We also received some very useful evidence on current practice, such as how practitioners carry out DoLS assessments, the challenges presented by the current economic climate and the practical difficulties in accessing the Court of Protection, which has been of enormous benefit in shaping our final recommendations.

1.5 The consultation process was well received by those attending consultation events. For example, Hospice UK commended the Law Commission on its "excellent and informative" presentations and "willingness to engage with a variety of different perspectives". Lancashire Council commented that information had been communicated in a "digestible and understandable way" and that consequently attendees have "a much better understanding of the proposals". The Voluntary Organisations Disability Group commented that the Law Commission had "done an excellent job" in engaging with charities and disability groups. A full list of events attended is provided in Appendix 2.

1.6 We received 583 written responses to the consultation paper, from a range of different individuals and organisations. These included:

(a) 263 from local authorities (including corporate responses on behalf of the local authority and personal responses from individuals working within local authorities);

(b) 206 responses from health organisations (including NHS bodies, personal responses from health care staff and independent health services);

(c) 152 from private individuals (including service users and family members and other unpaid carers);

(d) 67 from independent advocacy organisations and individual advocates;

(e) 60 responses from legal bodies (including law firms, professional associations such as the Bar Council and the Law Society, and personal responses from barristers and solicitors);

(f) 49 from best interests assessors;

(g) 43 from academia (including universities, academic research organisations and personal responses from academics);

(h) 42 from mental health groups such as Mind, specialist psychiatric service providers, and individual professionals (for example, psychiatrists, Approved Mental Health Professionals and clinical psychologists);

(i) 42 from end of life and palliative care organisations, including hospices and charities such as Hospice UK, Compassion in Dying and the National Council for Palliative Care;

(j) 26 from social housing organisations;

(k) 19 from health and social care providers; and

(l) 13 from members of the judiciary (including District Judges from the Court of Protection, members of the Mental Health Tribunal and judges of the Family Division of the High Court).

1.7 A full list of formal written responses is provided in Appendix 1. We are very grateful to all those who took part in consultation events and submitted formal responses.

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".

2.1 It was agreed that the Deprivation of Liberty Safeguards should be replaced by a new system called "protective care" by the majority of consultees.[5] Comments received on this proposal can be grouped into the following themes: whether the DoLS should be replaced, general comments on "protective care", alternative schemes, terminology and general comments (including on *Cheshire West)*.

SHOULD THE DOLS BE REPLACED?

2.2 Consultees who felt the DoLS should be replaced highlighted its existing problems, particularly post *Cheshire West*. For example, the CQC pointed to criticism that the DoLS are "complicated, unwieldy, difficult for people to understand and rely too heavily on people engaging with the legal system to gain protection". It also stated:

> The ten-fold increase in applications since 2013 / 14 has led to significant pressure on local authorities and a large backlog in applications. The current situation is unacceptable because it means that people are not consistently receiving the protection of external scrutiny and their rights may not always be safeguarded.

2.3 Professor Rob Heywood (medical law academic) argued that the DoLS:

> Have created an administrative and bureaucratic nightmare that has caused an already over-stretched system to reach breaking point. The statutory provisions are complex and not fit for purpose. More significantly, however, they were drafted at a time when it was impossible to foresee the outcome of the decision of the Supreme Court in *Cheshire West* and its subsequent impact. Given the wide interpretation that has now been given to the meaning of "deprivation of liberty", the DoLS have become too heavy a drain on finite resources and are no longer feasible in a practical sense.

2.4 Paul Greening (MCA manager) stated:

> There is general agreement that the current system of DoLS are unworkable, overly bureaucratic and failing to provide the necessary safeguards to many people deprived of their liberty. I think there is widespread support for finding a scheme that is more flexible, covers all living arrangements and is deliverable in an equitable and efficient

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[5] 279 consultees expressed a view on this proposal: 177 agreed, 29 disagreed and 73 held equivocal positions.

> way – yet still ensures that the appropriate safeguards against arbitrary detention are still provided for those people who need them.

2.5 Steve Broach (barrister) argued that:

> Amongst their many flaws, for me the fatal flaw is that they are restricted in their application to hospitals and care homes, setting up a two-tier system which treats disabled people differently depending on the setting in which they are deprived of their liberty, without any objective justification.

2.6 Mr and Mrs E, and HL stated:

> The current blasé attitude and tick box exercise that says that everyone is deprived of their liberty takes no account of a person's individual needs and circumstances, giving all power to the detaining authority and little chance for the person to influence change in their lives. Most importantly under the current regime we do not believe that we would have any hope of getting [HL] home again if faced with a 1997 situation.

2.7 Gloucestershire County Council agreed that the DoLS need to be replaced, stating that:

> It is overly complex and for the majority of service users and carers, does not provide better outcomes, or any real prospect for change. Hospital staff and care home managers are also generally confused and have struggled to understand what constitutes a deprivation of liberty often resulting in inappropriate referrals or blanket referrals for all of their residents leaving this to the best interests assessor to assess and decide if DoLS applies.

2.8 Many local authorities who agreed with our proposal to replace the DoLS emphasised resource concerns as a primary motivator. For example, Lancashire County Council reported that it has seen:

> A significant increase in DoLS applications, as well as domestic deprivations of liberty that have to be authorised by the Court of Protection, since the [*Cheshire West*] ruling … The current systems for managing deprivations of liberty in care homes, hospital and domestic settings is unsustainable financially, particularly in times of service retraction … Any new scheme must be person centred, sustainable and financially manageable.

2.9 Denbighshire County Council was similarly "supportive of a radical review and overhaul of the existing scheme, which we like others have found to be well intentioned but overly bureaucratic and unnecessarily expensive to administer".

2.10 Ashford and Canterbury Coastal CCGs recognised:

> The heavy burden of the current legislation and support the proposal for the radical overhaul of the Mental Capacity Act DoLS legislation. Shifting the focus away from the authorisation of deprivation of liberty to providing appropriate care and better outcomes would provide the much needed safeguards for the most vulnerable.

2.11 The NELFT NHS Foundation Trust argued that:

> Since the *Cheshire West* ruling the large increase in DoLS referrals, although it may have extended a legal protection, has resulted in a back-log of referrals where the assessment or authorisation has not been received, leaving patients and the Trust in a legally dubious position … We are therefore inclined to favour proposals for a more stream-lined and integrated system.

2.12 Dr Shaun Meehan (GP) argued for scrapping the DoLS legislation completely in the following terms:

> Any system which neglects the greater good for the greater number is not sustainable. DoLS is a financial black hole which will suck financial resources out of our social services, medical services and care homes. It is already taking the most precious medical resource, time, away from consultants, doctors and social workers for a tiny return if any.

2.13 Some consultees agreed that the DoLS should be overhauled, while also acknowledging the positive aspects. For example, Age UK stated that:

> Feedback we have received from older people, families, carers and professionals is that where the DoLS are effectively used, they can lead to positive outcomes … At its best the process can allow for proper consideration by families, social workers and care providers of an individual's right to autonomy and, as far as can be determined, their wishes and feelings.

2.14 Similarly, Somerset County Council agreed with many of the criticisms of the DoLS but also stressed that:

> It is important to highlight those aspects which have provided effective safeguards for individuals who lack capacity. We consider that the assessment process itself and in particular the best interests assessment has been very helpful in a number of cases in clarifying issues of concern and in prompting other professionals to explore potentially less restrictive alternatives to institutional care. The best interests assessors have done a sterling job in raising the profile of the Mental Capacity Act in their contacts with managing authorities and members of the public whose relatives are being assessed. Similarly we have evidence that the involvement of Independent Mental Capacity Advocates and the appointment of paid representatives has resulted in the more effective articulation of objections and necessary referrals to the Court of Protection. It is helpful that delays in the Court processes are now reducing.

2.15 Some consultees argued that the DoLS should not be replaced, but rather slightly tweaked or retained in their current form with full funding. For example, Harrow Council's social care practitioners stated that:

> Given the amount of time and training that has been needed over the 18 months since the *Cheshire West* Supreme Court judgement, there will be another significant learning curve and costs arising from starting a new approach. It would seem much more sensible to streamline the existing arrangements.

2.16 UHL Adult Safeguarding Team and practising BIAs argued that:

> A strength of the current DoLS system is that all professionals / agencies work and learn together and this benefits patients / service users. We also feel that we will have to "unlearn" the knowledge and skills we have acquired and this is a significant burden with 11,000 staff members to consider in our own organisation … We would prefer the system to remain as it is but with proper resources / investment.

2.17 Further, the London MCA / DoLS ADASS Network stated that among their members:

> The principle agreement was that the current system and processes are working and therefore the process needs to be tweaked rather than re-written. Investment has been made in training and knowledge is increasing around the role of the best interests assessor and DoLS. Changing it too much would be problematic, given that the DoLS impacts on such a large population of people and care providers.

2.18 University College London Hospital NHS Foundation Trust stated that:

> Consistent with views of our external partners, the general consensus is that the Mental Capacity Act and DoLS have gained some traction in embedding into everyday practice. Professionals are getting used to the terminology and roles. Improved training and awareness is reflected in the increase of referrals and especially since the Supreme Court judgement and the "acid test".

2.19 Lucy Bright (best interests assessor and academic) argued that the DoLS were "an effective and necessary safeguard", and felt that mostly they "work well in protecting the rights of those who lack capacity to consent to care and treatment in 24 hour settings".

2.20 The Mental Health Foundation and the Foundation for People with Learning Disabilities argued that:

> It would be better to do the minimal amount of legislative reform at the moment, just to try and streamline the current system, put resources into improving awareness and understanding of the Mental Capacity Act and DoLS as they stand, and begin to advocate for wholesale reform of all mental capacity / mental health law in the medium to long term future, to try and achieve what Northern Ireland is currently aiming to do.

2.21 A national online study undertaken by Steven Richards of Edge Training and Consultancy (sent to us after the consultation period had ended but submitted as a formal consultation response) asked best interests assessors the question "do best interests assessments under the DoLS have a positive impact for people?" Ninety-two best interests assessors responded to the survey, providing 468 examples of positive outcomes for people and / or their family or carers as a result of the DoLS assessments. These included the person being found to have capacity, having previously been mislabelled and treated as lacking capacity, the person being returned to live at home or in the community, improved access to social activities or the community, less restrictive care, safeguarding or Court of Protection referrals and highlighting poor use of the Mental Capacity Act. The study therefore concluded:

> The results of this survey provide clear evidence to support the importance of an independent professional face to face assessment bound by the requirements of best interests (section 4) of the Mental Capacity Act. While Lady Hale and others have

> commented that the DoLS procedure is too complex and could be simpler, it would appear from this study that the removal of the central protection of a direct independent professional assessment would deny the "independent check" which is so crucial to the care of vulnerable people […]
>
> What appears not to be working effectively in many cases are existing care assessments and reviews for people in care homes or hospitals. The 400+ examples given in the survey appear to be for many people who had had care assessments and reviews of care already but these had failed to identify and address concerns that best interests assessors subsequently found during their assessment. Why? Because they do not have the legal rigour or focus of a best interests assessment, they can be undertaken by unqualified staff and may not even involve the person having a face to face assessment as under DoLS for the best interests assessment. A serious concern therefore is that one of key proposals to replace DoLS is to rely on these assessments instead.

GENERAL COMMENTS ON "PROTECTIVE CARE"

2.22 A number of consultees took the opportunity to comment generally on the merits of the proposed scheme of "protective care". Some consultees were in favour of the general thrust of protective care. For example, Sue Garwood (housing consultant) particularly liked:

> The introduction of a graduated scheme which offers safeguards to vulnerable adults with impaired decision-making capacity at one end of the spectrum, through to a deprivation of liberty at the other.

2.23 Professor Rob Heywood (medical law academic) stated that:

> The proposed system would remove some of the administrative bureaucracy associated with the DoLS, whilst at the same time providing an appropriate set of safeguards to ensure that it remains compliant with human rights. Importantly, protective care does seem to provide more of a patient-centric approach, rather than focusing exclusively on the notion of "deprivation of liberty".

2.24 Paul Greening (MCA manager) explained the merits of protective care, stating:

> It encourages the understanding that all care and treatment provided to people who cannot consent to it must be in line with the Mental Capacity Act – including the obligation to consider less restrictive interventions at all stages of care. It also makes a closer link between restrictive care and the Care Act; encouraging a wider understanding of a person's care and treatment as a whole, rather than the current system where the DoLS are often seen as a separate "add-on" to the general care arrangements. It also, I think, promotes the idea that this is something that all health and social agencies and staff need to be involved in as part of their day-to-day practice, rather than something that is left to Mental Capacity Act or DoLS specialists.

2.25 Steve Chamberlain (best interests assessor and trainer) felt that protective care would "reduce the artificial but very real separation in practice between assessment and care management (or now Care Act work) and the DoLS scheme".

2.26 Care Forum Wales supported the intention:

> To transform the process from a reactive, technical solution to a technical problem to one that is more aligned with the ethos of the Social Services and Wellbeing Act (Wales) i.e. preventative, proactive and giving greater voice and control to the person.

2.27 A number of consultees raised concerns about various aspects of the proposed scheme. East Sussex County Council (Adult Social Care) felt that the new scheme was too broad and costly:

> It is our view that only those high risk complex cases, where people's mental or physical wellbeing is adversely affected by the restrictions, should come under the restrictive care scheme. All other cases should be part of a comprehensive supportive care scheme that takes account of the person's capacity and best interests and fits within mainstream practice.

2.28 John Young (best interests assessor and trainer) argued it was too complicated and stated:

> It is questionable whether the proposals relating to restrictive care and treatment will lead to the provision of the high quality person centred care which ultimately will provide the greatest benefits and improved outcomes for P. Indeed it can be argued that the financial cost of such proposals will inhibit the delivery of the high quality care that P has the right to expect.

2.29 Hertfordshire County Council expressed similar concerns:

> Whilst the proposals are supposed to lessen the bureaucracy of the current DoLS legislation and be a simpler process, it in effect feels a lot more complicated. The role of the Approved Mental Capacity Professional seems vast and we have concerns about the level of responsibility of these individuals.

2.30 The British Geriatrics Society argued that:

> Given the current economic climate and intense pressure public service funding, we question whether local authorities currently or in the future would have capacity to discharge all of the duties, which will be imposed by the proposed legislative framework … We are not confident that the proposed framework is sufficiently succinct to avoid this situation recurring, leading once again to an over bureaucratised and unfit framework dominated by process and which does little to uphold article 5 and 8 rights.

2.31 The Department of Health and Ministry of Justice argued that three "tests" should be applied to the proposed new scheme:

(1) does it realise real benefits for the person who may lack capacity and / or their family?;

(2) does it represent a good use of public funding? Or would this money, if spent elsewhere in the health and care system, realise greater benefits for service users and / or their family?; and

(3) viewed through the individual’s eyes and those of their family, would it make it easier and more likely for that individual and / or their family to engage with the scheme, realising the outcomes they would wish?

2.32 The response went on to express concerns that elements of the Law Commission’s proposals did not meet these three tests.

ALTERNATIVE SCHEMES

2.33 A number of consultees put forward alternative schemes to replace the DoLS or reforms to the current / proposed scheme. For example, Professor Richard Jones (solicitor and legal academic) called for “the DoLS scheme to be scrapped and replaced by a modified form of Mental Health Act guardianship”. He argued:

> This was one of the options identified by the Government in its consultation following the decision of the European Court of Human Rights in the Bournewood case. When compared with the proposed scheme, this option would be much cheaper, far less complex, would utilise the existing mental health tribunal system, and would eradicate interface issues.

2.34 The LGA and ADASS proposed an alternative scheme called a “Mental Capacity Act Care Authorisation”. This included a “pre-admission duty” on a local authority or the NHS to appoint an independent advocate when a person is being moved into residential care, supported living or shared lives schemes, and certain other forms of accommodation. If an assessing professional thinks that the “acid test” is met, he or she must refer the case to an Approved Mental Capacity Professional who will carry out and arrange the necessary assessments. If a person does not meet the acid test, the assessor would consider if the person requires a “Mental Capacity Act restrictive care plan”. This plan would specify all restrictions alongside their rationale and a risk management plan for delivery. A person’s wishes and feelings would also need to be specified. For the first three months every individual would be appointed an Independent Mental Capacity Advocate and after this time they would be appointed a supporter.

2.35 The Old Age Faculty of the Royal College of Psychiatrists suggested that where a person has made a health and welfare Lasting Power of Attorney, if the donor agrees with a placement, then there should be no need for an authorisation. It also argued that section 5 of Mental Capacity Act “could be used to greater effect, possibly making the need for further legislation about restrictions of liberty unnecessary”.

2.36 RadcliffesLeBrasseur LLP argued that GPs should have the power to certify as appropriate the care plan of those residents in care homes with dementia, and a right of appeal should be given to residents or their families who were unhappy with this. It argued:

> This would significantly simplify the system and free up local authority resources to deal with the rest of DoLS applications, which might more properly require their attention. Such a scheme would also reduce the perceived stigma of being “sectioned”, and reduce cost.

2.37 Nottingham City Council's Adult Social Care Department suggested that:

> For the majority of people who are content and where there is no family objection, then a more streamlined system should be adopted: one that puts more emphasis on the commissioners and providers of care evidencing that they have complied with the Mental Capacity Act and best interests decision making processes. In addition some form of dispute resolution process should be established so that expensive and adversarial hearings in the Court of Protection become a matter of last rather than first resort.

TERMINOLOGY

2.38 Some consultees responded to this proposal by commenting on the title of the new scheme. Most consultees were in favour of the term “protective care”.[6]

2.39 Many consultees compared the term “protective care” favourably to “deprivation of liberty safeguards”. As Barts Health NHS Trust explained:

> The current title “deprivation of liberty safeguards” causes a lot of misunderstanding and unnecessary distress to relatives. It is the major issue which results in complaints from relatives about the application of DoLS and distress to relatives. Despite all our efforts to explain DoLS to relatives in a reassuring way, Barts Health receives at least six calls a week from relatives who are confused and upset at learning that their loved one is being “deprived of liberty”.

2.40 Vincent Duffy (DoLS team leader) added:

> There is often a perception from people that by using the terminology of DoLS, that we are punishing the individual subject to it, or impacting negatively upon the individuals’ quality of life or, that we are undertaking a safeguarding investigation and therefore, it can be misleading. The term “protective care”, sounds more appealing, supportive and appropriate when moving forward in applying the schemes and therefore promotes positive engagement.

2.41 Harrow Council’s Social Care Practitioners furthermore stated:

> “Deprivation of liberty” is a difficult concept for many people, particularly where it is considered that the relevant person has no liberty to lose e.g. is bed bound with end stage dementia. A change of title is therefore sensible and protective care may be more relevant to a greater number of individuals.

2.42 Other consultees argued that the term “protective care” would be more accessible for service users, family members, care providers and practitioners, and was more in line with the Care Act 2014 and article 8 of the European Convention on Human Rights.[7]

2.43 Those consultees who did not support the title “protective care” frequently described it as “paternalistic” and “disempowering”.[8] Flintshire County Council suggested it has “resonance with ‘being in care” whilst Real Life Options (learning disability charity) felt

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[6] 185 expressed a view on the title of the new scheme: 87 agreed with protective care, 69 disagreed, whilst 29 held equivocal positions.

[7] For example, Brent SAB.

[8] For example, DAC Beachcroft LLP

"this sounds too similar to police terms such as 'protective custody'". Eva Sisa (social worker) argued that the title "protective care" was "patronising as there is a subtle suggestion that patients and service users are passive recipients of this sort of care".

2.44 Others noted the links to safeguarding. St Andrew's Healthcare commented:

> Protective Care suggests that the sole or main purpose of the care is to protect the person – it may be the case that this is but one outcome that the provision of a package of care and support is aiming to achieve.

2.45 Some consultees found the title too "euphemistic" and suggested keeping "safeguards", "rights" and / or "liberty" in the title to remind people of the true purpose behind the scheme.[9]

2.46 Many consultees suggested alternative titles for the scheme. These have been listed in full in Appendix 3. Examples included:

(1) "liberty safeguards" – for example Bill McMellon (best interests assessor) felt this would provide a positive message and maintain a link to the existing DoLS;

(2) "safeguarding of liberty (SOL's)" – for example, Rachel Goldsmith (social work student) suggested this would put "a more positive stance on the current word 'deprivation' but is also clearer in indicating what it does";

(3) "deprivation of liberty- prevention and protection" – which was suggested by Mr and Mrs E, and HL, who argued that it:

> Maintains the seriousness of depriving someone of their liberty and the protections in place for them to challenge and also the idea that where possible the least restrictive alternative is taken seriously and is at the forefront of the decision making process;

(4) "assured care and treatment" – for example Stuart Turner (social worker) argued that suggested "confidence in a process" and would be meaningful to professionals and lay persons alike; and

(5) "mental capacity safeguards" – for example Dorothy House Hospice Care felt this would emphasise links to the Mental Capacity Act.

2.47 A small number of consultees felt the new system should keep the title "deprivation of liberty safeguards". For example, Phil Spencer (GP) stated:

> I have no problem with the title as it stands. The advantage of the term deprivation of liberty safeguards is that it does say exactly what it is, which makes it memorable and relevant.

2.48 Some consultees made more general comments. For example, Dr Jonathan Waite (psychiatrist) argued that "no doubt 'protective care' will soon assume the same pejorative connotations as 'deprivation of liberty safeguards'". The Mental Health

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[9] For example, the Bar Council.

Lawyers Association argued that there needed to be a change in the meaning of liberty rather than a change in the terminology.

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*.

2.49 A majority of consultees agreed with this proposal.[10] The two aspects of this proposal – the introduction of a new code of practice and updating the existing *Mental Capacity Act Code of Practice* – are discussed separately below.

INTRODUCTION OF A NEW CODE OF PRACTICE

2.50 A number of consultees commented on the form and style of any new code of practice. For example:

(1) the Alzheimer's Society called for case studies and graphics to be used in the code to make it more accessible;

(2) Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs felt that the new code needed to be in "simple English" and "incorporated into the training and education curriculum for clinicians, allied health professionals and social work staff"; and

(3) PASAUK argued that the new code should be user friendly; give clear, unambiguous definitions and explanations; give examples and scenarios; and the language must be simple and accessible.

2.51 Dr Jonathan Waite (psychiatrist) noted that:

> The *Mental Capacity Act Code of Practice* contains much valuable guidance but never achieved the acceptance it deserved. Part of this was due to its size, weight and expense. A copy of the code should have been in every care home and hospital ward, it should have been mandatory for every donee of a lasting power of attorney to have one. A cheap, pocket-sized volume (like the British National Formulary) and a mobile app are needed, rather than a lavish coffee table book on art paper.

2.52 The Welsh Government called for further consideration to be given as to whether separate codes would be appropriate for England and Wales. ADSS Cymru and WLGA argued that Wales did not need its own code of practice as this is confusing for practitioners and "creates issues for service users moving across borders". Roger Laidlaw (best interests assessor) said:

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[10] 158 consultees expressed a view on this proposal: 152 agreed, none disagreed, and six held equivocal positions.

> The England and Wales code of practice was published before details of the Welsh scheme were clarified with the result that important differences were not discussed and Welsh staff either made errors or referred to the separate "Guidance for Supervisory Bodies". This must not happen again. The only acceptable alternative would be an entirely different but entirely complete code of practice being issued for Wales. My recommendation would be for there being one code covering both jurisdictions.

2.53 A number of consultees passed comment on the content of any new code of practice. For example, City and Hackney Safeguarding Adults Board called for the guidance to clarify the circumstances in which restrictive care authorisations should be drawn to the attention of an Approved Mental Capacity Professional for review and possible discharge.

2.54 King's College Hospital NHS Foundation Trust believed that the new code of practice should define concepts such as the length of time required for a restriction to become a deprivation of liberty, and what not being free to leave means.

2.55 Kent Community Health NHS Foundation Trust called for clarity on the issue of fluctuating capacity because:

> Within a health setting the difference between having capacity and therefore being able to make unwise decisions, and not having capacity and a best interest decision within the health setting can be the difference between life and death.

2.56 Tristan Wood (former housing association manager) believed that the new code should clarify the role of supported housing landlords:

> I think the key issues are what to do if concerns about a new or existing tenant's mental capacity arise in relation to their accommodation or their own or others' safety; issuing tenancy agreements where an individual lacks capacity; and respective responsibilities where a landlord houses someone with a third party care / support provider.

2.57 The Challenging Behaviour Foundation called for the code to address the situation of people living within a family home, and provide "guidance for educating families about the issues from an early age" in order to "prevent unintentional deprivations and build confidence in the system".

2.58 Torbay and South Devon NHS Foundation Trust and Torbay Council felt that the code needed to address when a deprivation of liberty would be considered as "imputable to the state" and the position of staff working within acute mental health settings.

2.59 Fourteen consultees suggested that there should be one single code of practice for the new scheme and the Mental Capacity Act. For example, Nottingham City Council's Adult Social Care Department argued that a single code "may facilitate better engagement of health and social care staff more generally and work towards its reconnection to the general principles of the Act". West Sussex County Council also noted that a revision of the *Mental Health Act Code of Practice* would also be necessary. It went on to state:

> The *Mental Capacity Act Code of Practice*, whilst having some flaws, has stood the test of time. Staff appreciate the clear, easy to read style that is accessible to all readers. Lessons should possibly be taken from this for a protective care code of practice.

UPDATING THE EXISTING MENTAL CAPACITY ACT CODE OF PRACTICE

2.60 Several consultees expressed a view on the way in which the *Mental Capacity Act Code of Practice* ought to be updated. For example, Tri Borough Councils described the code as “very good” but felt it “could benefit from more complex examples (and maybe case law)”.

2.61 Many felt that the current code was out of date. For example, Bradford BIAs noted that subsequent case law has shifted the emphasis of the Act such as (such as the Aintree[11] and Wye Valley cases[12]).

2.62 According to Judy Weiner (independent mental capacity advocate):

> Considering the changes in practice as a result of judgements, the *Mental Capacity Act Code of Practice* needs to be updated to be more specific in areas such as serious medical treatment and to incorporate what would now come under the Care Act and the protective care proposals and relevant roles.

2.63 Berkshire Joint Legal Team liked the current structure of the *Mental Capacity Act Code of Practice* and thought that it would be useful for the code to be refreshed but not restructured. However, it did note that:

> Both codes need to be regularly updated in light of recent case law. This does not happen with the current codes at present, meaning they are very much out of date and therefore unhelpful to both practitioners and families.

GENERAL COMMENTS

2.64 Some consultees addressed these provisional proposals by making general comments or raising broader issues. The Catholic Medical Association raised concerns about the exclusion of family members, relatives and carers from decisions about long term care provision, and stated that:

> We would prefer an informal approach wherever possible without the involvement of independent advocates, assessors and the courts to oversee clinical decisions that have hitherto been the province of multidisciplinary teams working in conjunction with the patient’s families and personal representatives. We believe that greater emphasis should be placed on individual needs within a family setting and with due consideration for the known and would-be wishes of the patient in a family setting. At the same time, we are concerned that the tendency to choose the less restrictive option may be to the detriment of the patient. For example, a person with severe

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[11] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591.

[12] *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60.

> dementia who has been incontinent and who is refusing personal care, must either be changed (with restraint if required) or left to sit in their own excrement.

2.65 The Faculty of Intensive Care Medicine and Intensive Care Society's Legal and Ethical Policy Unit stated:

> It should first be acknowledged that while DoLS are important, a patient's right to life must be seen as more important than their right to liberty. In other words, any regime for the authorisation of deprivation of liberty must be calibrated in such a way as to promote and not to hinder the delivery of safe, high quality care that places the patient at its heart. The current regime runs the risk of distorting the delivery of such care; any replacement regime must not do so.

2.66 Liquid Personnel (social work recruitment consultancy) emphasised the important role of best interests in addressing article 8 issues:

> Best interests assessors are from a range of health and social care professionals accustomed to undertaking holistic assessments of need; just because they are required to complete an assessment founded in article 5 does not mean they assess in a vacuum without consideration to other human rights … [article 8 issues] may not be specifically addressed in the best interest's assessment (though they are usually referenced) and then action is triggered through the respective supervisory bodies referral pathways whether that be through a safeguarding alert or a social work / case management route.

General *Cheshire West*

2.67 Some of the responses which we received commented generally on the Supreme Court's decision in *Cheshire West,* without necessarily considering one of our provisional proposals or questions.

2.68 Many raised concerns about the practical implications of *Cheshire West.* According to Professor Robert Heywood (medical law academic):

> Given the wide interpretation that has now been given to the meaning of "deprivation of liberty", the DoLS have become too heavy a drain on finite resources and are no longer feasible in a practical sense.

2.69 Dr Kate Dean (geriatric medicine) felt there was now a great deal of confusion around what constitutes deprivation of liberty and was concerned that the "acid test" seems to imply that all patients who lack capacity to consent to remaining an inpatient should be subject to DoLS procedures, whether by attempting to leave the ward or not. According to the Royal Hospital for Neuro-disability:

> We now regard it as clear that all of our patients / residents who lack capacity to consent to their care require the protection of the DoLS. They are either unable to leave or if with assistance they could they are only able to do so where arrangements for their ongoing care have been put in place.

2.70 Similarly Barts Health NHS Trust argued that virtually all patients in an acute hospital who lack capacity would now be considered deprived of liberty and argued that unless the acid test is replaced, rather than just “elaborated”, the new arrangements would be unworkable.

2.71 Some consultees provided statistical information on the impact of *Cheshire West.* For example, Robert Wheeler (surgeon) noted that in the hospital in which he is based, amongst the 145,000 annual inpatients, 30 to 40% would at one time pass the *Cheshire West* threshold. The Association of North East Councils reported that post-*Cheshire West* ten out of the 12 North East local authorities have experienced a ten-fold increase in DoLS referrals (while the other two experienced more than thirty times the previous number of referrals), and the additional cost of this activity was £6.5 million in 2015 / 16.

2.72 The Royal Hospital for Neuro-disability also reported that its patients had experienced significant delays in DoLS referrals post *Cheshire West.* As of the end of September 2015, 18 patients were awaiting the outcome of an application for renewal, 80 patients were awaiting assessment by the local authority, and seven patients had been assessed but were awaiting authorisation. It concluded that:

> It is our experience that whilst we are now making timely applications for both urgent and standard authorisations the relevant local authorities do not have the resources to respond to all our applications. We then have to put time and effort into following these up, at times with little success. We have a few DoLS applications where the responses have been outstanding for over a year.

2.73 Consultees told us that, following *Cheshire West,* the law is not applied in a uniform or consistent manner. For example, Dr David Jolley (psychiatrist and academic) told us that the present law is followed by some people, but ignored by others, and several responses from local authorities reported that in the face of the increased demand, they have not been able to respond as fully as they would want to.

2.74 Some consultees questioned the validity of *Cheshire West.* In an anonymous response from a safeguarding adults nurse, it was stated that:

> The problem we have now is that *Cheshire West* is requiring the same system of checks and balances for a person with advanced dementia who is supported and funded by their family to go to a care home which they have spent a long time agonising about – and a person with learning disabilities who is frequently restrained both in a care setting because of the risk to themselves, or for whom contact with a named individual is restricted against their wishes.

2.75 Stephen Ward (MHA and MCA lead) felt that whilst the decision provides clarity, it was not consistent with Strasbourg case law which refers to the “specific situation” of the individual concerned and the need to take into account a whole range of factors such as the type, duration, effects and manner of implementation of the measure in question. He argued that the acid test takes deprivation of liberty far beyond the scope intended by the European Convention on Human Rights and any scheme will remain unmanageable and prohibitively expensive unless the scope of deprivation of liberty can be returned to a more common sense interpretation.

2.76 Gloucestershire County Council argued that the acid test was “flawed” since it extends to “too many people who previously would not have met the threshold for [deprivation of liberty]”.

2.77 The Judges of the Family Division of the High Court felt that the Law Commission’s consultation should have sought views on whether *Cheshire West* should be the starting point for the new scheme, and whilst not offering a collective view, they noted that “a number of judges have expressed concerns about the implications of *Cheshire West* ”.

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?

3.1 A majority of consultees agreed that we have identified the correct principles to underpin protective care.[13]

3.2 For example the National Autistic Society welcomed the principles and noted that in order to deliver on these principles, "it is of paramount importance that the individual who lacks capacity, and their families and loved ones, are at the heart of the new system". Lyn Romero (Chief Social Worker for Adults in England) felt that the list of principles "rightly focuses on providing appropriate care and better outcomes for people who lack metal capacity and supporting family and carers" and "appropriately supports the step change in practice framed by the Care Act".

3.3 The Chartered Institute of Housing stated:

> We recognise that the aim is to develop a scheme which is more straightforward to understand and navigate, for the individual, for family and carers and for professionals involved in supporting the person, including housing professionals where the person lives in a supported living scheme.

3.4 Most consultees welcomed the focus on the Mental Capacity Act. For example, Rosemary Trustam (social worker) stated:

> I completely agree that the principles in the Mental Capacity Act should be applied to try to make sure every effort is made not only to ascertain the person's wishes / best interests but to engage them in the decision-making and communicate with them as far as is possible.

3.5 The British Geriatric Society felt that the "Mental Capacity Act ethos of protecting and upholding autonomous choice for adults with impairment of brain and mind function" had been "undermined by the legal 'fix' of the DoLS".

3.6 There was also widespread recognition that the new scheme should not just focus on technical compliance with article 5 but should also pay due regard to article 8 of the

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[13] 252 consultees expressed a view on this question: 201 said "yes", 10 said "no" and 41 held equivocal positions.

European Convention on Human Rights. For example, the Old Age Faculty of the Royal College of Psychiatrists stated:

> As doctors specialising in mental illnesses, we suggest that there is an implicit right to "patienthood" which allows all of us to expect treatment and care when we are ill, and this might be covered by Article 8.

3.7 Bindmans LLP argued that:

> Consideration of article 8 at an early stage may also go some way to preventing the principles of the Mental Capacity Act being used to justify the public law decisions being taken by statutory agencies not to investigate and / or provide services to incapacitated adults on the basis that to do so would be "disempowering" for the person in question.

3.8 Sarah Rochira (Older People's Commissioner for Wales) welcomed the recognition of the United Nations Disability Convention and that the new scheme seeks to address some of the current discrepancies that exist between the Mental Capacity Act and the UN Disability Convention. She further urged that reference should be added to the United Nations Principles for Older People, particularly the principle that "older people should be able to live in dignity and security and be free of exploitation and physical or mental abuse".

3.9 The British Medical Association questioned what the principle in relation to the UN Disability Convention would entail:

> If the Convention rights were fully realised, both the Mental Capacity Act and current mental health legislation would be non-compliant. The health and social care professions will be significantly challenged if any form of substituted decision-making, irrespective of the scale of an adult's cognitive disabilities, is impermissible. The principle only requires that protective care are "supportive" of the Disability Convention, and it will be interesting to see what this means in practice.

3.10 Shared Lives Plus supported the move away from a "one size fits all approach" to one which:

> Provides relevant safeguards for different sectors of adult social care, including Shared Lives. The current DoLS system was not designed to meet the needs of people living in community settings and is failing people who lack mental capacity who are living in Shared Lives arrangements.

3.11 Some consultees commented on the extent to which the DoLS legislation complies with the principles identified in the question. For example, Liquid Personnel (social work recruitment consultancy) argued that the DoLS failed to deliver improved outcomes and that "there are countless examples though sadly we only hear of the poor practice when a judgment is published". EKHUFT argued:

> The Mental Capacity Act and DoLS legislation slows the whole process. We need a new system that supports and enables acute care settings, patients and their families to work together, not an endless stream of form filling, jargon and even more people to liaise with. In my humble opinion, simple is best.

3.12 Some consultees agreed with the principles, but commented that the proposed scheme failed to comply, or at least fails to demonstrate how it complies, with the principles. For example, Warrington Borough Council stated that:

> Broadly these are the correct principles. However, the proposals do not appear to evidence how the new scheme will deliver against these principles.

3.13 Some consultees disagreed in particular that the scheme should be based in the Mental Capacity Act, and argued that the Mental Health Act should form the basis for the scheme. For example, Tim Gorvett (social care lead) stated that:

> The time has come to consider again adapting the Mental Health Act to accommodate such significant deprivations of liberty, arising from mental conditions, as require a procedure prescribed by law to justify. The Mental Health Act is relatively simple to deploy for practical purposes, Approved Mental Health Professionals are thoroughly conversant, perhaps more now than any other professionals routinely involved, with the complexities of detention, and above all their established role is precisely to define circumstances as qualifying a detention or not, with equally well-established safeguards designed in fact for far more robust use in much starker situations.

3.14 Joanna Burton (solicitor and trainee advocate) argued that the scheme should be based on the Care Act because the care arrangements for the person will be determined by assessments and care planning processes under that legislation.

3.15 The Law Society's Mental Health and Disability Committee was cautious about the notion that the scheme should be tailored according to setting because:

> it creates an inherent risk that it will leave certain groups of individuals without the benefits and safeguards afforded to others simply due to the setting in which they are placed or find themselves. As can be seen with the definition of supported living, these distinctions can often be artificial, as in many cases, a person's care arrangements and the nature of the restrictions are the same whatever setting they live in.

3.16 Some consultees suggested additional principles to which the scheme should comply. A frequent suggestion was that the scheme should be "person-centred". For example, Mind stated that:

> In defining and describing the protective care scheme, its aims and principles should be expressly person-centred, rather than relying on the fact that they are implicit in the principles because they are embedded within the legislation (Mental Capacity Act) and conventions (human rights, rights of people with disabilities) cited.

3.17 Some argued that more emphasis was needed on the person lacking capacity. For example, the Mental Health Foundation and the Foundation for People with Learning Disabilities stated:

> We strongly believe that for human rights to be meaningful, they need to go beyond technical compliance with jurisprudence; and should be able to change a person's life on the ground … We believe that the principles outlined are failing to put the care and well-being of the person at the centre of the safeguards, and therefore they might fail in terms of enhancing their rights or enhancing people's quality of life.

3.18 Roger Laidlaw (best interests assessor) argued that the DoLS have been falsely labelled as “excessively bureaucratic”, and that the main difficulty has been in willingness to implement the DoLS. He stated that the principle that the scheme should be non-elaborate may be “unrealistic and also result in it being under-resourced and under-scrutinised”.

3.19 Some consultees made general comment about the principles identified. For example, the Centre for Law and Social Justice and the Centre for Disability Studies, University of Leeds and CHANGE, Leeds questioned whether the Mental Capacity Act provides an empowering framework for the individual, pointing towards the “lack of procedural safeguards in the legislation” and that “people can lose significant autonomy”. It noted that ensuring full compatibility with the United Nations Disability Convention would “require a greater process of change over a longer timescale, as well as requiring policy decisions and the allocation of resource by Government”, but argued that compatibility with the United Nations Disability Convention “is a point that needs to be emphasised and considered further, particularly as regards the public law aspects of decisions”.

Chapter 4: The Scope of the New Scheme

Provisional Proposal 4-1

The scope of protective care should include hospital, care home, supported lives and domestic accommodation.

4.1 This proposal was supported by the majority of consultees.[14]

4.2 Many consultees felt that the current scheme, which requires all deprivations of liberty in settings beyond hospitals and care homes to be authorised via the court, is unduly burdensome and results in unnecessary distress and cost to the parties involved. For example, Bury Council and Bury CCG argued that this proposal would "reduce the need to approach the Court of Protection" and would therefore reduce "the cost and stress to 'P' and their families – particularly for cases where there are no issues / objections or mitigating circumstances".

4.3 A number of consultees were concerned that the present system discriminates against individuals based on setting, and many deprivations of liberty go unauthorised in other settings due to the impracticalities associated with going to court. Care Forum Wales noted "we have long argued that people in these settings are more vulnerable because of the lack of regulation and direct inspection".

4.4 The Mental Health Foundation and the Foundation for People with Learning Disabilities stated:

> Not including other settings than hospitals and care homes in the protective care scheme could leave some of the most vulnerable people at risk of being unlawfully deprived of their liberty. We believe that everyone's right to liberty should be protected, in particular the freedom of those who lack capacity. This protection should be granted, even when people need intensive care and treatment, and whether or not they are being directly cared or treated by the State.

4.5 It was argued that the current system, requiring all deprivations of liberty in these settings to go to court, meant the courts had reduced capacity to deal with more serious cases which would better benefit from the court's expertise. Dementia Care stated:

> Although there are weaknesses in the DoLS system, it is imperative that the Court of Protection route is not used for "routine" assessments and is reserved for disputed or complex cases only.

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[14] 247 consultees expressed a view on this proposal: 164 agreed, 22 disagreed and 61 held equivocal positions.

4.6 Consultees described their experiences of deprivations of liberty in these settings. For example the National Autistic Society stated:

> Many autistic adults who lack capacity live in supported living settings. These can often require intensive one-to-one, or two-to-one, support. Through our helpline and other direct contact with people with autism and family members we have been made aware of instances where, due to insufficient support in a care plan, individuals are not able to leave their homes. To all intents and purposes, many are deprived of their liberty, but DoLS do not apply.

4.7 Several consultees held equivocal positions. ARCO were concerned about the position of self-funders, especially because many would not have a proper care plan or any involvement from a public authority. Many consultees called for greater clarification of when the state would have responsibility for a situation involving a self-funder which would might be a deprivation of liberty.

4.8 Housing LIN stressed:

> We would like to see the differences between housing and residential care properly reflected in the language and future arrangements for mental capacity and deprivation of liberty in order to avoid any unintended consequences, for example, further muddying the distinction between housing with care and care homes for registration purposes.

4.9 Some wanted our scheme to focus upon the person’s care and treatment, rather than setting. Chris Lucas (best interests assessor) asked:

> Why focus on describing and defining types of accommodation and categorising deprivation of liberty or safeguards according to type? I would prefer that scheme could better be determined by the nature of the care plan / arrangements for the person … it is care arrangements and decisions, not accommodation that restricts a person’s liberty.

4.10 Some consultees also suggested the scheme should apply to other settings, including respite care, extra care housing, fostering settings, children’s homes and residential special schools. Essex County Council felt that the Secretary of State should be able to amend this list, or the definitions of any of these settings, to reflect changes in practice or case law.

DOMESTIC SETTINGS

4.11 Some consultees had concerns about the inclusion of domestic settings in the new scheme. Dr Clementine Maddock (psychiatrist and academic) described this as “a sledgehammer to crack a nut” and stressed the intention behind article 5 is to prevent abuse of detention by the State, rather than impose on the private lives of individuals.

4.12 Devon County Council argued:

> The state does not have sufficient control over domestic situations to be charged with responsibility for what takes place therein. The Court should continue to regulate such

> settings even if there is a significant degree of state intervention as it will be too difficult to define when a deprivation becomes imputable to the state.

4.13 Cheshire and Merseyside Strategic Clinical Networks and Greater Manchester, Lancashire and South Cumbria Palliative & End of Life Care Networks were concerned about the impact on palliative care patients living in a domestic environment, due to the duty to hold a coroner's investigation.

4.14 The Carers Trust noted:

> It needs to be made clear in legislation the implications for paid care providers as distinct from unpaid carers. There is some concern that although it may mean that some carers will receive more support at an earlier juncture when supporting someone who lacks capacity, the new legislation could also be used to "legislate" against carers if carers are seen to be providing "restrictive" care or depriving someone of their liberty unintentionally.

4.15 DAC Beachcroft LLP argued that the safeguarding duties in the Care Act 2014 already provided "adequate safeguards to ensure appropriate care and support arrangements are in place in a person's own home".

4.16 The Judges of the Family Division of the High Court did not agree with the inclusion of domestic setting in the scheme because:

> We do not consider that *Cheshire West* makes such a broad conclusion mandatory and are concerned at the infringements of other rights, particularly the article 8 right to respect for private and family life and the home that might be entailed in such a broad interpretation of the state's positive obligation to prevent unlawful deprivation of liberty. There is also a risk that the new scheme will fall into disrepute if it is seen as being too intrusive in this sensitive area.

4.17 However other consultees stressed the importance of ensuring there are adequate safeguards in domestic settings. Jill Lewis (social worker) stated:

> I am aware of packages where night-time supervision occurs even in domestic settings, either through input of paid carers as well as family, or through observation at a distance with assistive technology. I have experience of family carers who restrict external visitors more rigorously than paid carers because of problematic family dynamics.

4.18 The Alzheimer's Society, whilst supporting the proposal, noted:

> Research shows that 85% of people with dementia want to remain at home, yet only two thirds are able to do so. Carer burn out is cited as the reason for 38% of admissions to care homes. Any proposals around protective care in domestic settings must not place additional burden on families/carers as it this may reduce the likelihood of the person affected continuing to receive care at home.

4.19 The Department of Health and the Ministry of Justice accepted that the use of our scheme may be preferable in some cases to court authorisation, but were concerned that many citizens may perceive this “as unnecessary and obtrusive state involvement in their private and family affairs”. The Welsh Government supported the proposal.

DAY CENTRES

4.20 The consultation paper sought views about whether day centres should be considered within the scope of our scheme.

4.21 Bill McMellon (best interests assessor) agreed that it seemed unnecessary to create additional work for day centre managers by applying our scheme to them as well. A number of consultees were unsure whether confinement in a day centre would amount to a deprivation, as opposed to a mere restriction, of liberty. For example, the British Association of Social Workers noted that, as the person goes home at the end of the day and does not reside in that establishment, this would suggest the person is not under “continuous supervision and control” for the purposes of the acid test. However, Luton CCG noted that a person may spend “a substantial amount of time” in a day centre (over five hours, one to five days per week) and that people are frequently not free to leave within this setting.

4.22 A number of consultees argued that the new scheme should apply directly to day centres. Steve Broach (barrister) stated:

> Firstly, a day centre is likely to be run and be administered completely separately from a person’s place of residence. Secondly, it is quite possible in my view that a person might be deprived of their liberty in a day centre but merely subject to restrictions on their liberty in their home – for example, the supervision and control the person experiences may be much more intense at a day centre.

4.23 Kent County Council noted:

> There may be people who would have to be deprived of liberty during their day activities away from their residence but not whilst at their residence, in which case the scheme should extend to day centres.

4.24 Maxwell Gillott Solicitors argued:

> If a deprivation of liberty occurs at a day centre it should require “authorisation” in the same way as other environments. We don’t think it can be said that any and all deprivations of liberty in a day centre will result from someone who is also deprived of their liberty at home. We can see for example, that there may well be individuals who are not deprived of their liberty at home but, because of the level of control / supervision in the day centre, would be deprived of their liberty there only.

Question 4-2:

Is the definition of supported living provided under the Care Act 2014 appropriate for our scheme?

4.25 There was no overall majority in the responses to this question, but the largest number felt the definition of supported living provided under the Care Act 2014 was appropriate for our scheme.[15]

4.26 Consultees who felt the Care Act definition was appropriate noted this would help align the different legislative frameworks and avoid confusion. Worcestershire Health and Care NHS Trust stated that "a universal definition of supported living is necessary to avoid parties attempting to differentiate between settings". Steve Chamberlain (best interests assessor and trainer) felt this would "maximise consistency between the pieces of legislation and reduce any confusion between them". Tees Esk and Wear Valley NHS Foundation Trust felt that the Care Act definition already provides "a relatively clear distinction in terms of separation between [supported living] and somebody's own home".

4.27 A number of consultees, including Sense, noted that the new scheme needed to consider the position in Wales and any differences with the definition of supported living under the Social Services and Wellbeing (Wales) Act 2014.

4.28 Several consultees felt the Care Act definition was not appropriate for our scheme. Brent SAB argued that the definition was "difficult to really understand and arguably doesn't include those schemes that are not specifically adapted where floating support is available". Bury Council and Bury CCG were concerned that the definition excluded "disabled people who choose to live in accommodation that is not intended for occupation by those with care and support needs". CQC stated that for regulatory purposes it defines supported living as including "any settings where people receive care and support through Care Act arrangements" and therefore argued that they should be expanded to include "disabled people living in accommodation which is not intended for occupation by those with care and support needs".

4.29 The Court of Protection Practitioner's Association stated:

> Whilst some supported living placements are designed for persons who need care and support, many that we see are simply a tenancy, in an established property, in which a supported living care arrangement is set up within it. This may occur for more than one resident. Adults with learning disabilities and autism may have no requirements for physical adaptions to the property. The Care Act definition of supported living was developed for the purposes of the delineation of responsibility between public bodies i.e. the engaging of the local authority as responsible for placement once adaptations are made. In this instance the definition needs to be all encompassing. It is unsuitable for this purpose.

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[15] 150 consultees expressed a view: 70 said "yes", 46 said "no" and 34 held equivocal positions.

4.30 Some consultees suggested alternative definitions. Northumberland County Council suggested the definition of supported living for scheme should be that “the person has a care plan which includes 24-hour support from paid staff based in their accommodation or in immediate proximity to it”. The Housing and Support Alliance suggested the following definition:

> Where an individual or group of people occupy owned or rented accommodation and where the occupier or occupiers also buy care and or support. The care and support may be bought by the occupier directly, or on their behalf by a third party, including a local authority or CCG.

4.31 Sue Garwood (housing consultant) suggested the term “supported housing” instead of “supported living”. The latter was seen as a generic term which might include intensive support in ordinary housing.

4.32 Some consultees stressed that definition or type of setting should not be important and instead if a person is being deprived of their liberty, no matter what setting, they should be safeguarded in the same way within the scheme. For example, the Official Solicitor suggested that to adopt the Care Act definition of supported living:

> Or any other description of accommodation to limit the scope of the new scheme would both limit the classes of persons who benefit from the protection afforded by the “acid test” and create a new but similar distinction arising from the legal or physical nature of the accommodation rather than the restrictive nature of the care and treatment of the person.

4.33 Several consultees noted that the definition of supported living in the Care Act was inconsistent with the explanation given in the statutory guidance to the Act. Others called for further clarification on whether specific forms of housing were included under the definition including sheltered housing, extra care housing, assisted living schemes, and retirement housing.

4.34 Mencap highlighted the “reach principles”[16] and stated:

> It isn’t easy to get a definition that meets the principles and doesn't potentially widen it so much. In the end a definition that recognises that there is a wider interpretation based on reach principles but limits it for the purposes of the Care Act is probably the most pragmatic approach.

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[16] Paradigm, Reach: Standards in Supported Living (2003).

Chapter 5: 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.

5.1 A majority of consultees agreed with this proposal.[17]

5.2 Several consultees welcomed the extension of protections beyond hospitals and care homes to include supported living and shared lives accommodation. Susan Wilson (best interests assessor) stated that as a result "potentially many more individuals could meet the criteria and benefit from the increased safeguards".

5.3 Consultees were also particularly supportive of the need for safeguards to be in place before a move. The Bar Council explained:

> Barristers acting in mental capacity cases report that, once a person has moved and the situation on the ground has changed, it is hard to persuade a court or best interest assessor that it is in the relevant person's best interests to return to live at home.

5.4 Many consultees agreed that supportive care should not extend to people in family and other domestic settings. Tees, Esk and Wear Valley NHS Trust felt this would be "overly intrusive and inappropriate". Rachel Griffiths (consultant) stated:

> I agree with the omission of domestic accommodation here, due to the real problems of invading someone's privacy: the state (in the person of the regulator of health and social care) should not lightly breach someone's article 8 rights.

5.5 Other consultees (including those supporting the proposal) argued that some people living in their own homes have significant care packages and therefore can be equally vulnerable. For example, Peter Scanlon noted:

> The least restrictive option could be for a relevant person to remain at home to receive care in an environment where they are in a vulnerable position because of a family member for example and formal protective measures would be desirable and lead to prevent or delay a move to care home or supported living etc. This degree of intrusion may be proportionate.

5.6 Several consultees argued that, in reality, most people who lack capacity and are in some form of institution will be deprived of their liberty or otherwise experiencing some form of restrictive care. For example, Paul Greening (MCA manager) stated:

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[17] 114 consultees expressed a view on this question: 65 agreed, 18 disagreed and 31 held equivocal positions.

> I think that there are relatively few people who lack the capacity to agree to being in a care placement but have no restrictions on their activity or movement. There may be some, but the vast majority will face some restriction – and so need the protection of the restrictive care proposals. While this does not detract from the ideas behind Supportive Care, it does impact on the resources required to make the scheme work effectively.

5.7 PASAUK, whilst supporting the proposal, questioned why protective care focuses on a move, and instead asked whether it ought to be "built into all assessments, not just those completed when a move into institutional care is being considered".

5.8 Others felt that the scheme needed further safeguards in place. The Mental Health Lawyers Association argued:

> We consider it essential that any new scheme makes it clear from the outset that a genuinely contested question of residence for an adult falling within the "supportive care" scheme should be referred to the court, and that this should happen at the outset before remaining in residential or supported accommodation becomes a fait accompli.

5.9 Many consultees who disagreed with the proposal argued that supportive care should not be setting specific. For example, Chris Lucas (best interests assessor) argued that rather than accommodation, supportive care should be triggered on the basis of a "significant care plan that restricts P".

5.10 Others disagreed with the proposal because domestic settings had been excluded. West Berkshire District Council stated:

> The suggestion is that a domestic setting would never be considered for the first element of protective care yet they would be included in the second element of a restrictive care and treatment element. This may cause confusion and inequitable circumstances. We would suggest that the domestic setting is included in respect of either schemes or neither.

5.11 Bindmans LLP argued that:

> If one considers the benefits to an incapacitated adult of the safeguards built in to the protective care scheme, the balance tips in favour of both schemes applying equally to those in the family / domestic setting regardless of whether or not they are deprived of their liberty.

5.12 Steve Broach (barrister) commented that the distinction between settings is unhelpful and "will result in disabled people who are subject to significant levels of state intervention in 'ordinary' homes falling outside the scope of the scheme". He noted:

> I do not see any principled basis for adopting additional safeguards because someone happens to be living in the type of accommodation which meets the technical definition of "supported living". The trigger should be actual or anticipated state involvement in the person's living arrangements.

5.13 Many consultees disagreed with the proposal due to resource considerations. Nottingham City Council's Adult Social Care Department stated:

> Current arrangements under the Care Act and Mental Capacity Act if properly funded and supported should introduce sufficient protection for the people to whom this situation is likely to apply. Additional responsibilities seem disproportionate and those resources available should be concentrated on those most at risk, namely those people being deprived of their liberty or threatened with interference of their article 8 Human Rights Act rights.

5.14 A number of consultees held equivocal positions. Sunderland City Council stated:

> It is not entirely obvious that care homes fit within supportive care. If a person in a care home lacks capacity it is highly likely that they will require "restrictive care and treatment" as the threshold is set low following Supreme Court judgement. That being said the same could be argued for those lacking capacity in the remaining settings under "supportive care" as local authorities / CCGs become more adept at meeting the needs of individuals with highly complex needs in settings outside of traditional establishments.

5.15 CQC suggested:

> If the supportive care scheme is to be taken forward, there may be merit in considering whether care provided in supported living, shared lives accommodation and other domestic settings should be moved into the remit of this scheme, and out of scope of the CQC oversight of restrictive care (beyond our current regulatory responsibilities for providers of care in these settings).

5.16 Mencap stressed that:

> Thought should be given as to how we can ensure families get the support they need early on. This links to the Transforming Care Agenda about transforming care and support for people with a learning disability and behaviour that challenges and it would be useful if proposals around "family home" settings are explored and developed using expertise from families involved in shaping the Transforming Care work programme.

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.

5.17 This proposal was supported by a majority of consultees.[18]

5.18 For example, Devon County Council stated that the proposal:

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[18] 170 consultees expressed a view on this proposal: 108 agreed, 35 disagreed and 27 held equivocal positions.

> Serves to include more people than the previous definition provided within the DoLS scheme (individuals with conditions such as an acquired brain injury may inadvertently be excluded) and therefore serves to provide protection to a greater number of vulnerable adults.

5.19 Brent SAB agreed in the following terms:

> The qualifying criteria for supportive care should be the test under the Mental Capacity Act and not the Mental Health Act. Ensuring that anyone who lacks capacity, in line with the section 2 – section 3 of the Mental Capacity Act test rather than the Mental Health Act definition, will ensure that non-mental health professionals are empowered to assess and make decisions without requiring formal diagnosis. In practice that will mean not only that those with disorders arising from brain injuries, drug and alcohol issues etc. qualify for safeguards but also that care managers must routinely consider whether the care provided is the least restrictive.

5.20 The Royal College of Anesthetists commented that:

> The capacity test as stated by the Mental Capacity Act should definitely be used, although we appreciate that, in practice, the test may cause some difficulties. This is because the question of asking someone to weigh up the merits and pitfalls of where they want to live is quite a complex one. It might be worth having a short statement within the guidance somewhere recognising this and stating that it’s important to bear in mind a person’s wishes where they have capacity for certain parts of this question and to emphasise the importance of a person’s living arrangement being one which is most in line with the person’s wishes whilst not negatively affecting their safety and care needs.

5.21 Some consultees agreed with the proposal, but noted the implications for certain groups. For example, Berkshire Joint Legal Team stated:

> We think this is reasonable and it would be helpful to mirror consistency with the Mental Capacity Act but we note the possible widening in scope to those in residential rehabilitation settings for the purposes of detoxification and rehabilitation for drug and alcohol consumption if not using the Mental Health Act definition of a mental disorder.

5.22 East Sussex County Council supported the proposal in principle but was concerned that it:

> Would bring more people into scope, such as people in a vegetative state, people who have a mental disorder as a result of an alcohol or drug abuse or people who neglect themselves. This would significantly increase the workload which would be unmanageable unless it could be achieved within mainstream practice.

5.23 A number of consultees disagreed with the proposal. For example, Dorset Advocacy stated that:

> We can envisage very few situations in which a person would lack capacity to consent to placement, yet not require one of the more restrictive interventions that would trigger a restrictive care authorisation.

5.24 Dr Jonathan Waite (psychiatrist) argued that:

> It is difficult to conceive of a person with "pure" dependence on alcohol or drugs who lacked capacity to make a decision on supportive care. If the dependency were more complex, then they would come under the Mental Health Act … The same would apply in "brain injury".

5.25 The Alzheimer's Society questioned:

> Whether the Mental Capacity Act is compatible with the United Nations Convention on the Rights of People with Disabilities? Removal of the "impairment of, or a disturbance in the functioning of, the mind or brain" from the assessment would better align the pieces of legislation and prevent inconsistencies.

5.26 The Tri-borough Councils suggested that the trigger for supportive care should not be incapacity:

> Someone who lacks capacity to [decide where to live] is vulnerable but many people who have capacity to make that decision are also vulnerable. This also risks labelling and stigmatising and is unlikely to help with implementing the principles of the Mental Capacity Act, for example, it isn't going to encourage staff to try and support someone to make a decision with lots of support. If the criterion were that the person needs support with at least some of their major decision-making, this would be less stigmatising but the people who would fall into the scheme would still be vulnerable because they need someone else to provide them with information and other types of support.

5.27 Some consultees emphasised the need for clarity. For example, Hertfordshire County Council suggested that:

> Clarity is required with regards to exactly what is being assessed in terms of capacity under the new scheme e.g. is it the capacity to consent to where someone is accommodated for the purpose of care and treatment or is it the care and treatment itself?

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.

5.28 This was supported by the majority of consultees.[19]

5.29 Consultees who agreed with the proposal frequently stated that it would ensure that a proper assessment takes place (either under supportive care or through other mechanisms such as the Care Act or NHS continuing health care). Many consultees

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[19] 191 consultees expressed a view on this question: 98 agreed, 32 disagreed and 61 held equivocal positions.

reported that currently assessments are often inadequate or are not being completed at all. A response from an anonymous family carer commented that in her experience care home staff are not trained to undertake full needs assessments and too often local authorities delegate their assessments to unqualified staff. Other consultees reported lengthy battles with local authorities and the NHS in trying to arrange an assessment in the first place.

5.30 Other consultees welcomed the ability to utilise existing assessment processes and combine assessments. For example, the Care Council for Wales stated:

> Our understanding is that the majority of these situations will be where there is already some managed care service involved whether it be a care home or shared lives arrangement, so care assessments will occur except where people pay for their own care. It is logical therefore for assessments to be integrated into existing care assessments as long as the process does not introduce further substantial administrative burden.

5.31 Many consultees (including those supporting the proposal) raised concerns about the resource implications. For example, Hertfordshire County Council stated:

> We agree with this proposal in principle, but have concerns with regards to the practicalities of implementing and overseeing such a process. Given the huge numbers of people who would be deemed eligible for supportive care, we have concerns that there are insufficient resources to ensure staff are trained to a level at which they can identify eligible service users and complete assessment accordingly.

5.32 Some consultees felt that additional duties should be placed on care providers. Denbighshire County Council noted:

> We are in agreement with this proposal, however we feel that an equal duty to report be placed upon care providers to notify the local authority where it appears that a person is eligible for supportive care; without this duty placed on providers local authorities may not be aware of those individuals and therefore able to fulfil its duty.

5.33 Consultees who disagreed with this proposal frequently argued that it was unnecessary. Newcastle City Council's Legal Services stated "this again seems to be an unnecessary duplication of work that would be done under the Care Act 2014". Lancashire County Council stated "this should be addressed by robust care planning within the remit of the Care Act".

5.34 Others disagreed because they felt the proposal was too narrow. Surrey CCG Mental Health and Learning Disability Collaborative argued that "any person who requests an assessment should receive one irrespective of their type of accommodation".

5.35 However the Tri-Borough Councils argued that the proposal was too broad:

> If the accommodation has been arranged by the state, the person will already have had an assessment. If the person is a self-funder, an assessment is too intrusive. They, or their family (or, possibly, friends), have chosen to go down the private route and not via social services (or they might have asked for a care home placement which the local authority have decided they didn't need) – they should not have social

> services checking up on them; if there are any issues then the provider should make a safeguarding referral.

5.36 Many consultees disagreed with the proposal on the basis of resources. For example, Northumberland County Council pointed out that the Government has announced that it would delay its funding reforms until 2020 (including those that would have meant more self-funders would receive assessments and support) and therefore the cost of this proposal would be "considerably greater than originally anticipated". It further argued that:

> The scale of the implications of *Cheshire West* is such that it would be unwise to add further to the already daunting task facing local authorities, even if the procedural requirements are simplified.

5.37 Nottingham City Council's Adult Social Services Department argued:

> The likely outcome of this proposal is that assessing capacity in this area will default to local authorities with care homes and health partners etc. failing to take responsibility for decisions within their remit, thus negatively impacting upon the development of good practice.

5.38 Professor Julian Hughes (psychiatrist and academic) and Charlotte Emmett (law lecturer) stated:

> We are concerned that by simply introducing a system of oversight –the local authority checking that they have been carried out and the correct forms completed – does not necessarily mean that the process itself has been carried out properly and the legal standards of the Mental Capacity Act applied.

5.39 Some consultees held equivocal positions. A number of consultees wanted care providers to have a greater role in the assessment process. For example, Stephen Down (best interests assessor) commented that care homes could be responsible for assessing capacity "as part of their pre-admission assessment".

5.40 A number of consultees felt that responsibility should not just rest with local authorities. Medway Community Healthcare argued "the funding authority should be responsible for these proposals". Central Bedfordshire Council stated "this should be the responsibility of the care commissioner and not the local authority, unless the local authority is the responsible care commissioner". NHS Nene and NHS Corby CCGs stated:

> Why, for supportive care, is the requirement on the local authority? This is about prevention, good care planning and monitoring. All professionals involved should be proactively engaged and sited on "supportive care". The need for the requirement of local authority involvement is over burdensome.

5.41 Several consultees discussed the position of self-funders and questioned how the local authority would be notified of individuals who require assessments. Peterborough City Council stated:

> Although local authorities already undertake assessments for a large percentage of people entering these settings, there are still a number of self-funders who are not

assessed in this way. With the delay in the introduction of part two of the Care Act 2014 there a danger that local authorities will be underfunded for these assessments. Additional funding to cover the assessment and overview of self-funding placements will need to be made available.

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.

5.42 A majority of consultees agreed with this proposal.[20]

5.43 Consultees who supported the proposal frequently argued that it would help to ensure that assessments are of a high quality. Roger Laidlaw (best interests assessor) stated:

> My perspective on documents such as mental capacity assessments and statements about best interest produced in current practice is that they are often of poor quality. This situation is likely to persist until such time as effective workforce training takes place and requirements would have to be forcefully asserted to overcome objections to the novelty by staff and because of the perception from managers that this would interfere with other priorities such as case management and prompt hospital discharges.

5.44 Jill Lewis (social worker) stressed the need for a “nationally agreed curriculum” developed by the relevant professional regulation bodies. Rachel Ward (independent mental capacity advocate) highlighted the current “lack of monitoring”, which she felt was necessary in order to ensure assessors meet the required standard. Brighton and Hove City Council suggested an approval process similar to that of existing Approved Mental Health Professionals. The British Association of Social Workers stated:

> The required training and eligible professions should be set out in regulation as is currently the case for DoLS. The respective national professional registration bodies will need to work together to agree the competencies are required. The local authorities should then comply by providing / commissioning training based on a nationally agreed curriculum.

5.45 Swansea City and County Council felt that it should be made explicit that “a person with expertise” includes “family members or direct care staff or others who know the person well”. Barchester Healthcare suggested that care homes may be able to contribute “by providing information from care planning, risk assessments and knowledge about lifestyle”.

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[20] 174 consultees expressed a view on this question: 109 agreed, 27 disagreed and 38 held equivocal positions.

5.46 Many consultees argued that the assessor must be "independent". For example, Gloucestershire County Council commented that it is "difficult to view the situation critically when there has been a lot of involvement in the case" and that an independent assessor "has the benefit of being able to provide a different and impartial view point".

5.47 Many consultees generally agreed that this proposal would require greater investment in training to ensure good practice and therefore stressed the need for adequate funding. Bradford BIAs argued:

> The House of Lords recognised the competence deficit around Mental Capacity Act assessments and the tendency towards risk-averse decision-making. Any new scheme will fail if this is not addressed. Just saying that local authorities must do better is not good enough. If the Department of Health does not step up to the plate with more money, more leadership and more high quality training provision then the new scheme will fail to deliver real rights and protections for service users.

5.48 Several consultees suggested generic assessment templates or forms. Eleanor Murphy (best interests assessor) argued:

> A guided assessment template could be used across all services and authorities. Government produced Mental Capacity and Best Interest Documents would drive up the status, adherence and efficacy of the process, and could be introduced as part of the implementation of the new schemes.

5.49 Consultees who disagreed with the proposal frequently raised resource considerations. Dr Hugh Series (psychiatrist and academic) stated:

> This [proposal] may be quite arduous to implement. First, it will create a significant new training requirement (not necessarily a bad thing, but costly), and second there will be a new need to identify and engage "a person with expertise". This may mean that specialists have to become involved in care arrangements much more than they are at present. This may be a good thing, but it will be costly.

5.50 Nottingham City Council's Adult Social Care Department commented:

> If this means that the local authority will now need to check the expertise of other professionals apart from the best interests assessors they employ, then this is a huge additional burden to place on local authorities outside of their commissioning role. This is already something that should be present in the regulated services as part of their contract specifications, commissioning arrangements and professional competency frameworks. Managing Authorities should train and check the suitability of their own staff when allocating work. They have much closer knowledge of their competence and can swiftly act as required.

5.51 A number of consultees felt that, where a person was under NHS continuing health care, this should be the responsibility of the NHS. Bristol City Council argued that CCGs should be given some statutory responsibility in the implementation and administration of the new scheme.

5.52 Several consultees suggested that the proposal was not necessary. Camden Council and Camden Safeguarding Adults Partnership Boards noted that the proposal duplicates existing statutory responsibilities and commented:

> We wonder whether this [proposal] is necessary, or whether it might be more effective to look at why some of the existing statutory responsibilities are not being met at present and address this.

5.53 The British Geriatrics Society was concerned that more assessments may result in further delays for transfer of care. They explained:

> [The] timeliness of the assessment process is paramount to avoid delayed transfer of care: presently there is an escalating problem with delayed transfer of care in the NHS for both NHS and social care reasons.

5.54 The joint response from Shropshire Partners in Care, Telford and Wrekins Council and independent care providers felt that this requirement should be more rigorous and that local authorities should "notify Health and Care Professions Council when concerns are experienced regarding assessors competency".

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.

5.55 A majority of consultees agreed that local authorities should be required to keep under review the health and care arrangements for any person who falls within supportive care.[21]

5.56 Consultees who supporting this proposal argued that it would help to ensure that vulnerable individuals had adequate safeguards, especially those that would traditionally not fall within the responsibilities of local authorities such as self-funders. Some service users and family members provided personal experience of instances where care plans had not been properly constructed or not provided at all. One family carer (who wished to remain anonymous) explained that her husband who suffers from dementia had not received a mental capacity assessment despite being placed in a care home several months ago. We were also informed by a group of family members of adults with learning disabilities that local authorities often fail to provide any ongoing support and assume that family members will carry on looking after their sons / daughters.

5.57 Several consultees argued that the NHS should also be responsible for supportive care. London Borough of Barking and Dagenham Council argued:

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[21] 197 consultees expressed a view on this question: 106 agreed, 28 disagreed and 63 held equivocal positions.

> There would need to be a clear expectation or duty on the NHS to keep under active review those people who are receiving their care through NHS continuing health care funding. While many local authorities have a passive review system … many CCGs have an even less developed review system, as they have no culture or history of keeping care packages under review. This could mean that people receiving [NHS continuing health care] could slip through the net. We believe that the duty to keep [NHS continuing health care] funded individuals under review should first and foremost lie with the NHS rather than the local authority.

5.58 PASAUK commented that self-funders may not always want local authorities to be involved in their care and support, and instead "the local authority should therefore be required to ensure that care processes are reviewed by a professional external to the care provider".

5.59 Nottinghamshire County Council, whilst in agreement with the proposal, highlighted that the new scheme "assumes incorrectly that social work teams have the capacity to care manage and keep 'cases' open indefinitely".

5.60 Many consultees commented on the timings of reviews. The National Autistic Society stated:

> Many people on the autism spectrum and their families already report inadequate reviews under the Care Act (and its predecessor legislation), often going much longer than a year between substantive care reviews. This would be inappropriate length of time between reviews for someone under the supportive care regime.

5.61 Maxwell Gillott Solicitors suggested that there should be "a requirement to set a review date on completion of the assessment, which would also require review with any significant change of circumstances". Living Options Devon (advocacy provider) felt there should be a mandatory initial six week review, followed by reviews at least once per year. St Andrews Healthcare felt the review should take place at the same time as the review of the care and support plan under the Care Act 2014, to minimise the administrative burden on local authorities.

5.62 Many consultees who disagreed with this proposal highlighted practical concerns. Roslynn Azzam (DoLS lead) argued:

> It will be necessary to define "keep under review". For example, will it always be sufficient for the local authority to link in with the existing review arrangements of the care manager? Can the local authority rely on information from the care co-ordinator, care provider or advocate to inform them of any changes between reviews? Would it ever be incumbent on the local authority to actively review a situation to assure itself that nothing has changed if the planned review is delayed or does not take place? If so, how often? … If this responsibility is generally to be discharged through other agencies, it may be better to give the responsibility to others to notify the local authority of any changes and then give the local authority responsibility to respond to these notifications appropriately.

5.63 Nottingham City Council's Adult Social Care Department stated:

> If the scheme is introduced it would make more sense for service providers to keep a person's circumstances under review with a role for advocacy or the person's representative to request a review if and when necessary. The idea that all people in this situation will have and retain an allocated health or social care worker is outdated and does not fit into existing local authority service models.

5.64 Several consultees held equivocal positions. The ADSS Cymru and WLGA argued that the proposal is already contained within the Mental Capacity Act and the Social Services and Well-being (Wales) Act 2014, and there is a need to ensure that the new scheme "aligns with expectations and duties under existing legislation rather than creating new responsibilities that already exist".

5.65 Many consultees highlighted the position of self-funders. West Berkshire District Council stated that:

> There is a significant impact here for those numbers of self funders in the current care system. There are substantial numbers of self funders within our area and with the delay in changes to the funding system we are less likely to be notified of them through normal channels. There are likely to be big transition costs for West Berkshire to implement this requirement.

5.66 Hampshire County Council highlighted that in many cases, local authorities will not be aware of many self-funders who could fall within the remit of supportive care, and therefore "would rely on receiving information from providers". SARCP questioned whether care providers would be required to refer relevant individuals, and felt that if so, training would need to be provided. Housing LIN explained:

> It is clear to us that it is quite common for housing providers to make referrals to local authorities to which there is little or no positive response, leaving the housing provider to deal with the situation as well as they can. With budget cuts and eligibility criteria for care being tightened, this is likely to continue.

5.67 Many consultees highlighted concerns relating to the use of care plans. Derbyshire County Council argued that "whenever workers are under pressure the review of a stable package of care or placement is the first thing to be postponed" and this proposal could therefore "have the effect of collapsing an already precarious system". Stephen Down (best interests assessor) stated:

> There is too heavy a reliance on care plans. Whilst I would agree that these restrictions should be part of the process, there is not one generic care plan for each person. Many services will have their own, some hand written some electronic. The care plan doesn't always follow the resident as there may be format issues, electronic systems would all need to be changed. For those how move between areas each may have its own paperwork.

5.68 Bury Council and Bury CCG questioned whether the proposal could be seen by self-funders and their families as being "interference", and whether legally an authority have access to information under data protection rules.

5.69 Many consultees highlighted resource-related concerns. Mencap stated:

> We welcome the proposal that ongoing safeguards would be available to the person. However in practice we think there may never be enough resources to make these a reality … Currently local authorities are supposed to review people's care, but this is not always done as often as it should be or as consistently. The ability to have a light touch may be used to excuse the role of reviewing people who are being supported for extensive periods of time under the banner of little change.

5.70 Hampshire County Council added:

> If the remaining Care Act funding reforms are introduced as expected in 2020, there will be an enormous additional pressure on local authorities who will start to engage with much higher numbers of self funders, who come to the local authority for a care account and assessment. It will be challenging to resource the necessary additional oversight in terms of monitoring restrictions on these additional self funders' care arrangements.

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.

5.71 The proposal was supported by a majority of consultees.[22]

5.72 For example, Oxfordshire County Council felt that the proposal was "in line with good practice and the aim of improving outcomes", and "also ensures transparency is promoted". Camden and Islington NHS Foundation Trust highlighted that the proposal would, in particular, "ensure that principle 5 of the Mental Capacity Act (consideration of the least restrictive option) is reflected and recorded". Jill Lewis (social worker) stated:

> I think it will be very helpful for the individual, families and professionals to discuss and agree options and to clearly record them. Organisations and professionals who work to high standards will already do this, and this legislation should make it possible to hold to account those who have not previously been clear.

5.73 Some consultees supported the proposal in principle, but also suggested amendments. For example, Swansea City and County Council stated:

> The principle of recording the full decision-making process is agreed but it is felt it should be recorded in the assessment or equivalent records and not in the care plan. The care plan needs to be a practical informative document for all staff to support the individual and it therefore needs to be clear and concise on what is required. If there is a lot of detail regarding the decision-making process around all the options, this is

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[22] 183 consultees expressed a view on this question: 128 agreed, 29 disagreed and 26 held equivocal positions.

> likely to result in an unwieldy and lengthy care plan containing information not directly relevant to the care and support being provided.

5.74 Several consultees (including those supporting the proposal) raised concerns about the resource implications, stressing that more funding would be required in order for this to be properly implemented.

5.75 Consultees that disagreed with the proposal frequently argued that it was unnecessary. Brent SAB argued:

> This is already a legal requirement (in that it is required by the *Mental Capacity Act Code of Practice* and public law principles), but is only binding on local authorities if they have responsibilities under the Care Act to complete an assessment. The delayed funding reforms will impact on this. It isn't practical, or in our view necessary, to duplicate this duty under the proposed system ... Instead it would be more sensible to make it very clear than the duty is on any assessor or care provider to ensure they comply with the duties set out in the *Mental Capacity Act Code of Practice*.

5.76 Camden Council and Camden Safeguarding Adults Partnership Board stated:

> We suggest that many of the supportive care and the restrictive care and treatment provisions could be addressed within assessment and care planning within Care Act processes. Rather than develop a new set of legislative requirements, would it perhaps be possible to examine the duties under the Care Act to make them more robust and ensure the existing safeguards are implemented?

5.77 Others argued that the primary responsibility should not be on local authorities in all cases. Roslynn Azzam (DoLS Lead) stated:

> Where the care coordinator is employed by the NHS or other provider, it may not be possible to influence whether assessments are carried out and care plans completed. There is currently quite a variety of quality and detail in the recording of best interest decisions, which each agency should be addressing through its quality assurance and practice improvement. It is not clear that the local authority can bring about this change on a case by case basis effectively within a reasonable resource. In my experience, where the supervisory body has raised concerns with care coordinators that there may be some less restrictive option that is yet to be considered, this can lead to lengthy and protracted discussions where practitioners can become defensive about their professional judgment. A similar tension could arise if the local authority providing supportive care is seen to be scrutinising the work of other professionals.

5.78 Others had concerns with the use of care plans. Michelle Pratley (barrister) stated:

> Unfortunately, in my experience it is not uncommon for care plans to be excessively long, narrative documents that describe in some detail how various decisions were made but fail to document the arrangements for P's care accurately, concisely and comprehensively. Adding a requirement for the care plan to record various options that were considered and not pursued would exacerbate this problem. In my view where a best interests decision needs to be made about P's accommodation, care and / or treatment, the proper place to record the options that were considered and the benefits and burdens of each is in a separate best interests assessment. The best

interests assessment should also record any options that were precluded from consideration on public law grounds, especially if such options were sought by P or P's friends or family members.

Provisional Proposal 6-7

Under supportive care, a person's care plan must make clear the basis on which their accommodation has been arranged.

5.79 It was agreed that under supportive care a person's care plan must make clear the basis on which their accommodation has been arranged by a majority of consultees.[23]

5.80 Many consultees argued that currently it is not clear whether people are being placed as a result of a best interests decision under the Mental Capacity Act or a public law decision under community care legislation. Families told us that local authorities and the NHS frequently offered services and care home placements to their loved ones on the basis of the cheapest option available, but dress this up as a best interests decision. Others reported that in practice service users are being offered no choice over their placements (since the local authority or the NHS will only offer to provide a single "choice" of placement based on the cheapest provider) thus leaving no room for best interests decisions. Many felt that clarity over the legal basis on which accommodation had been arranged would provide for greater clarity and allow decisions to be challenged.

5.81 Others argued that where a person lacks capacity it is important that the tenancy arrangements be included in the care plan. Living Options Devon (independent advocacy provider) stated:

> As a service we have raised concerns regarding tenancies for those who lack capacity and this is an area where we continue to see poor practice, therefore we welcome the proposal that local authorities must ensure that accommodation arrangements are clearly stated in the person's care plan.

5.82 Others thought it would help people to understand their status and rights. For example, the London Borough of Barking and Dagenham Council felt this proposal would help in cases where "respite care is arranged, to ensure that there is clarity between respite care and permanent care, and to prevent 'slippage' from one into another".

5.83 Some consultees who agreed with the proposal made wider comments about its implementation. Denbighshire County Council suggested that "it would be useful if maybe the Code of Practice could also stress the need to show how the individual's perspective has been taken into account". Dimensions (learning disability care provider) raised concerns that in many cases the person's living arrangements were decided years ago, so the evidence may not be available.

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[23] 159 consultees expressed a view on this question: 116 agreed, 20 disagreed and 23 held equivocal positions.

5.84 Several consultees raised the issue of self-funders. For example, North Tyneside Council stated:

> Currently we feel self funders are vulnerable as they may never see an independent assessor and we have come across cases where the person hasn't wanted to be in the care home but families have sold their homes to fund care and they have nowhere else to go. We would like to highlight that self funders choose to go into homes when the time is right for them, care homes don't turn this business away and they sometimes take people on a self-funding basis whom the local authority would think doesn't meet the threshold for care.

5.85 Many consultees who disagreed with the proposal argued it was unnecessary. For example, Christine May (hospice transition coordinator) stated:

> If a mental capacity assessment is recorded for accommodation and a person does not have capacity to make the decision on the place of care then a best interests decision is made and recorded with recorded demonstration of consultation and options. This is not new. If you want it to be more robust [then] produce a clear standard form which is the one thing lacking in the mental capacity assessment, consultation and outcome.

5.86 Some consultees held equivocal positions. The ADSS Cymru and the WLGA stated:

> This underlines the need for considering options / alternatives and the rationale for decision making, which should already be happening as part of the care planning process.

5.87 Others were concerned about compliance. For example, West Sussex County Council noted:

> Whilst making clear the legal basis of person's accommodation should be current best practice, this often presents challenges to social care staff as the law in the area is not always clear.

5.88 A number of consultees felt that this proposal, if it were to be implemented, would be best placed in the Care Act.

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?

5.89 A majority believed that changes were needed.[24]

5.90 Healthwatch Staffordshire stated "current provision is open to interpretation" and the Mental Capacity Act fails to provide clarity. Calderdale Council (Adults, Health and

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[24] 120 consultees expressed a view on this question: 61 said "yes", 26 said "no" and 33 held equivocal positions.

Social Care Services) argued that “we need a formalised and simplified way of managing tenancy agreements if the person cannot consent”. Chris Lucas (best interests assessor) suggested:

> A clear legal framework is needed so that the requirements from different housing providers doesn’t vary as it does now … The current situation does not give people who lack capacity any certainty about what they need to do to arrange accommodation, which is discriminatory.

5.91 A wide range of suggestions for changes were submitted. For example:

(1) Sitra suggested a streamlined approach for Court of Protection applications to sign or end a tenancy or alternative means of signing or ending a tenancy without use of the Court;

(2) Dr Jonathan Waite (psychiatrist) wanted “comprehensive but brief” guidance, plain English specimen tenancy templates and audio and video information, and clarity on the rights of health and social care professionals to enter people’s homes;

(3) Camden and Islington NHS Foundation Trust called for a local authority power to terminate tenancy agreements when the landlord is acting inappropriately;

(4) The Sanctuary Group (service provider) suggested a requirement that an Approved Mental Capacity Professional must make a best interests assessment prior to signing a tenancy on behalf of an incapacitated person;

(5) South Gloucestershire Council wanted a greater role for advocacy, including advocates being able to sign tenancies on the person’s behalf;

(6) Central Bedfordshire Council called for an “appointee system” whereby tenancies could be signed on the person’s behalf without someone becoming a deputy or done; and

(7) the Chartered Institute of Housing suggested greater joint working between housing and care providers.

5.92 Many consultees highlighted existing problems. For example, Brent SAB referred to the difficulties caused:

> Where the individual takes on the tenancy, either with or without capacity and then ceases to require or make use of the support available … Presently the only mechanism the landlord has to recover the property so as to offer the placement to someone who does need / would use the support is eviction proceedings, but this might not be relevant in many cases because there may be no breach of the terms of the tenancy contract. In practical terms not only does this mean there is a financial risk for providers who are unable to guarantee income to cover the cost of on-site support, posing a significant risk for the viability of such projects, it also often results in a “silting up” of tenants unwilling to move from accommodation they have a legal right to occupy, but not requiring / utilising the level of input offered.

5.93 Housing LIN refereed to the following situation:

> As we understand it, if the landlord had express or implied knowledge of the tenant's incapacity when taking on a tenancy, the landlord may not be able lawfully to evict for breach of the contract if a tenant cannot help causing nuisance or annoyance – that could count as disability discrimination. This might be argued to be an imbalance in favour of the occupant rather than the landlord.

5.94 In general, consultees were critical of the existing procedure to sign and end tenancies via the Court of Protection. However a number of consultees felt this did not cause difficulties. Brent SAB, for example, argued this process was simple and cost effective as "applications can be done in bulk and considered on the papers rather than with a hearing". It suggested that local authorities be required to make applications this way so individuals benefit from the economy of scale.

5.95 Housing LIN also suggested:

> If local authorities know that applications needs to be made to the Court of Protection in the absence of a Lasting Power of Attorney, they may be more likely to engage earlier with people who have progressive cognitive decline while they still have the capacity to make key decisions about where to live, future care, appointing an Lasting Power of Attorney etc. This is not only legally advantageous, there is a consensus that the outcomes for individuals are better if people move to a supported housing setting when they still have the mental capacity to agree to the move, learn their surroundings and feel part of the community. They may also be more likely to support the individual to make his / her own capacitated decision.

5.96 Sitra suggested that statutory guidance should make clear that:

> A tenancy can remain unsigned if there has been a best interest's assessment by the local authority whilst an application is made to the Court of Protection. The application process can be streamlined so that when an application is made accompanied by a local authority best interest's assessment it can be ratified by the Court of Protection unless there is an objection. We also believe this should apply to licence to occupy except in respite or short stay situations.

5.97 Some consultees argued that no changes were needed. Weightmans LLP stated:

> Individuals are already largely protected and don't require further protection. We have seen no real evidence that landlords are adversely affected to the point whereby changes ought to be made.

5.98 The Court of Protection Practitioners Association added:

> A tenancy signed by an incapacitated person is voidable and not void ab intio. The powers of the Court of Protection and financial deputies are effectively supported by guidance: Applications to the Court of Protection in relation to tenancy agreements (2012). The streamlined procedure appears to work adequately.

5.99 Some disagreed with the question on the basis that improvements could be made without changes to the law. For example, the Mental Capacity Act Project stated that "the involvement of a family, community or professional advocate at the stage of a change of accommodation" is key to ensuring that "any signed or implied contract is in the citizen's best interests (where they lack capacity)". Durham County Council (Children and Adult Services) felt there were "training issues for landlords in relation to tenancies and for practitioners involved in placements to ensure legal safeguards are put in place".

5.100 Housing and Support Alliance commented on the current uncertain case law in this area:

> It would be very helpful to see if there was any way that the opposing judgements on void and voidable contracts could be reconciled. The *Wychavon* judgment[25] concluded that a contract with someone who lacks capacity is void, but Commissioner Jacobs (2006)[26] (and … common law) held that there is no minimum level of understanding by which a contract is void. We understand that until these two opposing views are tested directly against each other, both could be referenced. This would mean that a case specifically deciding whether a contract was void or voidable would need to be brought and that is unlikely. It does however remain an issue where people are forced into unnecessary Court of Protection authorisation when Wychavon is relied upon because decision makers may not be aware of, or understand, the alternative position.

Question 6-9

What difficulties arise when landlords require tenancies to be signed by a donee or deputy, and how might these be addressed?

5.101 One hundred consultees responded to this question, providing a number of examples of the difficulties which arise when landlords require tenancies to be signed by a donee or deputy.

5.102 Consultees noted that difficulties occur where an individual does not already have a donee or deputy in place. Care England stated:

> It remains a problem that so few people who lack mental capacity when entering into tenancies have created Lasting Powers of Attorneys: often they are people with significant learning disabilities who have never had the relevant capacity. Demanding that all potential tenants have Lasting Powers of Attorneys or Deputies is often unrealistic and, where possible, expensive and time-consuming.

5.103 Where an individual does not have an appointed donee or deputy, consultees explained that the process of applying to the Court of Protection is particularly lengthy and costly. Dimensions (learning disability care provider) explained:

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[25] *Wychavon DC v EM* [2012] UKUT 12 (AAC), (2012) 15 CCLR 221.

[26] CH/2121/2006: Voidable contracts and mental capacity.

> All too often Dimensions are advised that Court of Protection orders are in place or are being applied for. Once suitable housing has been found, it then transpires that the person cannot proceed as this is not actually the case. Unfortunately this means people are losing out on homes, because of the CQC requirement for a Court of Protection Order to be in place.

5.104 It further added:

> When a Court of Protection makes applications for housing and / or benefits, the receiving authority often pass queries to the applicant. These are not always passed back to the Court of Protection. Dimensions recommends that when making an application, evidence of status must be easily supplied and copied to the local authority to allow them to respond directly to the Court of Protection rather than the applicant.

5.105 Several consultees stressed the need for a fast track system, either utilising best interests decision-making within the Mental Capacity Act (London Borough of Barking and Dagenham Council), using a tribunal-type system (Tri-Borough Councils) or a digital application process to the Court of Protection (Bristol City Council).

5.106 Some consultees highlighted problems in cases where an attorney or a deputy has been appointed. West Sussex County Council noted that having a deputy or donee may prevent someone receiving help “through a Department of Work and Pensions appointee”. Oldham Council highlighted conflicts of interest where deputies or donees are family members, or where there are disagreements with family members and the local authority regarding where to house the individual.

5.107 Others noted that difficulties can arise when determining who is responsible for breaches of that tenancy. Steve Broach (barrister) explained:

> In my experience the greater problem (at least anecdotally) is landlords simply obtaining signatures to tenancy agreements from disabled people who lack capacity to sign them, leaving the person vulnerable to a finding of intentional homelessness if they then breach the terms of the agreement. This may need to be addressed both through amendments to the Mental Capacity Act 2005 as proposed above and by a major public information campaign targeted at both landlords and disabled people and families to highlight the existing legal arrangements set out in the consultation paper.

5.108 DAC Beachcroft LLP stated:

> We are aware of difficulties where a person signs a tenancy on behalf of another in terms of contractual rights and obligations and access to housing and other benefits for P. A provision for substituted signature with the rights, liabilities and obligations remaining with P would provide for some clarity.

5.109 There was some debate over whether an attorney or deputy should always sign the tenancy. Tristan Wood (former housing association manager) stated:

> I think it would be helpful in the proposed code of practice to dissuade landlords from requiring tenancies to be signed by a donee or deputy on the grounds that the procedure is time-consuming and costly, disproportionate and potentially

> discriminatory and that provision of accommodation as a “necessary” should safeguard receipt of housing-related income.

5.110 Housing LIN stated:

> A key concern with tenancies that are not lawfully signed is the risk that the premises would not be treated as the person’s “own home” and that the package being provided would be more likely to be seen as providing care together with accommodation, hence triggering registration as a care home.

5.111 Warrington Borough Council argued that:

> The main issue currently is lack of consistency. Some landlords accept an unsigned tenancy agreement, whereas others want the security of an authorised signatory, either under a Lasting Power of Attorney or by a Deputy. Where a Deputy is required, this factors in delay and the added expense of a court application. It would be helpful if there was a universal approach – could an appropriately trained designated officer in the local authority be granted authority to sign tenancy agreements, without the need for a court application?

5.112 However Healthwatch Staffordshire noted:

> It should not be assumed that a registered provider is duty bound to accept a tenancy as they are free to act as they wish. They need to have in place criteria for accepting someone deemed to not have capacity and it should be accepted that if those criteria are not met they are no more expected to grant a tenancy than a private sector landlord.

5.113 Several consultees provided suggestions as to how these difficulties might be addressed. Peterborough City Council called for “further guidance” to ensure “support for tenancies if someone loses capacity after agreeing a private tenancy in order to protect their rights to remain within that accommodation”. Thames Valley Safeguarding Network suggested “better publicity for Lasting Power of Attorneys and court appointed deputyships” and “increased liaison with landlords, estate agencies who deal with supported living schemes and insurance companies”. Anchor (housing and care provider) stated:

> Increasing public awareness regarding capacity issues and the need to plan ahead would reduce the number of people in this situation. Simplifying and speeding up the processes used by the Court of Protection would help significantly to reduce the current issues.

5.114 Mencap argued:

> There needs to be clear legislation that landlords must offer tenancies based on written evidence from social care or health authorities that a best interest decision has taken place to agree that it is in the best interests for people to move in.

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?

5.115 A majority believed that local authorities and the NHS should not set personal budgets for disabled people living at home by reference to the cost of meeting the person's needs in residential care.[27]

5.116 Many consultees argued that care and treatment should be allocated on what is best for the individual, rather than what is most cost effective. It was also argued that, since it is usually cheaper to meet the person's needs in residential care, personal budgets costed on this basis would make it very difficult for a person to remain in their home. For example, Calderdale Council Adults, Health and Social Care service stated that "the focus must be on allowing the person to remain at home as long as possible and residential care considered as the (more restrictive) last option". The Alzheimer's Society described the process of aligning personal budgets to costs of a particular form of support as "regressive and inappropriate". Ian Penfold felt that:

> Such a practice will almost always result in a disproportionate interference with the person's right to respect for private life and the home under article 8 ECHR, read with the right to independent living and community support in Article 19 of the UN Disability Convention.

5.117 Kent County Council referred to the Care Act statutory guidance and stated:

> Personal budgets are based on assessed needs and not the cost of provision. If appropriate care can be provided at home, a person should not be effectively forced into residential care by budgetary constraints.

5.118 It also referred to the Care Act statutory guidance which states that local authorities "should not have arbitrary ceilings to personal budgets that result in people being forced to accept to move into care homes against their will".[28]

5.119 Steve Broach (barrister) however noted that this does not currently apply to CCGs. He stated:

> The Care Act statutory guidance goes a significant way towards prohibiting this practice by local authorities, but there is no guidance of similar force to CCGs, so far as I am aware. As such at least two CCGs have adopted "maximum expenditure policies" of this type. This should be expressly prohibited under the new scheme under

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[27] 160 consultees expressed a view on this question: 26 said "yes", 85 said "no" and 49 held equivocal positions.

[28] Department of Health, *Care and Support Statutory Guidance* (2016), para 10.27.

> the key principle of respecting rights. As the Commission is aware this proposal is central to the “LB Bill” promoted by the Justice for LB campaign.

5.120 Steve Chamberlain (best interests assessor and trainer) felt the law should go further, explaining:

> This is already illegal through case law. A rigid ceiling for personal budgets fetters professional judgement. However, this is often ignored. An amendment to the Care Act could make this more explicit, as it affects all people, whether they have capacity to consent to their accommodation arrangements or not.

5.121 The Carers Trust commented that setting personal budgets based on residential care could have “significant impact on carers if this places too great a reliance on carers to ‘top-up’ care that should otherwise be provided by paid staff”. A family carer (who wished to remain anonymous) stated that “from my own experience, this would be at a huge psychological and emotional cost to my son and would ultimately lead to more expensive care as the situation deteriorated”.

5.122 The British Geriatrics Society was concerned any reference to costs would introduce incentives to deliver care which is insufficient to meet the individual’s needs. It noted that currently many individuals are not receiving any support at home and so whilst a living at home may appear cheaper “this is not necessarily meeting the needs of the vulnerable adult concerned”.

5.123 Some consultees disagreed with the question. Derby City Council’s Safeguarding and Professional Standards Team at stated:

> The pressure at the moment comes … from reduction in Local Authority funding, so unless this is addressed then there will always be a pressure in relation to value for money. Having separate NHS and local authority funding does not help in this respect; joined up funding would help to promote funding decisions which were based on the holistic outcomes for the person.

5.124 Lincolnshire County Council Adult Care Directorate and Lincolnshire Partnership NHS Foundation Trust commented:

> Lincolnshire County Council is aware that a number of Councils are currently considering this course of action and will itself consider how best to respond to this question in light of the financial circumstances it faces following the Comprehensive Spending Review … Determinations should be made on a case by case basis. Whilst the financial implication of such cases is potentially huge there should be a clear auditable trail of ethical and defensible decision making achieving the right outcome for the service user.

5.125 Essex County Council argued:

> The local authority, CCG and NHS have a public law duty to manage public finances most effectively. They can’t meet this duty without considering the cost effectiveness of all appropriate care packages. It would be financially unsustainable for local authorities to be unable to take a view on the most cost effective provision for an individual and to fund in accordance with that view.

5.126 Some consultees did not express a particular view relating to this question, but instead provided general comments. For example, Anchor (housing and care provider) stated:

> The practice of setting the level of personal budgets with reference to the cost of care in a residential setting is currently widespread. This adversely affects the amount of care provided and the quality of this care. Domiciliary care providers are being placed under increased pressure with regard to the increased living wage, working time directives and downward pressure on funding. It is important that these issues are considered in any review of social care funding and commissioning.

5.127 Cambridgeshire County Council explained its approach to personal budgets:

> For people with social care needs, there is an expectation that everyone receives a “personal budget” to commission their care and support – the calculation of the budget should be based on the needs of the individual, but the cost of traditional services would be taken into account when setting the budget calculator, as the personal budget is viewed as an alternative way for care to be provided, not an additional service and therefore, costs should be comparable. Often the final budget is lower than a traditional care home based service, as there is a general view that care can be provided in the community cheaper than in residential or residential nursing care.

5.128 Brighton and Hove City Council highlighted that there is “no open discussion about what is an acceptable minimal level of care, or amount of choice”. It argued that:

> All will be influenced by wider economics and demography. Even setting personal budgets by reference to meeting the person’s needs in residential care will depend on which residential care home. Prices range considerably unless the cost reference is that above which the Local authority will not pay.

5.129 We also received comments from consultees suggesting that this question does not fit within the scope of our project. Lancashire County Council stated “this is a matter of public law and should not come within this remit”. Sheffield Citizens Advice added “we question why a resource question is being directly asked here and not in relation to the other key issues in the consultation?”

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.

5.130 It was felt by the majority of consultees that such a duty should be introduced.[29]

5.131 John Lish (service user) argued that:

> This duty requires that the person's humanity is respected even if they lack the capacity to decide where they live. I would like to see the agreement duty widen to include an appropriate family member/s.

5.132 Rosemary Trustam (social worker) felt that the introduction of a new duty:

> Should give better protection to the person's needs and preferences being understood and acted upon - and avoid making them powerless in the face of authorities who don't usually actually know them or know how to ascertain their wishes. I'd hope this might ensure people and families who know them are also properly consulted and listened to.

5.133 Ernie Holden stated that:

> Authorities must be seen to bend over backwards to take full account of the wishes and feelings of the individual, otherwise, given government's financial cuts, a "cabbage culture" will set in where people are treated as vegetables to be stored at lowest cost ... followed by more Southern Cross stories.

5.134 Centre for Law and Social Justice and Centre for Disability Studies, University of Leeds and CHANGE, Leeds supported a new duty:

> We are in strong support of the need to ensure that accommodation choices reflect the wishes and views of the person. However, this needs to be much more clearly defined with regard to issues around mental capacity and a finding that somebody lacks mental capacity. The obligations around supporting a person to exercise their legal capacity ought to be more prominent in such discussions, and such obligations should survive any finding that somebody 'lacks mental capacity' to ensure that their

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[29] 185 consultees expressed a view on this question: 135 said "yes", 15 said "no" and 35 held equivocal positions.

> wishes are central. We are also concerned that such aspirations may be hindered by a lack of resources and cuts to budgets.

5.135 People First stated that “this is one of the most important points of the Laughing Boy Bill; it is about choice and control”. The Patients Association commented that “a duty on local authorities and the NHS would be necessary and appropriate to ensure sufficient protection for the person, and their families”.

5.136 The Court of Protection Practitioners Association felt that a duty “would be the single most effective way of reducing section 21A appeals”. Steve Broach (barrister) felt the proposal should go further and “apply whenever the state is involved in making living arrangements for a disabled person”.

5.137 Some consultees (including those supporting a new duty) queried the need to secure a declaration from the Court of Protection. For example, Kent County Council argued:

> This will build in considerable delay and expense and is a significant shift from the position that the Court of Protection is only to be involved if there is a dispute. Not only would this result in considerably more work for professionals, it will inevitably delay moves for individuals.

5.138 Many consultees expressed a preference for mediation rather than the Court, should a donee and decision maker disagree. Others felt a tribunal would be best placed to deal with these issues rather than the Court of Protection.

5.139 A number of consultees suggested that the duty should include a role for independent advocacy. Maxwell Gillott Solicitors argued that an advocate could then “choose whether an application to the Court of Protection was necessary or not, depending on the views of the person who lacks capacity”. Some felt that the views of family members should also be considered.

5.140 Some argued that additional legislation was not necessary. DAC Beachcroft LLP stated:

> This is consistent with existing provisions of section 30 of the Care Act and the principles of consultation in best interests under section 4 Mental Capacity Act 2005. We do not consider that further legislation in this area is necessary or helpful and, if considered necessary, would sit best within the Care Act rather than Mental Capacity legislation.

5.141 Some consultees did not support a new duty. The Old Age Faculty of the Royal College of Psychiatrists explained:

> UK law has stated that a Lasting Power of Attorney cannot consent to a deprivation of liberty, with the effect that even those with a Lasting Power of Attorney cannot be placed in a care home by the agreement of the person they appointed … specifically to make that decision for them. Were this question to be agreed, the effect would be that every placement in a care home would have to go to the Court of Protection, which appears ludicrous, and a denial of the right of individuals to appoint someone who can decide for them what they want after they have lost capacity.

5.142 West London Mental Health NHS Trust felt that the existing requirement to instruct an Independent Mental Capacity Advocate in relation to moving into alternative accommodation "provides sufficient safeguards in most cases". North West ADASS stated:

> Our perception is that the two bullet points are already a part of making a Best Interests decision in care planning for a person who lacks capacity in this issue. If that's the case then we do not see why we need a new "duty" to reinforce that? It should just be normal practice with reference to care planning.

5.143 Rosylnn Azzam (DoLS Lead) noted that:

> Unless there is movement on the local authorities' ability to take into account their wider financial responsibilities in considering funding decisions, this duty would only create more conflict in deciding what the "most appropriate" living arrangement is.

5.144 Several consultees held equivocal positions, but pointed to resource issues. South Gloucestershire Council argued:

> This will undoubtedly increase the need to apply to the Court of Protection for a declaration. This requirement is not reflected in current local authority and NHS funding and any increase will create additional financial strain if additional resources are not made available. In addition, the Court of Protection is already struggling to cope with the rise in Mental Capacity Act and DoLS related work, so any additional workload will have a serious impact.

5.145 A number of consultees pointed to the overlap with social care law. Devon County Council stressed:

> The answer to this question must always be restricted to those options that are available to the person. That will be governed by the agreement of the commissioning body to fund a certain option and any consideration of alternatives that are not economically viable must fall within the public law arena.

5.146 Sefton Council suggested:

> The duty should be to secure the most appropriate living arrangement for that person bearing in mind the local authorities duties to achieve best value in the provision of services and the use of its resources.

5.147 Some consultees felt the NHS should be involved in the process as opposed to solely local authorities.

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?

5.148 A majority agreed that local authorities and the NHS should be required to report annually on issues relating to living arrangements and community support.[30]

5.149 Many felt that this requirement would ensure that public bodies are more accountable. Kathy Liddell (family carer) argued:

> No one should have to live in a situation that is not working and often people with learning disabilities are placed in living arrangements that suit the local authority rather then what suits the individual because it is all down to space available rather than pre-planning and thinking ahead. Local authorities and the NHS should not be able to just send people a long way away from their families if those people do not want to go.

5.150 Vicki Jackson (family carer) argued that – in addition to a duty to report – any exceptions should be the subject of "independent review to ensure that the arrangements are in the overall best interest of the individual despite their wishes" and that "any inconsistencies should also be expressly included as part of the care plan".

5.151 Rosemary Trustam (social worker) argued:

> Despite there being local Partnership Boards (in theory making strategic decisions and monitoring) and policies about placing people locally, there's been no accountability on commissioners who have placed people elsewhere, nor therefore any urgency if placed inappropriately nor any imperative to ensure appropriate local facilities or services where there have been clear shortfalls.

5.152 The Court of Protection Practitioners Association added:

> Unfortunately P's wishes are not universally recognised, by care providers and local authorities, as a central factor in determining where s / he should live. Indeed, in our experience overly paternalistic considerations tend to overshadow the protests of the subject. This [duty] … would potentially refocus the public authorities on the wishes of P.

5.153 Some consultees referred to clause 6 of the second draft of the LB ("Laughing Boy") Bill in their response – on which question 6-12 was based. For example, Nick Hodge explained that any new requirement should mirror clause 6 by specifying in more detail what information must be reported on. Dr Eliza Kitis (family carer) similarly pledged her

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[30] 170 consultees expressed a view on this question: 88 said "yes", 39 said "no" and 43 held equivocal positions.

family's support for the inclusion in the new legislation of all the provisions contained in the LB Bill.

5.154 Consultees who disagreed frequently argued that it would not be an effective use of resources. West Berkshire District Council stated:

> We query what would this actually achieve? Each decision is made on a case by case basis and cannot be measured in such blunt terms. It is likely to be unhelpful and create an environment in which unrealistic targets and measures become more important than the individual requirements and solutions for each person. We feel it is far better for this to be monitored in-house through local scrutiny processes.

5.155 Newcastle City Council Legal Services argued:

> It would likely lead to local authorities having to defend decisions in the public arena where they could not refer to a person's particular circumstances, for reasons of confidentiality, and would result in pointless exercises in public relations.

5.156 Peter Bartlett (mental health law academic) commented:

> I have methodological concerns as to how robust the statistics would be. It suggests that choices are either a) consistent or b) inconsistent with P's wishes and feelings. The difficulty is of course that wishes and feelings are a lot more complicated than that. While I very much like the idea that we should be keeping the pressure on local authorities to take wishes and feelings seriously, I am less convinced that this will be a successful way to do it.

5.157 Others questioned whether wishes and feelings could be reported in this way. Devon County Council, for example, argued:

> The majority of people if asked would say they wanted to go home and not have to live in institutional care. However, they may lack insight in to their needs and not be able to make an informed decision on such issues. Furthermore, they may struggle to understand the fact that their needs cannot be safely met in a domestic setting for a sum of money that represents a realistic proposition to the local authority.

5.158 Some consultees held equivocal positions instead focusing on how this could be implemented. Leeds City Council, for example, stated:

> Given the current issues with the DoLS data collection … and the demands it places upon the service, we would express caution as to what local social services authorities will be expected to report on. More importantly, the use of such data needs to be clear and how it will be used to improve services as at the current time there seems to be a lack of action after the reports have been released. Too much of the current data collection seems to be of limited use to local social services authorities and more essentially P themselves - is the latter not what health and social care data collection should be about?

5.159 Brent SAB reported that:

> Nationally Safeguarding Boards have found it difficult to secure accurate data to demonstrate the effectiveness of safeguarding investigations as service users / carers do not often respond directly to questionnaires unless assisted by staff, but having staff / advocates assist in gathering feedback can also impact on the results.

5.160 Many consultees noted the need to ensure this task does not become a burden on local authorities.

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.

5.161 A majority of consultees agreed with this proposal.[31]

5.162 Many consultees argued that this duty was essential to ensure the Liberty Protection Safeguards operate effectively. For example, the Centre for Law and Social Justice and Centre for Disability Studies, University of Leeds and CHANGE, Leeds stated:

> We are supportive of the potential requirement for registered care providers to refer a person for an assessment under this scheme, in order to tackle low referral rates. This is a vital protection in a system which can too easily rely on assertion of rights by the people who have least power and least knowledge of their rights.

5.163 The Bar Council added:

> Provision for referrals seems essential if local authorities are to have responsibility for ensuring that safeguards are in place in respect of placements which they do not fund (including in respect of self-funders and those under NHS care).

5.164 Many consultees noted the need for awareness raising campaigns. Bill McMellon (best interests assessor) noted:

> Referrals will only happen if people understand the scheme. At present, understanding of the Mental Capacity Act is sketchy at best. A massive effort would be needed to raise understanding in care homes and hospitals (and of course supported living) if the relevant criteria are to be properly understood so that appropriate referrals follow.

5.165 The DoLS Leads for Bracknell Forest Council, Royal Borough of Windsor and Maidenhead and Slough Borough Council suggested there be time limits and referral forms, whilst the Law Society's Mental Health and Disability Committee stated "this duty should be accompanied by effective monitoring". Other consultees felt there should be specific sanctions if the registered care provider did not do this.

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[31] 189 consultees expressed a view on this question: 131 agreed, 27 disagreed and 31 held equivocal positions.

5.166 Medway Council reported that:

> We already have in place a requirement for providers to refer individuals for assessment under DoLS however, in our area we still consider that approximately 50% of providers have yet to make application. This is despite attempts to engage with them.

5.167 Tristan Wood (former housing association manager) suggested that the duty should be a requirement of unregulated support providers too and become a standard contractual requirement set by local authorities, with compliance monitored by local authorities through contractual reviews.

5.168 Housing LIN added:

> Making referrals a requirement may strengthen housing providers' hand although local authorities need also to be required to respond. These provisions could be in the Guidance rather than in the legislation itself.

5.169 Some consultees disagreed with the question. For example, Bindmans LLP stated:

> The responsibility for assessing people should lie with the relevant local authority … and we would be concerned that placing a duty on others would open the doors to their saying that nobody referred that person / brought them to their attention. However, whilst we would not wish to impose a duty on registered care providers to make a mandatory referral, an assessment should be triggered following a reasonable request by the person in question, anybody named by him or her, a family member or carer (under supportive care) or an advocate or relevant person's representative or appropriate person (under restrictive care and treatment).

5.170 Your Voice Counts (advocacy provider) argued:

> We know from long experience that the even the simplest directions in the Mental Capacity Act and DoLS continue to be routinely misunderstood or very often consciously ignored by providers. Understanding and adherence amongst providers in our view remains incredibly poor and many appear unaware of / unconcerned by their obligations under the DoLS and Mental Capacity Act generally, very often perceiving this still to be "new" legislation.

5.171 Other consultees raised resource concerns. East Sussex County Council stated:

> We believe that the proposed new scheme and new duties on providers would result in providers automatically referring every new resident or client for a social care assessment for fear of not meeting their responsibilities. This would be unmanageable for local authorities within the current financial climate.

5.172 West Sussex County Council noted this duty "will apply to a far wider group of people with consequent resource implications for care providers, as well as local authorities". Stoke-on-Trent City Council, Staffordshire County Council and North Staffordshire Combined Healthcare Trust stated "the current reporting requirements for DoLS are complex and time consuming and this would only add to the burden without additional resource". Surrey CCG Mental Health and Learning Disability Collaborative was concerned that that care providers will need to receive specific training and advice around the new scheme to enable them to meet their obligations.

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?

5.173 A majority of consultees agreed that the duty to make referrals for protective care should be a regulatory requirement which is enforced by the CQC, Care and Social Services Inspectorate Wales or Healthcare Inspectorate Wales.[32]

5.174 The Care Council for Wales stated:

> Our view is that the wishes of people are fully integrated into care arrangements and it would therefore be odd if the question of potential deprivation of liberty was not subject to regulation.

5.175 Peter Scanlon stated “the CQC is the only regulatory body that could realistically enforce this”. Professor Peter Bartlett (mental health law academic), whilst recognising the potential short-comings of the CQC, felt that “we cannot solve everything at once, and since the CQC would be the logical home for the role, that is where it should reside.

5.176 Some consultees qualified their agreement. The Court of Protection Practitioners Association stated:

> We are concerned to ensure that, where the protective care scheme applies to a domestic home (the family home), the close family members, who are providing care, are not going to be subject to auditing / scrutiny as though they are professional care providers. In the process of caring for a brain injured husband or daughter at home any professional review or assessment is highly intrusive and must be handled with considerable sensitivity. We are concerned that the CQC (or equivalent) ought to be given clear red lines when it comes to regulating the domestic sector and that consideration should be given to altogether less heavy-handed mechanism to audit their arrangements.

5.177 Leeds City Council added:

> Only if CQC expertise is radically improved and that local social services authorities and practitioners are involved in setting the parameters as to how CQC enforce such practice. Where professionals are already involved there should be enough scope for capturing such data performance, i.e. referral numbers, who has made them, etc. Similarly, there should be consideration given to how local social services authorities’ contract teams can enforce some of the areas that you have suggested that CQC are

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[32] 168 consultees expressed a view on this question: 126 said “yes”, nine said “no” and 33 held equivocal positions.

> made responsible for. Such a move would ensure that there is no disconnect between professionals doing the assessments and the services who inspect the care providers on behalf of the local social services authorities.

5.178 Consultees who disagreed with a regulatory requirement sometimes noted the current failings of the regulatory bodies. Warrington Borough Council noted:

> Currently, there is a duty placed on care providers to inform CQC of all DoLS requests but data suggests that this has not been adhered to. Therefore, would the duty proposed be more rigorously enforced? There needs to be a proportionate response.

5.179 West Midlands Regional DoLS Leads Group added:

> One Council in the West Midlands in particular does not believe CQC has been effective and the monitoring role of CQC could be given to Safeguarding Adult Boards.

5.180 St Andrews Healthcare, felt that a regulatory requirement would be overly burdensome and unmanageable considering the "severe financial pressure" placed on the care sector.

5.181 Stephen Ward (MHA and MCA lead) argued that regulation does not improve standards and there was instead a need to "promote a national programme of education of care providers". Others felt that the current law is adequate and does not need to be extended.

5.182 Sitra commented:

> Whilst accepting there needs to be some oversight of the legislation to ensure that referrals are being appropriately made, we are wary that this might end up with whole services being subject to de facto regulation, causing conflict and uncertainty. Some safeguards will need to be built into the legislation in order to guard against potential regulatory mission creep.

VIEWS OF THE REGULATORS

5.183 The CQC, whilst agreeing in principle, was concerned about the practicality of any new regulatory requirement. It stated:

> Supported living and shared lives locations are not required to register with CQC; the provider of these services is. While our monitoring of DoLS currently includes the requirement for providers to notify CQC of the outcome of applications, we continue to find significant under-reporting. If a similar requirement were to be introduced for the protective care scheme, there would be a need to drive improvement in the system in this regard in order for CQC to be able to operate as an effective monitor. We would also need to clarify who would be expected to notify CQC in respect of care provided in supported living and shared lives accommodation.

5.184 It added:

> As CQC does not currently have any power to inspect private dwellings, we are concerned that we would not be able to effectively monitor referrals for restrictive care

> if the care provider was unaware of the regulatory requirement, chose not to adhere to it, or where there was no on-going state involvement in the person's care.

5.185 The other DoLS regulators did not respond to the consultation.

GENERAL COMMENTS

5.186 Some consultees provided general comments on chapter 6 which did not fall directly within our provisional proposals or consultation questions.

5.187 Some provided general views on the proposed system of supportive care. For example, Mind described supportive care as an "inclusive and preventative approach" and stated:

> Extending safeguards to people who are vulnerable but are not deprived of their liberty should help prevent people from being cared for in more restrictive ways and make it more likely that people who are deprived of their liberty will receive the safeguards.

5.188 The British Medical Association argued that:

> In identifying those who may be vulnerable, and subject to significant interference in their article 8 rights before article 5 rights are engaged, [supportive care] offers the potential to expand necessary protections to a wider group of adults vulnerable to rights infringements. It may also offer welcome opportunities to adapt care such that deprivations of liberty can be kept to a minimum.

5.189 The Royal Borough of Greenwich BIAs forum suggested that supportive care would ensure that:

> A greater level of scrutiny should occur prior to placement as once the person is placed in a care home they become institutionalised and lose confidence in their abilities. The forum felt that the scheme appeared to enshrine best practice ensuring those without family or friends would be given access to an advocate.

5.190 However the Tri-Borough Councils noted:

> All these things should already be happening and already be being recorded; if they are not happening then asking local authorities again to do it will have little impact. If they are already happening, recording them twice will not improve outcomes or provide meaningful safeguards but will pointlessly divert resources from other work.

5.191 Some consultees raised resource issues. Steve Benson (mental health workforce development officer) commented:

> Your assumption that most people in care already receive annual care planning reviews (and that protective care can be seamlessly slotted into those reviews) is very wide off the mark. Many people in care homes don't receive local authority residential reviews from one year to the next … If rigorously enforced the supported care requirement for regular reviews of care / nursing home residents will have major resource implications for many local authorities at a time when budgets are being cut. I don't believe it is achievable without a serious injection of new money from government.

5.192 Some commented on the name “supportive care”. Hospice UK and the National Council for Palliative Care stated “the term ‘supportive’ has a distinct clinical meaning and may cause unnecessary confusion”. Rachel Griffiths (consultant) noted that the terms is used in learning disability settings as a euphemism for “restraint” (as in the case of Winterbourne View).

5.193 Many consultees raised general resource issues. Integritas Support Ltd (training provider) stated:

> As a consequence of years of austerity and cuts to public services (which are continuing) there just doesn’t seem to be the knowledge, people, scrutiny, priority and oversight to ensure that the Mental Capacity Act is being correctly and consistently applied.

5.194 Some highlighted practical issues. For example, Rachel Hubbard (best interests assessor) was critical of recording formats used for assessments which are “often not adequate to show effective mental capacity assessment and best interests decision-making so standard formats may be required”.

5.195 London Borough of Lambeth’s DoLS Services added:

> The idea that there is a significant number of people who lack capacity for their accommodation choice, who are freely allowed to come and go from their place of residence without any of the staff taking any action to ascertain the person’s whereabouts, is a misplaced one. Simply put, everyone in a care home, supported living or shared lives setting who lacks capacity for their accommodation choice will fall into the Restrictive Care and Treatment scheme.

5.196 Some highlighted conflicts of interests. Action on Elder Abuse stated:

> We are concerned that, in the current climate, it may not be realistic to expect employees of a public authority, even if not in a direct line-management situation, or even where there is an on-paper demarcation of roles, to feel or be able to recommend actions or to act continually contrary to their overall employer's policy / financial best interests.

Chapter 6: 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.

6.1 The proposal was supported by a majority of consultees.[33]

6.2 For example, Flintshire County Council welcomed the Mental Capacity Act definition (as opposed to the Mental Health Act definition) as this was “broader and more people would benefit from the safeguards under the restrictive care and treatment scheme”. Barts Health NHS Trust noted that:

> This current situation results in a significant gap in the protections for patients who lack capacity to take decisions but who cannot reliably be determined as having a mental disorder … These currently excluded patients are just as likely to require the protection of DoLS or its successor as patients whose lack of capacity arises for other reasons and it is perverse to exclude them.

6.3 Brent SAB argued:

> In practice requiring a Court of Protection application or formal diagnosis of mental disorder before any restrictive care regime could be adopted could prove counterproductive as there are already significant resource issues for the Court and secondary mental health services. Furthermore, it is very clear that those with acquired brain injury, drug and alcohol issues etc would only qualify for restrictive care safeguards provided they lacked capacity on the issue in question and it was in their best interests to receive restrictive care. So, provided this is widely understood, widening the qualifying criteria from the current regime, won’t actually increase the numbers affected.

6.4 Some consultees agreed with the proposal, but also expressed reservations. For example, Tees, Esk and Wear Valley NHS Trust commented that:

> There are few instances where it cannot be argued that a disorder of the brain has given rise to a degree of disorder of the mind and they are generally those identified in the proposals (persistent vegetative state or minimally conscious state caused by a concussion or brain injury, or someone suffering from a stroke or locked in syndrome). In these cases it is also a distinct possibility however, that capacity remains particularly in someone suffering from a stroke or locked in syndrome. It may

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[33] 144 consultees expressed a view on this proposal: 112 agreed, six disagreed and 26 held equivocal positions.

> be preferable in all of these instances that the deprivation of liberty is authorised by a Court, particularly given that this group of people will have inevitably moved to their setting from a hospital setting where it appears there is no regime in place for people who are subject to restrictive care and treatment unless there is a deprivation of liberty and almost an assumption is drawn that accommodation in a hospital for someone who lacks capacity to consent to it will inevitably be a deprivation of liberty?

6.5 The Court of Protection Practitioners Association stated that:

> The definition should be extended as set out in the proposal above to bring it into line with the Mental Capacity Act … We pause only to note that we consider that the technical niceties of potentially excluding a pure brain injured person who lacks capacity from the protection (if the Mental Capacity Act definition at section is used) is a matter of no practical import. Probably due to ignorance, we note that practitioners on the ground, working with these patients, routinely utilise the Mental Capacity Act scheme to manage their care and disputes without this point being taken.

6.6 The ADSS Cymru and WLGA were concerned about including people dependent on drugs and alcohol, stating that:

> The implications of adding this group would need to be thought through and may need to have some specification about the length of time someone is or is likely to be impaired if it is not a permanent state. Consideration as to how this will sit alongside the Mental Capacity Act will need to be given.

6.7 Some consultees disagreed with the proposal. Derbyshire County Council recognised that the proposal would be legally “neater” but felt it would “divert health and social care professionals’ attention from helping people, especially after people have been minimally conscious for more than 28 days”. Bedford Borough Council argued that the proposal would “significantly widen” the scope of the new scheme and “would be unachievable without appropriate resources in place”.

6.8 A number of consultees held equivocal positions. For example, Nottingham City Council’s Adult Social Care Department stated that:

> We can see the logic of taking this approach but it may need further consideration about exclusions or clarifications required in a code of practice. We are concerned about the impact this would have on services as the exclusion of people who are dependent on alcohol or drugs currently prevents restrictions being imposed upon them. The present definition retains a sense that people with drug and alcohol problems have some responsibility for their choices and will be most likely to succeed in gaining some control over their substance misuse if they voluntarily choose to engage (though we recognise the effectiveness of entry into treatment via the criminal justice system). They should not simply be detained to stop them drinking or using drugs and we are concerned that this proposal will result in service providers and families demanding that restrictions amounting to a deprivation of liberty be used simply as a way to stop people misusing substances.

6.9 Similarly, Peterborough City Council stated that:

> Taking this definition we might expect a high volume of people meeting the criteria for the restrictive care and treatment framework. The current issue around lack of appropriately trained and qualified professionals to oversee the function will need to be addressed. In particular the issue of restriction due to physical impairment requires more consideration in relation to individuals at end of life.

6.10 Some consultees doubted the significance in practice of the issue which the proposal was seeking to address. For example, Dr Jonathan Waite (psychiatrist) questioned whether any brain disorders which might cause a lack of decision-making capacity could not be subsumed within the definition of mental disorders in the *Mental Health Act Code of Practice.*

Provisional Proposal 7-2

A person would be eligible for safeguards if: they are moving into, or living in, a 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.

6.11 A majority of consultees agreed with this proposal.[34]

6.12 For example, Derbyshire County Council argued that "it is positive that these safeguards could apply to people in supported living and shared lives" and felt that this would relieve pressure on adult social care departments and the Court of Protection".

6.13 Kent County Council supported the proposal and also noted that:

> Providers are not currently making standard DoLS applications in advance of the person's move. Whilst it is good practice to consider restrictive care and deprivation of liberty in the care planning process, so that any move is a planned move, this often does not happen and there are gaps in practice which need to be addressed in an effective way. The ultimate responsibility falls back on local authorities, which again have resource implications.

6.14 A number of consultees (including those supporting the proposal) raised resource concerns. For example, the London Borough of Barking and Dagenham Council agreed with the proposal but suggested that the resource implications needed to be "fully impact-assessed". Peterborough City Council felt that the current lack of appropriately trained and qualified professionals to oversee the function will need to be addressed. East Sussex County Council commented that:

> The protective care principles are only achievable with a smaller and more manageable cohort of people within the restrictive care category. It is essential that

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[34] 137 consultees expressed a view on this proposal: 84 agreed with it, 16 disagreed and 37 held equivocal positions.

> any new framework that replaces the DoLS is only applicable to people who really require protection.

6.15 Similarly, West Sussex County Council commented that the proposal was drawn too widely and argued that:

> A narrower group of people, more closely corresponding to the pre Supreme Court cohort, should fall within the restrictive care provisions. This proposal would have huge resource implications, which may include customers not currently even caught by the *Cheshire West* acid test.

6.16 Nottingham City Council's Adult Social Care Department raised concerns about the capacity test in the proposal (capacity to consent to care and treatment) as opposed to the current DoLS test (capacity to consent to be accommodated to receive care and treatment), and whether "this could mean that the assessor is expected to assess a number of areas of capacity which may be outside of their field of expertise".

6.17 Some consultees put forward alternatives to our proposal. For example, Devon County Council suggested that the "acid test" set out in *Cheshire West* should be used instead, accompanied by a list of "indicators" that the person is under continuous supervision and control and not free to leave. Steve Broach (barrister) argued that the trigger for the enhanced safeguards should be actual or anticipated restrictive care or treatment and noted that the setting in which this care or treatment is irrelevant (with the potential exception of different treatment for hospital settings).

6.18 Some consultees made general comments in response to this proposal. Housing LIN noted that sometimes "it is a support provider, not a registered care provider who is restricting a person's liberty or even depriving them of it". Furthermore:

> It may sometimes be the landlord who installs potentially restrictive features either with that purpose in mind (e.g. out-of-reach door handles or exit sensors), or for other reasons but used for restrictive purposes (e.g. CCTV). In addition, it seems that it could be either the landlord or support provider monitoring or implementing restrictions instead of, or as well as, a care provider.

6.19 The Royal Hospital for Neuro-disability commented that:

> The distinction between the schemes which apply to care homes and in a hospital setting is capable of causing some confusion in our particular context. We would consider, and would welcome, that your proposals relating to protective care in hospital settings and palliative care should apply to us … We recognise that in our long-term care we operate in a similar way to a nursing home where our patients / residents are under the supervision of clinical and nursing staff. We are not sure whether under your proposals there would be a difficult dividing line needing to be drawn between those of our patients who are in a hospital / palliative care setting and those long-stay residents for whom your restrictive care and treatment scheme relating to care homes may be applicable. In our case this issue could arise in relation to different patients in the same ward.

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); or

(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.

6.20 No overall majority was reached but the largest number of consultees agreed with the proposal.[35]

6.21 Consultees supporting this proposal agreed that the list would provide a certain degree of clarity. The Judges of the Family Division of the High Court commented that a checklist would be useful in helping people to identify when a deprivation of liberty might be in prospect, and suggested that an additional checklist factor might be that relatives or close friends object to the arrangements. The Nursing and Quality Directorate for Dorset Healthcare University NHS Foundation Trust argued that this proposal has potential to solve the problem of what is a deprivation of liberty and would simplify matters for staff and for the person and their representatives or family. Similarly, St Andrews Healthcare thought that the list was helpful as it clarifies issues that previously could not be authorised under a DoLS standard authorisation i.e. contact with third parties.

6.22 SEAP (advocacy provider) argued that the proposal was "person-centred and supportive" because it did not focus on whether a person is deprived of their liberty but

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[35] 222 consultees expressed a view on this question: 91 agreed, 47 disagreed, whilst 84 held equivocal positions.

on a set of safeguards that reduces the need for more intrusive intervention ensures a person is protected at an earlier stage.

6.23 The Bar Council commented:

> It is noted that the Law Commission have been concerned to ensure that no proposal would narrow the definition of the objective element of deprivation of liberty set out in the *Cheshire West* judgment. We agree. The provisional proposal that restrictive care and treatment should include those who are under continuous or complete supervision and control or are not free to leave does not represent any narrowing of the objective test for determining whether a person is deprived of their liberty. The change from "continuous supervision and control" to "continuous or complete supervision and control" is also agreed. "Continuous" and "complete" are more or less synonymous when used in this context.

6.24 Many consultees (including those supporting the proposal) raised resource concerns. For example, the Royal Borough of Greenwich BIAs forum commented:

> The number of people who would meet the criteria for restrictive care would be unmanageable. Therefore the proposed scheme would not address one of the key issues relating to DoLS, which is the "scale of the problem" post-*Cheshire West.*

6.25 Social care professionals from Sheffield City Council argued that the volume of work is likely to increase as the approach will be more inclusive and extends the range of people to whom the safeguards will apply.

6.26 For many consultees, this proposal was an opportunity to discuss the merits or otherwise of the *Cheshire West* decision. North Tyneside Council told us that they thought that the Supreme Court ruling in *Cheshire West* provided clarity but were concerned that the other requirements listed in our proposal could easily slip into a "Winterbourne situation", where staff could become too controlling in the person's life. Richard Rook (former Department of Health policy manager) acknowledged the potential benefits in shifting the trigger point for safeguards to restrictive care and treatment, but suggested that "in the current political and financial climate the Government will reject it as 'gold-plating'". He added:

> *Cheshire West* has (rightly or wrongly) now provided quite a lot of certainty about what it means as a matter of law. As such, the problem is no longer principally one of health and social care professionals being unable to identify deprivation of liberty. Rather, the problem is now more one of acceptance. In many cases, what the law now says is a deprivation of liberty … does not look like one to those involved and so they are reluctant to accept that it must be treated as one.

6.27 Paul Bowen QC (Brick Court Chambers) supported the proposal in the following terms:

> It is sensible not to make restrictive care dependent upon a "deprivation of liberty" because of the sterile debate this is likely to lead to in many cases and the arbitrary distinctions that are often drawn between what is and is not a deprivation of liberty. It is better to err on the side of caution, as Baroness Hale put it in *Cheshire West,* at paragraph 57.

6.28 Some consultees commented on specific elements of the list. The Law Society's Mental Health and Disability Committee felt that the scheme should not apply solely on the basis that the person is not allowed to leave the care setting unaccompanied, since "this restriction is minor compared to those who are physically retrained or medicated to control their behaviour". Professor Peter Bartlett (mental health academic) commented in respect of criterion five (the use of controlling medication), that "it were my loved one, I would want somebody looking at the situation whatever the purpose of the administration of the drug was".

6.29 Some consultees suggested alternative proposals. The Disabilities Trust stated:

> It may be more straightforward to divide this into two concepts: care and treatment which is welcomed and accepted, and care and treatment that is resisted or unwanted although some level of intervention is required. Both would require oversight to check that rights are respected and abuses identified, but it would be recognised that there is a difference between the two situations.

6.30 A multi-agency response from Buckinghamshire argued that the list should begin with the acid test – with clear explanations and examples of what might constitute restrictive care. Similarly Cambridgeshire County Council favoured criteria based on the acid test.

6.31 Dr Jennifer Reid (elderly care) suggested that:

> For the new scheme to be beneficial for vulnerable patients there needs to be a differentiation between people being restrained against their will (people who are objecting against the restraint either verbally or physically) and people who are being restrained but are not objecting (a lot of my dementia patients do not have capacity to stay in hospital but are not objecting or showing distress at being kept in, likewise the comatose patient cannot give capacity and may be subject to restraints (such as bed rails to prevent falling from beds) but is not objecting).

6.32 Some consultees questioned aspects of the list in the proposal. For example:

(1) Irwin Mitchell LLP questioned whether factors three to seven in the list would essentially fall within the first and second concepts;

(2) Yorkshire and Humberside MCA DoLS Regional Forum queried how anyone meeting any of the criteria in the proposal would not also satisfy all elements of the acid test.

(3) Garden Court Chambers' Court of Protection Team questioned how criterion four (the use of barriers) would be distinguished from general restrictions for usual practical reasons such as safety;

(4) The Royal College of Anaesthetists asked whether "people whose baseline functional status / physical condition is preventing them from leaving" would be included in the list;

(5) The British Psychological Society suggested that further clarification is needed on whether the restriction comes if the person is not given the support / assistance to leave the premises;

6.33 Central Bedfordshire Council was concerned that professionals may view or interpret the list as being exhaustive and exclusive. It argued that definitions and categories, whilst being an informative tool for good practice, can unintentionally be limiting.

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?

6.34 No overall majority was reached by consultees, but the largest number of consultees held an equivocal view.[36]

6.35 Many consultees agreed that some of the cases listed should be included in restrictive care and treatment, but not all. For example, Hywel Dda University Health Board raised concerns about the inclusion of people who were being unable to leave premises without assistance, arguing that “this does not mean that they are restricted / deprived of their liberty”. It further commented that “the restriction / deprivation only occurs if the assistance is unreasonably withheld, or the assistance is not available”.

6.36 The British Geriatrics Society commented that:

> We believe it is important to avoid the situation where otherwise well cared for people are regarded as ‘deprived’ because they are being protected from likely harmful consequences of their condition (such as wandering inadvertently into a hazardous situation). We believe that the notion of ‘freedom’ this implies for people with moderate or severe cognitive impairment is intrinsically faulted since their condition of

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[36] 173 consultees answered this question: 57 answered “yes”, 49 answered “no” and 67 held equivocal positions.

> its nature restricts their freedoms. The British Geriatrics Society supports a return to the principle of necessity (to prevent harm) as the determinant in identifying whether safeguards need to be applied.

6.37 Your Voice Counts (advocacy provider) stated the following about the question:

> We have always struggled with the notion that people should require DoLS / restrictive care where their inability / difficulty to leave a premises is caused by illness or disability rather than by "the state". Particularly for people in domestic settings where the local authority may be providing support to alleviate and counter isolation and where without the intervention of the state the person would be much less able to leave their home. In these instances it seems that the state is sometimes alleviating, not causing, deprivation of liberty.

6.38 The Royal College of Anaesthetists commented that in all the cases listed in this question:

> It may be appropriate to consider the use of restrictive care and treatment safeguards. Each case could be considered on an individual basis. For example, a person who has never been able to leave the premises without assistance during their entire life would probably have had similar assessments in childhood. That's not to say that their case may never need to be reviewed. Relatives and carers, if available, could also be part of the process.

6.39 Some consultees answered "yes" to the question. For example, Mills and Reeve LLP stated that:

> It is our view that, looking at a confinement objectively in line with current case law, these categories of people should come within the regime. We believe that, following the most recent decision in *KW v Rochdale*[37], it is clear that these are relevant considerations. This category of patient may well be common in the community. This [list] will assist commissioners in seeking out the less visible patients who might, objectively, be confined and thereby deprived of their liberty.

6.40 Durham County Council (Children and Adult Services) argued that:

> Using this list would clarify what "not free to leave" means and therefore it would be useful to include people who fall into the categories described in the restrictive care scheme. They are not being prevented from leaving their accommodation but cannot do so without assistance and so the scheme would ensure that their article 5 right to liberty is appropriately promoted in their care arrangements.

6.41 A number of consultees answered "no" to the question. For example, Weightmans LLP stated that:

> An automatic passage into the restrictive care and treatment safeguards would appear arbitrary and inadvisable. Surely all the circumstances of a placement should be considered in deciding which part of the protective care regime it should fall under?

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[37] *Rochdale Metropolitan Council v KW* [2014] EWCOP 45.

> Certainly there should be some pointers towards an arrangement being subject to protective or restrictive care, to provide some guidance, but no more than that.

6.42 A number of consultees argued that the "acid test" as stated in *Cheshire West* was the best way to identify people who should be eligible for the restrictive care and treatment safeguards. Bradford BIAs stated that:

> The acid test will apply to most of such people so why complicate matters with additional lists and categories? One of the best things about the acid test is that it has done away with having to agonise over whether P is deprived or merely restricted of liberty based on totting up the various restrictions in place. This [question] seems to take us back to making those kinds of highly subjective distinctions. There is a much simpler distinction already in place - does P meet the acid test or not?

6.43 Essex County Council argued that the factors listed in the question:

> Relate solely to the needs and condition of the person. We do not believe that the needs or condition of the person should form the basis for applying restrictive care and treatment. This approach can be prejudicial and discriminatory. We recommend that a clear distinction is drawn between the needs of the person and the actions of others in response to the needs. An objective analysis of the actions and restrictions, as a matter of fact, should guide the decision about referral to any tier of the scheme.

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?

6.44 No overall majority view was reached in response to this question, but the largest number of consultees felt that there were not any specific forms of care and treatment that should automatically mean that the person is eligible for the restrictive care and treatment safeguards.[38]

6.45 Many consultees argued that all cases should be assessed individually. For example, Hertfordshire County Council stated that:

> We do not feel an exhaustive list is useful and that each situation should be looked at on an individual basis and based on the person's needs – having a list of types of care and treatment that automatically result in a case being placed under the restrictive care and treatment regime detracts of the person centred principle of the Mental Capacity Act.

6.46 Similarly Care England commented that it would "rather see an emphasis on person-centeredness" in the provision of care and treatment, "so that eligibility rests with the person and the effect of specific provisions on them". Essex County Council argued that

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[38] 144 consultees expressed a view on this question: 59 answered "yes", 61 answered "no", whilst 24 held an equivocal position.

if the effects of the treatment are not taken into account "this will lead to a generalised approach which is neither person centred nor specific to circumstances".

6.47 Several consultees agreed that specific forms of care and treatment should trigger eligibility. One of the most frequent suggestions was the provision of covert medication. Dr Val Williams (academic) stated that:

> The administration of medication for the purposes of control of behaviour would seem to be a most important situation, in which safeguards should always be applied. In our research, we had a case where someone was given medication without being aware of it (Williams and others (2012)).[39] This may happen very regularly with people with learning disabilities, and so they will not necessarily object to the treatment (as they are ignorant of it).

6.48 A number of consultees submitted that the safeguards should automatically apply where the person objects to the care and treatment. The Disabilities Trust stated that the safeguards should automatically apply in:

> Instances in which an individual is not only expressing a wish to leave, but is actively seeking to leave in a physical way which is likely to cause harm to themselves or others, and where physical restraints or medication must be used to prevent this. On occasions where an individual has expressed a desire to leave, is aware of possible routes to leave by, but has not initiated any action towards leaving, the automatic safeguards would not be appropriate.

6.49 Other suggestions included:

(1) the use of medication or restriction to reduce a person's libido or propensity to pose a risk to others (Peter Scanlon);

(2) where there are objections from "P" or the family (Bury Council and Bury CCG);

(3) the use of physical and chemical restraint (West Berkshire District Council);

(4) where family contact is denied (DoLS Leads for Bracknell Forest Council, Royal Borough of Windsor and Maidenhead and Slough Borough Council);

(5) certain "operational" or "medical procedures" (Berkshire Joint Legal Team);

(6) constant supervision and one-to-one observation (Ashford and Canterbury Coastal CCGs);

(7) where medication that alters mood or behaviour is administered, or is used to sedate the person (Practitioner Alliance for Safeguarding Adults UK);

(8) where the person is kept isolated from others (Oldham Council);

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[39] *Best Interests Decisions: People and Processes. London: Mental Health Foundation,* Williams, V., Boyle, G., Jepson, M., Swift, P., Williamson, T. and Heslop, P. (2012).

(9) where the person has clothes, mobility aids and personal items removed from them, or has restricted access to personal funds (Warrington Borough Council);

(10) the use of assistive technologies, such as tracking devices (British Geriatrics Society); and

(11) where a care facility uses locked doors (Luton Borough Council).

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.

6.50 A majority of consultees agreed with the proposal.[40]

6.51 For example, Swansea City and County Council agreed with the proposal and argued that "the individual often gets lost in the current complex and process driven assessment for DoLS". The Challenging Behaviour Foundation agreed with the proposal and added that the local authority "must arrange for this to be carried out independently and in partnership with the person's family and friends". Care England felt that the proposal aligns well with the Mental Capacity Act. West Midlands Regional DoLS Leads Group argued that the proposal was "the cornerstone of the current scheme that an assessment for a deprivation of liberty takes place and can only be authorised if it is in the person's best interests".

6.52 Some consultees agreed with the proposal, whilst voicing concerns about how local authorities would become aware that an assessment is needed, especially where self-funders are involved. For example West Berkshire District Council stated:

> Currently managing authorities are required to notify a local authority of any person living within a regime that may amount to a deprivation of liberty. As a result of action taken following a recent Court of Protection hearing, it became apparent many managing authorities were not notifying the local authority of potential deprivations. This has resulted in two substantive scoping exercises to establish the scale of the requirement and ensure applications are made.

6.53 Some consultees disagreed with the proposal. It was frequently argued that the NHS should be given responsibility. For example, the ADSS Services Cymru and WLGA stated:

> If the client's care needs are managed and funded by the NHS, i.e. under Continuing Health Care, then it should be the NHS care coordinator who should be required to ensure the appropriate assessments are made and that any restrictive care is in that person's best interests. A multi-disciplinary team approach may assist discussions

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[40] 141 consultees expressed a view on this proposal: 97 agreed, 17 disagreed and 27 held an equivocal position.

> and decisions about what is in the client's best interests, but it does not make sense for a local authority to take the lead where care management is from the NHS. This is already causing difficulties with the present process of the DoLS scheme.

6.54 Bristol City Council commented that:

> There is a strong case for giving CCGs / Health Trusts some statutory responsibility in the implementation and administration of the new scheme, at least to have sufficient number of Approved Mental Capacity Professionals within their respective organisations. This is a concern from a legal perspective and from a practical point of view. When the DoLS were introduced in 2009, the Primary Care Trusts worked in partnership with the local authorities and they were fully engaged in the implementation of the scheme because they had a statutory responsibility to do so. However, this involvement, input and partnership working dwindled when the supervisory body responsibilities were completely transferred to the local authorities in April 2013.

6.55 A number of consultees raised concerns about local authority conflicts of interest. For example, a safeguarding nurse (who wished to remain anonymous) argued:

> The local authority may be funding the package of care and it is asking them to approve what might be their own economic decisions. Many older people are funded by local authorities in care homes who never get outside the front door (aside from possible medical appointments). It would be difficult to assess such a package to be in the person's best interests divorced from financial constraints. I fear it would be a purely administrative rubber stamping exercise.

6.56 Some consultees commented on the proposal without taking a firm stance. For example, Bill McMellon (best interests assessor) commented on the knowledge which local authorities have about the person's situation:

> This [proposal] assumes that the local authority has any knowledge at all of the person's circumstances. It seems to me that some of the most valuable work under DoLS has happened where there have been private placements and the care home have subsequently had misgivings about the family's attitude to care. The local authority cannot reasonably be expected to ensure anything about assessments of which they have no knowledge, that is to say those made by private funders without the authority being aware that they are taking place.

6.57 City and Hackney SAB argued that:

> The success of restrictive care will also depend on ensuring that care and support service providers working with the person (particularly where the person is already in a care setting) are competent enough to recognise that a person's care needs have changed (increased) to the point that they may require sufficiently restrictive care to justify enhanced formal safeguards. This will enable the provider to notify the local authority of this in a timely manner so that the authority can make or consider a referral to the "restrictive care and treatment" scheme.

6.58 Nottingham City Council's Adult Social Care Department asked a number of questions:

> How will a local authority know if this is occurring in the case of people funded via other means e.g. continuing health care and self-funders. How can a local authority be responsible for something it may not have been made aware of?

6.59 Liquid Personnel (social work recruitment consultancy) commented:

> What works well in DoLS now (in my opinion) is there are well established pathways for submissions of requests and supervisory bodies have developed an administrative infrastructure to support the process. The same will be required for the new proposals.

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?

6.60 The majority of consultees agreed that the assessment should determine best interests, before deciding whether it is necessary to authorise restrictive care and treatment.[41]

6.61 For example, Medway Council stated that the starting point should be best interests because:

> There is a risk with the current assessment that starts from whether the person is deprived of their liberty and then whether this is in their best interests – the danger in such an approach is to "rubber stamp" rather than complete a proper best interests analysis, with due consideration of whether there is a less restrictive option.

6.62 Kiklees Council argued this question "is probably the most significant part of the proposals" and agreed that "best interest decision making should be the start of any DoLS process and not at the end as currently laid out in current DoLS processes".

6.63 Rachel Ward (independent mental capacity advocate) argued that this would improve best interest decision-making:

> I get the feeling that once assessors have decided that the care is necessary it then precludes the outcome of the best interests' assessments. It is stated to be in their best interests because it is necessary. Changing this would put more impact on considering wide best interests considerations.

6.64 The Law Society's Mental Health and Disability Committee stated that:

> In practice many community social workers do not conduct detailed best interests assessments or hold best interests meetings. They tend to be viewed as the sole preserve of DoLS best interests assessors who have Mental Capacity Act 2005 expertise. DoLS best interests assessors frequently find poor recording of best

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[41] 168 consultees replied to this question: 125 said "yes", 17 said "no" and 26 held equivocal positions.

> interests decision-making processes, including the recording of consultations with the service user and family.

6.65 Some consultees argued that a best interests assessment should not be required before deciding whether it is necessary to authorise restrictive care and treatment. Paul Bowen QC (Brick Court Chambers) commented:

> The question whether the proposed care and treatment is in P’s best interests will be affected by whether restrictions are necessary in order to provide that care and treatment. If restrictions are necessary then it is pointless to consider first whether it is in P’s best interests to receive the proposed care and treatment without restrictions.

6.66 Roslynn Azzam (DoLS lead) stated that:

> From the care provider’s point of view – deciding whether the care is in the person’s best interest should always come first – but asking the Approved Mental Capacity Professional to confirm this before considering if the care is restrictive would lead to the Approved Mental Capacity Professional becoming involved in care planning discussions unnecessarily where the person is not in need of these safeguards.

6.67 Some consultees commented on the question without taking a firm stance. For example, Professor Peter Bartlett (mental health law academic) commented that:

> If the Mental Capacity Act is being implemented properly, ongoing best interests assessments ought to be occurring as a matter of routine, whether or not the care is formally “restrictive”. Indeed, ensuring that proper best interests assessments are occurring is, or should be, part of the logic of the supportive care regime. Such ongoing assessment must, surely, be expected to continue when care reaches the stage of being “restrictive”. If that is occurring, then best interests assessments should already be in place. Insofar as the question suggests that this is not the case, it is a matter for overall Mental Capacity Act compliance and the supportive care measures.

6.68 The Centre for Law and Social Justice and Centre for Disability Studies, University of Leeds and CHANGE, Leeds argued that:

> Consideration should be given to the broader care planning sequence. Currently, initial decisions as to a person’s needs and possible care options are public law decisions, and not guided by the person’s best interests. However, the Care Act places an important emphasis on the involvement of the person in their care assessment and planning, regardless of their mental capacity … The assessment as to capacity to consent to the particular care plan should then take place, with support to enable the person to understand the options and to make a decision. The issue of deprivation of liberty should then come in after the capacity assessment, and if the care plan entails an actual or potential deprivation of liberty, issues such as the least restrictive alternative should be reconsidered … It is then that the question of whether any deprivation of liberty is in the persons best interests becomes pertinent - because authority for appointing a substitute decision maker, and authority to act, is premised upon this. This is a fluid, dynamic and ongoing process.

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?

6.69 A majority of consultees agreed that eligibility for restrictive care and treatment should be based on a best interests decision, taking into account the prevention of harm to the person and the risks to others.[42]

6.70 Many argued that this would reflect existing practice. For example, Chris Lucas (best interests assessor) stated that:

> This is how DoLS is currently used in reality, but best interests assessors have to perform linguistic gymnastics to justify it, so it would be sensible to be honest about this and for the new scheme to reflect this reality.

6.71 The Challenging Behaviour Foundation stated that "it is vital to support the person not to harm others as this could lead to more restrictive conditions in the criminal justice or mental health systems". Similarly, the National Family Carer Network commented:

> There is an issue to consider in relation to people who have committed an offence. If the risk of "harm to others" is ruled out as a legitimate factor in decisions about restrictive care, people who could be supported (with restrictions) in community settings might be kept in prison or in hospital (i.e. a more restrictive environment) unnecessarily.

6.72 Many consultees referred to the need to avoid having to use the Mental Health Act in such cases. For example, Brent SAB stated that:

> It isn't appropriate to rely only on powers under the Mental Health Act to intervene to put in place protective measures because often these will not apply to the individual. Also (whilst we continue to challenge the stigmatisation) there is still a stigma attached to mental health.

6.73 Care England argued that:

> The requirement within the Mental Capacity Act to concentrate to the avoidance of other issues on the best interests of the person, and exclude the risks or effects on others, has led to a certain intellectual dishonesty. We appreciate that mental health law and common law can be used to protect other people from actions of someone lacking mental capacity, but we would welcome this extension of the best interests principle as suggested here.

6.74 The Tri-Borough Councils answered "yes" to this question and commented:

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[42] 173 expressed consultees a view on this question: 109 said "yes", 40 said "no" and 24 held equivocal positions.

> There is nothing in the DoLS provisions to say that working out whether being deprived of their liberty is necessary to prevent the person coming to harm should be done in a different way from when the person's liberty is being restricted … In working out whether it's in their best interests to be deprived of their liberty, the best interests assessor can take wider consequential benefits into account, as would be done for any other best interests decision taken under the Mental Capacity Act … The main Mental Capacity Act does bring wider benefits and harm into a best interests decision, but actually does ultimately only focus on what's best for that person. The new scheme needs to continue with this ethos; if there is a need to protect others from harm, this should be achieved via different legislation, possibly the Mental Health Act.

6.75 Some consultees answered "yes" to the question, while also noting concerns. For example, Bedford Borough Council argued that:

> There needs to be evidence both of prevention of harm, as well as risk to others. If the primary need is risk to others, the Mental Health Act should be considered. Without this there is a danger that the revised system would be adopted due to cost (eligibility of section 117 aftercare services) and this would deny persons of appropriate assessment and treatment.

6.76 Paul Bowen QC (Brick Court Chambers) stated that risks to others should be considered:

> Only if the risk they pose to others has a significant impact upon P's welfare. The restrictive care and treatment regime should not become a mechanism of preventive detention. In J Council v GU [2012] EWHC 3531 (COP) (in which I acted for GU) the measures imposed in GU's care home were agreed because they were clearly necessary for GU's welfare and the alternative would have meant admission to a psychiatric hospital under the Mental Health Act.

6.77 Dimensions argued that "harm to others" must not be used to "remove people from the family home where the family have chosen (as adults) to live with a moderate element of risk to themselves".

6.78 Some consultees argued that risks to others should not be taken into account. For example, Hertfordshire County Council argued that this "steers too far into the Mental Health Act criteria" and "detracts from the fundamental person centred principles of the Mental Capacity Act". Devon County Council suggested that Mental Health Act Guardianship could be amended to deal with such cases, and added:

> The Mental Capacity Act is clearly said to be only concerned with the individual's best interests and it is a contrivance to place within that definition the risk of involvement from criminal justice or mental health agencies as a reason to impose restrictions upon an individual purely for the protection of others.

6.79 A number of consultees offered general comments in response to this question. For example, Bill McMellon (best interests assessor) stated that:

> It is not always that easy to separate harm to others, who will respond in harmful ways if they feel that they have been badly treated, from harm to oneself. So this has rarely

> caused me problems within DoLS. Is there any way that the main focus could be on P with room somewhere for risks to others to be registered?

6.80 Bradford BIAs noted that:

> The Mental Capacity Act is silent on harm to others, which suggests that best interests decisions can only be made to protect P, not to protect others from P. Clearly it is, to some extent, in P's best interests to be prevented from harming others (for example to prevent retaliation or having to move placement) but how far can this be taken before it goes beyond the remit of the Mental Capacity Act?

Provisional Proposal 7-9

Cases involving serious medical treatment should be decided by the Court of Protection.

6.81 This proposal was supported by a majority of consultees.[43]

6.82 East Sussex County Council recognised that currently the Court of Protection has jurisdiction to approve "serious medical treatment" under the Mental Capacity Act, and that this proposal would maintain the current legal position.[44]

6.83 A number of consultees emphasised that clarity was required as to which cases should be determined by the Court of Protection. London Borough of Barking and Dagenham Council argued that currently the definition of serious medical treatment is "broad and is left to clinicians to determine". It added that the examples in the *Mental Capacity Act Code of Practice* are restricted to major interventions, such as neurosurgery, electroconvulsive therapy and termination of pregnancy, whereas there are many more minor treatments which could be considered serious medical treatment within the Mental Capacity Act definition. Lancashire County Council suggested that examples of serious medical treatment should be included in a revised *Mental Capacity Act Code of Practice*.

6.84 The Court of Protection Practitioners Association agreed with the proposal and commented that:

> The expertise is only available within the senior judiciary in our experience. Albeit that there is some scope for the case management to be streamlined in these cases and addressed by specially trained circuit judges. These cases often take an unacceptably long time to come to a resolution.

6.85 It also raised concerns over access to justice in serious medical cases, and argued that:

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[43] 153 consultees expressed a view on this proposal: 96 agreed, 27 disagreed and 30 held equivocal positions.

[44] 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.

> Non-means tested legal aid ought to be available to P and a close family member of P in order to challenge a case which may result in the ending of a life. The pro bono actions of solicitors firms are often the only way that serious challenge to a health care decision can be mounted.

6.86 Mr Justice Charles (Vice President of the Court of Protection and President of the Upper Tribunal (Administrative Appeals Chamber)) agreed with the proposal and added that "there may be a need for an urgent / out of hours process to challenge or obtain approval for medical treatment". He added that "the 24 / 7 availability of a High Court Judge does this and some of the cases warrant that level of decision making at a later stage".

6.87 The Royal College of Anaesthetists supported the proposal, but added that:

> Protocols to follow in an elective situation will be different from those in an emergency situation which is time critical. These processes will need to be clearly and concisely outlined. It will also need to be very clear to health care providers what is expected to occur if a person who lacks capacity presents themselves to a hospital requiring emergency or life-saving treatment. In emergency situations healthcare professionals would be expected to act first and seek authorisation at the earliest opportunity (unless there was a valid advance directive / refusal of treatment which had been signed by the autonomous individual prior to them lacking capacity).

6.88 The Welsh Government, whilst agreeing with the proposal, emphasised the importance of determining and supporting any advance decisions in the process. The Mental Capacity Act Project partially agreed with the proposal but argued cases involving serious medical treatment should be decided by the Court of Protection only "where there is any dissent, including cases where P's wishes and feelings are known to be at odds with the treatment".

6.89 Those who disagreed with the proposal thought that it could generate complications in urgent situations. For example, Jill Lewis (social worker) commented that a court application may not be possible in urgent life threatening cases. Professor Peter Bartlett (mental health law academic) argued:

> If there is dispute, and if there is time for a full hearing, with proper representation and evidence, fair enough; but so many of these cases require immediate decisions as a matter of urgency. In these situations "evidence" (if, speaking as a lawyer, that word can really be used) may be phoned or faxed in, the argument is on the fly (sometimes with the Official Solicitor's agent not even having met the person they are in theory representing), and with no time for meaningful deliberation or consideration prior to issuing judgment.

6.90 Some consultees used this as an opportunity to raise wider issues. According to Rachel Griffiths (consultant):

> It will remain the case that some situations are so serious for the individual that the Court should decide. However the boundary between decisions that fall within Mental Capacity Act ss 5 and 6 and those that must go to the Court should be revisited. Some situations, such as people kept alive in minimally conscious states for extended periods of time, are far more common than they were, and persist far longer than formerly. There should be consideration (outside this consultation) of whether such

> situations can be brought safely within the concept of best interests and be decided outside the Court, and if so what safeguards would be appropriate to prevent misuse.

6.91 The National Centre for Post Qualifying Social Work commented that:

> With a robust tribunal system and a system of second opinions and advocacy, we believe these issues could be resolved at a more local level. A set of practice guidance for tribunals will be required and a clear appeals process which has a direct line to the court of protection will be required to ensure escalation is available.

Question 7-10

Should all significant welfare issues where there is a major disagreement be required to be decided by the Court of Protection?

6.92 A majority of consultees believed that all significant welfare issues, where there is a major disagreement, should be decided by the Court of Protection.[45]

6.93 The Mental Capacity Act Project stated that this proposal was in line with "natural justice" and was widely supported by the members of the public it consulted. Bracknell Forest Council argued that significant welfare issues require the expertise and judicial authority of the court to resolve a major disagreement and without this judicial involvement, there is the "risk that matters will fester without resolution". The Judges of the Family Division of the High Court also agreed with the proposal.

6.94 Many consultees referred to the case of *London Borough of Hillingdon v Neary* to illustrate the dangers of local authorities acting beyond their powers without the sanction of the court.[46] The Mental Health Lawyers Association commented that:

> We consider it essential that any new scheme makes it clear from the outset that a genuinely contested question of residence for an adult falling within the "supportive care" scheme should be referred to the court, and that this should happen at the outset before remaining in residential or supported accommodation becomes a fait accompli. If such issues are omitted from the list of the decisions which require an application to court we consider this will have a chilling effect on the article 8 rights of those the scheme is designed to protect.

6.95 Maxwell Gillott Solicitors suggested that there should be an explicit obligation on the local authority and CCG to bring such cases to the court's attention. A disagreement to the Court of Protection's attention, "notwithstanding a duty also on the advocate and / or Approved Mental Capacity Professional to bring the matter to the Court of Protection".

6.96 Others were concerned as to whether (and how) "significance" would be identified and how a disagreement would be characterised as "major." Nottingham City Council's Adult

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[45] 162 consultees expressed a view on this proposal: 97 said "yes", 25 said "no" and 40 held equivocal positions.

[46] *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [33].

Social Care Department called for guidance on what is meant by major disagreement. Barts Health NHS trust suggested that unless "significant welfare issues" was tightly defined, it would become wholly unworkable.

6.97 Dr Jonathan Waite (psychiatrist) commented that there should be a role for mediation and a tribunal procedure in such matters before resorting to a court. Bristol City Council thought that there should be a new section on mediation in the *Mental Capacity Act Code of Practice* and all involved in the process encouraged to use mediation. Similarly, Care England told us:

> We support informal mediation as a starting point, but intractable disagreements should be referred to the Court. Providers of social care are sometimes caught in the cross-fire of disputes, and it can be impossible to be sure of giving the best care to an individual when there are major disagreements about what indeed is in the person's best interests.

6.98 Those who disagreed with the proposal frequently argued that a tribunal would be better placed to consider these cases (at least in the first instance). Flintshire County Council argued that all disputes should initially be considered by a tribunal and if there remains a dispute, the matter should be considered by a higher court. It added that "mediation should also be considered as part of the remedial process, where appropriate", as it has "proved to be good practice and effective in certain circumstances". Similarly, South Gloucestershire Council argued that "a new tribunal system should suffice in the first instance, with a right to appeal to the Court of Protection where this process has failed to resolve the disagreement".

6.99 West Berkshire District Council stated that the Court of Protection was the right judicial body to hear such cases but suggested that the process could be simplified. It added that:

> We would also welcome some guidance regarding transportation of an incapacitated adult to an alternative placement. The present law requires a Court of Protection application, even where there is no disagreement.

6.100 Sefton Council suggested that paragraph 8.3 of the *Mental Capacity Act Code of Practice* should be amended to be less ambiguous about when to make court applications:

> It is clear that the Court certainly believes that significant welfare issues where there is a major disagreement should be decided by them, so the code and the law should reflect this.

6.101 The Carers Trust informed us of the wider issues it faces when dealing with the Court of Protection:

> Carers Trust's evidence to the House of Lords Select Committee on the Mental Capacity Act highlighted some of the significant issues faced by carers when dealing with the Court of Protection. These included both financial and the delays and length of the process. If the Court of Protection is to be used for the more serious decisions and disagreements this could severely impact on the emotional wellbeing of carers who are already coping in difficult situations.

6.102 Vicki Jackson (family carer) thought that the involvement of the Court of Protection should be a matter of last resort and that an advocacy service would be more cost effective.

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 (e.g. 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.

6.103 A majority of consultees agreed with this proposal.[47]

6.104 Many who supported the proposal commented on the Approved Mental Capacity Professional role. For example Lyn Romero (Chief Social Worker for Adults in England) stated:

> The role builds on the recognition gained through the development of the best interests assessor role and recognises the opportunity to put in place advanced accreditations and specialised skills in working with people with capacity issues … It gives responsibility and accountability to Approved Mental Capacity Professionals as decision makers in authorising any required restrictions to ensure the right balance is stuck between care and protection … I believe this proposal will lead to fewer abuses of human rights; reduce the amount spent on legal processes and expensive use of doctors and ensure timely decisions.

6.105 Devon County Council commented that the proposal offers "a clear role, a route for increased professional independence and recognition". Jo Pope (hospice associate director) argued that the new role of Approved Mental Capacity Professionals "has merit and if truly embedded within the parameters set out in the reform would be exceptional for the person at the centre". The Chief Social Worker's Practice Reference Group for Adult and Mental Health Social Work further described the role as "an exciting specialist role that will enhance skills and knowledge within service systems, potentially benefiting implementation in the wider workforce".

6.106 Consultees who argued that the proposal would ensure more flexibility and make the process less resource intensive. Professor Peter Bartlett (mental health law academic) argued that the proposal had adopted a "cooperative model" which deals with the situation "practically and sensibly, as well as not undercutting the role and authority of the carers". Emma Fowler (psychology student) felt the proposals would "help to both reduce demands and increase psychological resources, such as role latitude".

6.107 Brent SAB commented that:

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[47] 310 consultees responded to this proposal: 157 agreed, 75 disagreed and 77 held equivocal positions.

> Requiring the Approved Mental Capacity Professional to either undertake the assessments or quality assure those they delegate to other professionals will ensure the entire workforce remain engaged with proposed regime whilst maintaining high standards of assessment.

6.108 Some consultees supported the proposal because they felt it would lead to the removal of the supervisory body. Torbay and South Devon NHS Foundation Trust stated:

> The Approved Mental Capacity Professional role will provide a greater authority to scrutinise, monitor and place conditions / recommendations to care plans across all professional boundaries. This will remove an entire layer of bureaucracy currently fielded within the supervisory body role, which is seen by some as now resembling a rubber stamping exercise, to some extent.

6.109 On the other hand, North Yorkshire County Council stated, whilst generally agreeing with the proposal, that:

> The removal of the role of the Supervisory Body in supporting and reinforcing best interests assessor’s decisions would mean a degree of professional isolation and responsibility for an Approved Mental Capacity Professional that we would not support, and it could potentially be a catalyst for poor decisions for individuals.

6.110 Many consultees (including those supporting the proposal) raised resource concerns. Derby City Council’s Safeguarding and Professional Standards Team noted:

> We feel that at present the role of the Approved Mental Capacity Professional is very wide and while we support their role being central to the safeguards, it could be envisaged that it will be a full time role. Having a specialist role does have a number of advantages but sometimes there is a risk that practitioners may lose some perspective if they are not involved in front line assessments and care planning. It will also mean the creation of a number of new posts which again would need to be resourced.

6.111 Hartlepool Borough Council, disagreeing with the proposal, argued that at a time of austerity the new Approved Mental Capacity Professional role “makes little sense and adds limited value”.

6.112 ADSS Cymru and WLGA commented on workforce issues:

> Experience has been that Approved Mental Health Professional’s take up from other permitted professional groups (nurses, occupational therapists and psychology) has been minimal across Wales. There needs to be a way of ensuring that other professionals take up this role and so responsibility does not just fall back onto local authorities and their staff. Interestingly there seems to be a better mix of professional groups for the current best interests assessors and so there may be lessons that can be learned from this.

6.113 The College of Occupational Therapists were concerned that the new role would prevent occupational therapists from acting as Approved Mental Capacity Professionals. It stated that:

> Some of the proposed changes will make it difficult for occupational therapists to continue to act as best interest assessors as they currently only do stand-alone assessments and do not carry cases or review them. This would result in a loss of the breadth of experience that best interest assessors currently have … Occupational therapists in particular bring expertise about how a person can still safely take part in the occupations and activities that are meaningful to them despite the need for a deprivation of liberty. They also bring valuable expertise about how environmental adaptations can be used to reduce the need for deprivations of liberty. Equipment and adaptations such as assistive technology can in many instances provide the least restrictive option for individuals and their families.

6.114 Consultees who disagreed with the proposal sometimes argued that the new Approved Mental Capacity Professional role was ill-defined. Tim Gorvett (social care lead) felt that the role "merely aggregates a bundle of vague tasks which it appears they may or may not have to carry out or delegate". Some argued that the new role would be detrimental to the social work profession. Kelly Kaiser (social worker) stated:

> I strongly doubt that [the new] roles will be commensurate in terms of remuneration for such a level of responsibility, and as there are whispers that all social workers will be required to become Approved Mental Capacity Professionals I fear this will lead to a further belittling of our profession as we have often seen with the Approved Mental Health Professional role, where contracts bind people to such a role with no option to opt out on often much lower rates of pay than this job deserves.

6.115 Others doubted whether the proposal delivered a sufficiently independent system. SEAP (independent advocacy provider) stated:

> We also have reservations about the Approved Mental Capacity Professional delegating responsibility for the assessment to a professional already working with the person. If this is the professional who placed the person in a care home it would call into question whether the person would be treated fairly.

6.116 Steven Richards (advocate and trainer) explained:

> What will happen in practice is that Approved Mental Capacity Professionals will ask for evidence and be sent very poor care plans with little evidence of capacity being assessed or best interests considered. Given this the Approved Mental Capacity Professional will then have to go out and assess the person directly to be sure less restrictive options could not be applied and it is in the persons best interests to remain in the care home or hospital.

6.117 Some consultees suggested changes to our proposal. East Sussex County Council suggested that:

> We believe that the Approved Mental Capacity Professional should only be used for pre-*Cheshire West* type cases involving people who are objecting to their care, distressed or where there are safeguarding concerns. It is not feasible nor desirable for Approved Mental Capacity Professional's to quality assure, oversee or facilitate all restrictive care assessments using the broad eligibility criteria for restrictive care proposed.

6.118 Eleanor Murphy (best interests assessor) suggested the Approved Mental Capacity Professional could instead be modelled on a DoLS Team Manager role, with best interests assessors retaining their status and role.

6.119 Joanna Burton (solicitor and trainee advocate) suggested an independent best interests assessor should be appointed, similar to the Investigating Officer in child care planning. They would be appointed if a care plan interfered with an incapacitated person's ECHR rights and would be independent of the local authority and detaining authority.

6.120 The London Borough of Lambeth BIAs argued that if more resources were put into initial social work training, then "the quality of all existing assessments would be higher" and "so there would be a reduced need for the independent check of the Approved Mental Capacity Professional".

TERMINOLOGY

6.121 Several consultees commented on the title "Approved Mental Capacity Professional". Some were concerned that it would soon become referred to by its acronym "AMCP" which is unpronounceable and would be confusing. The Court of Protection Practitioners Association considered that "learning disabled people may struggle even to say my 'AMCP'".

6.122 Mind suggested that "it is important not to create confusion with Approved Mental Health Professionals (AMHPs)" so the name needs to be pronounceable and easily distinguishable from AMHPs. Bill McMellon (best interests assessor) felt that the new title "will be particularly confusing for people on the boundary between the Mental Health Act and the Mental Capacity Act".

6.123 Alternative suggestions included Mental Capacity Officers, Approved Protective Care Professionals, Mental Capacity Accredited Professionals and Approved Best Interests Assessors.

6.124 Consultees who were in favour of the name change felt it reflected the role's additional level of responsibility and would distinguish the role from a person completing a best interest's assessment as part of their daily caseload. Nottinghamshire County Council stated:

> The revised title and different role of Approved Mental Capacity Professionals (AMCP) is welcomed and sits well with the Mental Health Act and the role of the Approved Mental Health Professional (AMHP).

ELIGIBILITY TO BECOME AN APPROVED MENTAL CAPACITY PROFESSIONAL

6.125 Several consultees commented on which professions should be eligible to become Approved Mental Capacity Professionals. Currently best interests assessors must be an Approved Mental Health Professional, a social worker, a nurse (first level), an occupational therapist or a psychologist. The consultation paper did not provisionally propose to amend this list.[48]

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[48] Consultation paper, para 7.69.

6.126 Several consultees argued that the list should be expanded to include speech and language therapists. Integritas Supported Limited (training provider) described them as "gifts" in assessing capacity and understand the Mental Capacity Act, whilst Nottingham City Council stated:

> Our experience of them as facilitators of best interests assessors assessments and enablers of Mental Capacity Act principles makes them ideally placed in our eyes to be excellent Approved Mental Capacity Professionals.

6.127 The Tri-Borough Councils stated that the list should include all allied health professionals including speech and language therapists and dieticians.

6.128 The Court of Protection Practitioner's Association supported the widening of the list to include doctors, but did not support the widening to "second tier nurses (even if they are experienced mental health nurses) or police officers". It also suggested that further consideration might be given to enabling experienced mental health professionals and advocates to take on this role. Judy Weiner (independent mental capacity advocate) felt that Independent Mental Capacity Advocates should be able to become Approved Mental Capacity Professionals.

6.129 The SAB National Chairs Network suggested the inclusion of "those who do not have formal qualifications but have relevant experience" and suggested that the new name would be "Mental Capacity Accredited Professionals".

6.130 Many consultees noted the importance of ensuring health professionals take on the new role. For example, Sharon Thompson (MCA and DoLS project lead) stated "best interests assessors who are health professionals are a very valuable resource". Alternatively, the Chief Social Worker's Practice Reference Group for Adult and Mental Health Social Work stated:

> With the Approved Mental Capacity Professional's accountability to the local authority and the depth of legal and social care knowledge required to make it effective, it would be helpful for the proposals to consider whether this should be a specific social work role.

6.131 Some consultees argued for quality, rather than quantity, when determining who should be Approved Mental Capacity Professionals. The Bar Council stressed:

> The best interests assessor role has become quite generic in recent times as Supervisory Bodies scrambled resources and went on overdrive to train more social workers to become best interests assessors in the wake of the Supreme Court judgment. The best interests assessor role is not meant for everyone, so not all best interests assessors should become Approved Mental Capacity Professionals – it is better if it is a small group of experienced practitioners are trained to do this.

6.132 Nikki Mardell (MCA and DoLS lead) suggested the Approved Mental Capacity Professional be a new profession, "independent of nurses, social workers, occupational therapists or psychologists" to reduce potential conflicts of interest.

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.

6.133 This proposal was supported by a majority of consultees.[49]

6.134 For example, the Royal College of Anaesthetists commented:

> This would seem sensible, as the Approved Mental Capacity Professionals are ones most likely to know the required length of restrictive care and treatment, but only after discussions with healthcare professionals responsible for the provision of restrictive care and treatment.

6.135 PASAUK suggested that the Approved Mental Capacity Professional should also be required to recommend a review date. Several consultees commented on the process of reviews and renewals, and called for a less onerous process in certain cases. Leeds City Council highlighted that:

> Major thought needs to be given to deciding whether P needs to go through the exact same assessments where it is unlikely that they will regain capacity and where they will be deprived year on year. Currently, the renewals are creating huge resource implications for local social services authorities - some of these renewals have not highlighted any significant change in P’s situation, particularly that which warrants all assessments to be started from scratch again.

6.136 The Carers Trust recommended that carers must play “an integral part of this process, especially if the restrictive care is being provided in a family setting as the impact on the family may be significant”.

6.137 There was some discussion as to whether the 12 month maximum duration was appropriate. Some consultees noted that there needs to be flexibility in granting short authorisations in unstable circumstances and that a maximum of 12 months matches the expectations of care reviews. The West Midlands Regional DoLS Leads Group suggested that in cases of deprivation of liberty the maximum duration should be 12 months, but in other cases there should be no time limits. It stated, “there is currently no expectation that a care or support plan has an identified time span, so we do not see why a restrictive care plan should be time limited. Dimensions (learning disability care provider) was concerned that due to the lack of resources, reviews would not take place within the specified time.

6.138 Some consultees called for longer maximum authorisations. Bath and North East Somerset Councils described the 12 month duration as an “arbitrary figure” and suggested a three or five year time limit (with at least yearly reviews) in certain cases

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[49] 137 expressed a view on this proposal: 96 agreed, 17 disagreed and 24 held equivocal positions.

such as “a long term non-contentious placement for someone with a learning disability in a care home”.

6.139 Vicki Jackson (family carer), whose brother suffers from severe autism, recounted her personal experience. She described the DoLS as:

> Overly protective and appears to ignore the fact that [her brother’s] situation will not change during his lifetime given the nature of his disabilities … this type of assessment can potentially cause distress for the person being assessed as they have no understanding as to the purpose of the assessment and it is disruptive to their routine. This is a key feature of autism the need for routine and continuity.

6.140 Somerset County Council suggested that in settled care arrangements, where there is no objection and unlikely to be significant changes in care needs, “the Approved Mental Capacity Professional should be able to approve arrangements for a maximum of two years subject to an annual review confirming no change”. Medway Council suggested a five year authorisation time-limit in such cases.

6.141 Many consultees argued that the current “renewal process” places a strain on resources and can be a rubber stamping exercise. Dementia Care recommended that in certain cases the annual renewal process should be a much shorter process. Roslynn Azzam (DoLS Lead) questioned whether, at this stage, the medical evidence must automatically be updated for deprivations of liberty or only if there has been a change to the person’s condition.

6.142 A number of consultees called for parity with the Mental Health Act approach. For example, Worcestershire Health and Care Trust suggested a consistent specified duration should be granted in all cases at the outset of an authorisation (similar to section 3 of the Mental Health Act). Robert Robinson (solicitor for HL) called for a fixed term of 12 months in every case with discharge being possible within a shorter period, as under the Mental Health Act. South West Yorkshire Partnership NHS Foundation Trust recommended that Approved Mental Capacity Professionals should be able to set time frames of 28 days, three months, six months or 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.

6.143 This proposal was supported by a majority of consultees.[50]

6.144 Relatively few consultees provided substantive comments on this provisional proposal, with most simply agreeing without comment. London Borough of Barking and Dagenham Council, who supported this proposal, felt that the current timescales were

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[50] 107 responses expressed a view on this proposal: 91 agreed, eight disagreed and eight held equivocal positions.

adequate and “it would be helpful to clarify whether the timescales include weekends and bank holidays”. In a response from a group of BIAs from East Sussex it was stated that equivalent assessments are “sensible if they are of sound quality and available”. Nottinghamshire County Council called for “firmer guidance” to clarify equivalent assessments, noting that “current guidance is too general and therefore at risk of interpretation”.

6.145 A number of consultees disagreed with the proposal. Surrey CCG’s Mental Health and Learning Disability Collaborative did not see any need to alter the current balance between primary and secondary legislation. ADSS Cymru and the WLGA disagreed on the basis that “Wales and Welsh Ministers should use the same documentation and timescales indicated in English law”.

Question 7-14

What should the timescales be for the assessments under protective care and what records should be contained in the assessment?

6.146 No overall majority view was reached by consultees on the question of timescales for assessments. The largest number suggested 28 days. Others suggested 21 days and 14 days.[51]

6.147 Several consultees reported widespread non-compliance with the current timescales. For example, both West Berkshire District Council, and Berkshire Joint Legal Team noted that the current timescales of 21 days for standard authorisations and seven days for urgent authorisations “are difficult to comply with, particularly within the context of volume” and suggested that 28 days would be more reasonable. Rachel Ward (independent mental capacity advocate) commented that the current timescales “are not complied with” and are therefore “pointless and should be amended to a realistic compromise”. The Alzheimer’s Society suggested that the current timescales are breached in over half of cases. Peterborough City Council noted that the current timelines “are not being achieved nationally for a large percentage of cases”, and called for a balance to be struck between “best practice” and “achievability”.

6.148 Amanda Colclough (best interests assessor) suggested a nuanced approach:

> I would like to see a scheme which requires a more thorough assessment depending on the level of restriction together with the objection or dispute involved. From a practical point of view the safeguards are often needed in urgent situations and the envisioned planned move is more the exception than the rule. I think there is a need for some kind of short term “holding power” similar to section 5(2) in the Mental Health Act. The time then required for a fuller assessment involving an Approved Mental Capacity Professional will depend on the depth of assessment required.

6.149 Hywel Dda University Health Board suggested different timescales within protective care, consisting of a 28 day limit for restrictive care, a 14 day holding power and a 28

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[51] 141 consultees answered this question: 31 said 28 days, 24 said 21 days, and 10 said 14 days.

assessment period for a deprivation of liberty, and 14 days for the hospital scheme. The Tri-Borough Councils suggested timescales depending on the urgency of the situation:

> If someone is objecting or they need to move urgently (for example, because of severe self-neglect at home) then the timescale should be 7 days; if someone needs to leave hospital, it should be three or four days; if a move is planned in advance and no one is objecting, then a longer timescale would be appropriate, maybe 21 or 28 days.

6.150 Few consultees responded to the question of which records should be contained within the assessments. Swindon Borough Council argued that the same information and records should generally be available as now. The Tri Borough Councils suggested a standard form on which the Approved Mental Capacity Professional can record their conclusions. Maxwell Gillott Solicitors suggested there must be "specific detailed assessment of capacity and best interests, as now, and also thorough consideration of the less restrictive alternatives". The Alzheimer's Society commented that a record of the assessment should be made that "captures the decision and reasons for it", which should include "what other options were considered and why they were not taken".

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.

6.151 A majority of consultees agreed with this proposal.[52]

6.152 For example, Stephen Ward (MHA and MCA lead) stated that:

> Under the current scheme an equivalent assessment may only be used if it meets all the requirements of the standard assessment (including being made by a qualified DoLS assessor), if there is no reason to believe it may no longer be valid and is less than a year old. In my view equivalent assessments should be available for unlimited time, provided there are no reasons to believe they may no longer be valid and the Approved Mental Capacity Professional should make a statement accordingly when using an equivalent assessment.

6.153 The Department of Health and Ministry of Justice focused on the use of mental health assessment:

> The Department is aware that some stakeholders are frustrated by the possible need for separate or new assessments of whether an individual has a mental health disorder for the purposes of DoLS. The relative benefits of such a requirement clearly depend on the nature of the mental health disorder. With this caveat though, the Department is supportive of providing more scope to use existing medical evidence

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[52] 130 consultees expressed a view: 105 agreed, nine disagreed, while 16 held equivocal positions.

> (subject to a judgment of validity) for example, in the cases where a mental disorder is permanent and degenerative.

6.154 Several consultees argued that greater use of equivalent assessments would reduce costs. For example, Lambeth Council's DoLS Service reported that doctors are paid a minimum of £173 for a mental health assessment (plus travel) "often for an assessment which gives no extra information than was already available and on record". Similarly, Flintshire County Council stated that:

> It is not always clear why repeat assessment would be required in so many cases. Each re-assessment and extra layer of oversight uses resources that are then not available to deliver services. It is useful to remind ourselves of how unnecessarily over-used many of us felt the latest deprivation of liberty safeguards had become.

6.155 Cambridgeshire County Council commented that it could not see the value in "repeatedly assessing for evidence of unsound mind for people with learning disabilities or dementia".

6.156 Some consultees agreed with the proposal, subject to additional safeguards. For example, the Court of Protection Practitioners Association suggested that "the essential contents of the assessment" must be prescribed. Lincolnshire County Council Adult Care Directorate and Lincolnshire Partnership NHS Foundation Trust called for equivalent assessments to be "time-limited to ensure such assessments are current and reflect the needs of the service user rather than reflect an entirely different set of circumstances". The Mental Health Lawyers Association argued for "a strict six month time limit" and a requirement to arrange a fresh assessment within that limit, if there has been "a significant change in circumstances.

6.157 Consultees were often supportive of using equivalent mental health assessments, whilst expressing concern about using equivalent mental capacity assessments. Rachel Griffiths (consultant) felt that "no assessments should be current for longer than one year", and "great care must be taken over use of 'old' assessments of mental capacity, remembering that capacity is time and decision specific".

6.158 But not all consultees favoured time limits. Bill McMellon (best interests assessor) stated that:

> Isn't the important thing that the assessment remains valid, not how long ago it was done? If a person with dementia was reasonably believed to lack their own capacity to make the necessary decision two years ago, why should things be any different now, particularly if the care plan and home staff, and their GP, say that they are not?

6.159 Bedford Borough Council agreed with the proposal, but also commented:

> There is a need to ensure frontline staff have the appropriate skill and knowledge base to undertake assessments that would be fit for purpose and can be used as an equivalent assessment. Currently frontline staff are stretched due to competing demands on time and assessments and assessment may not be to the level and depth required to help determine if a person is subject to restrictive care. Additionally, there is inconsistency in the application of the Mental Capacity Act and best interests

> process and resources would be necessary to ensure all staff are operating at a sufficient level.

6.160 Some consultees disagreed with the proposal. For example, Swindon Advocacy Movement argued that “the use of equivalent assessments marginalises the oversight of an independent professional”. Rita Panayides (best interests assessor and trainer) stated:

> Consider if an Approved Mental Health Professional relied on other people’s assessments in determining if detention was the least restrictive form of care? The whole point is that the properly trained and qualified professional is independently liable for their decision while working within a precise legal framework. If we lose that we lose the key safeguard.

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.

6.161 This proposal was supported by a majority of consultees.[53]

6.162 In support of the proposal, the Bar Council commented:

> There is a clear perception that within the current DoLS scheme those responsible for granting standard authorisations are not adequately scrutinising the assessments and recommendations of best interests assessors. Ensuring that the “Approved Mental Capacity Professional” is acting as an independent decision maker crystallises responsibility. It is likely to improve the quality of assessment and the quality of decision-making; such improvements will flow from a clear delineation as to where responsibility lies for making any particular decision.

6.163 Several consultees noted that the proposal would enhance the status of the new role. Grey Slay (mental health professional and quality assurance lead) argued that the proposal “would give the Approved Mental Capacity Professional the same authoritative function as that held by Approved Mental Health Professionals”.

6.164 Some consultees supported the proposal because they felt it would mean the removal of the supervisory body. North West ADASS commented that “the idea that a supervisory body can apply the same level of scrutiny as the court has always been problematic and … unrealistic”. Others argued that the supervisory body role was unnecessary in many cases, duplicating work, and its removal would therefore save time and resources.

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[53] 191 expressed a view on this proposal: 98 agreed, 32 disagreed, 61 held an equivocal position.

6.165 Several consultees noted that, even if the supervisory body role was removed, some form of oversight would still be necessary. For example, Berkshire Joint Legal Team argued that since the local authority is to be made responsible for scrutinising the decision, “it must have some power to challenge and require alterations to be made to those decisions”. Paul Greening (MCA manager) stressed that “this shouldn't, however, extend beyond this into 'second guessing' the Approved Mental Capacity Professional's judgement”.

6.166 Stephen Ward (MHA and MCA lead) noted that local authorities were already experienced in operating in this way:

> We have 30+ years of experience of managing detention under the Mental Health Act in this way. The local authority, as supervisory body, cannot be expected to examine assessments to the level required and therefore places a huge legal responsibility on assessors. Formally placing the legal accountability on the Approved Mental Capacity Professional and asking the local authority to scrutinise the application to ensure lawfulness is a better approach.

6.167 Many consultees commented that there must be clarity in the relationship between the local authority and the Approved Mental Capacity Professional. St Andrews Healthcare suggested that Approved Mental Capacity Professionals should be part of a separate social work team from those making care management decisions. A joint response from North West Training and Development Team and Pathway Associates felt Approved Mental Capacity Professionals should “be independent like the Children and Family Court Advisory and Support Service”. Others noted it would be difficult to achieve true independence but agreed it would be the ideal. Some consultees felt our proposals should go further and grant Approved Mental Capacity Professionals more power.

6.168 Richard Rook (former Department of Health policy manager) suggested that the proposal could go further:

> So that Approved Mental Capacity Professionals are not merely independent, but judicial decision-makers. In other words, rather than being independent professionals working on behalf of local authorities they would be part of the judicial system – be that the tribunal service or the Court of Protection … There is no reason in principal why judicial decision-makers need be lawyers – many Tribunal members are not, nor (at least until recently) were all coroners. Nor do judicial decision-makers need to do that full-time. They can still practise their profession when not being judicial.

6.169 He added that the role of local authorities could be reduced even further:

> I do not see why it should be necessary for local authorities to “accept” and scrutinise applications for protective care when they are not providing the care in question. It is the actual care providers who require authorisation, and who therefore need to assure themselves that the authorisation is (at least) valid on its face.

6.170 Consultees who disagreed with the proposal frequently argued that greater oversight of decision-makers was needed. For example, Age UK stated:

> In our view this “light-touch” approach to supervision of the Approved Mental Capacity Professional role is insufficient, particularly given the wide variation in the quality of

> current best interests assessments. We have received worrying reports that the quality of assessments has fallen as the numbers being requested post-*Cheshire West* have risen.

6.171 Similarly, Your Voice Counts (advocacy provider) commented:

> We know that the quality of work and "independence" of current best interests assessors varies enormously; many being self-employed and paid large sums to complete a large amount of assessments very quickly. We know that many other best interests assessors are employed within local authority DoLS teams with very differing approaches and that many - certainly not all - are reluctant / unwilling to challenge their local authority social work colleagues regarding how people have been placed or what other less restrictive options might be considered. Many sadly appear to have fallen into a pattern of '"rubber stamping" DoLS authorisations with little regard for the views of the relevant person or, where referrals are made, of their Independent Mental Capacity Advocate or relevant person's representative. While there are also some excellent best interests assessors, we would have little faith generally in the ability / willingness of many best interests assessors to act "independently" or to be the arbiter of when independent advocacy support should be provided.

6.172 Other consultees were concerned to ensure that the supervisory body role should not be removed. A multi-agency response from Buckinghamshire noted:

> A significant layer of scrutiny would be lost, if the supervisory bodies no longer existed. They are not just a tick box signing group, as has been intimated. The scrutiny they offer is important, they challenge the best interests assessors regarding the conditions of their assessments, as well as following up cases that cause concern, once assessments have been completed, especially when events are occurring that are not in a person's best interest. Currently, Supervisory Bodies will work on behalf of individuals to ensure that their rights are protected. It is not just where DoLS paperwork is signed off. They have a well-established role; if they no longer existed, then something will need to replace them.

6.173 Derek Boothby (MCA lead) reported that the supervisory body for Wakefield Council is more than a signatory and for example provides advice to best interest assessors over difficult cases, and ensures that training is up to date. He added that many best interest assessors reply on the supervisory body for updates on case law and practice issues.

6.174 Bradford BIAs commented:

> If local authorities no longer have the legal responsibility for signing deprivation of liberty authorisations will they allocate scarce resources to maintain scrutiny of the standard of Approved Mental Capacity Professional assessments? … In an era of diminishing resources, higher workloads, hostility to social workers and open press access to the Court of Protection, this would leave Approved Mental Capacity Professionals in the firing line and feeling vulnerable.

6.175 A number of consultees put forward alternative structures. Stuart Turner (social worker) suggested an independent board should be established which would mediate in disagreements, and review Approved Mental Capacity Professional's decision-making. The Law Society's Mental Health and Disability Committee suggested the establishment of a panel of health and social care professionals to whom the Approved Mental Capacity Professional would be accountable for their decisions.

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).

6.176 A majority of consultees agreed with this proposal.[54]

6.177 The National Centre for Post Qualifying Social Work stated:

> We support this proposal but emphasise the need to work with higher education institutions and employer stakeholders to develop a new fit for purpose scheme. The endorsement scheme previously developed by the College for Social Work and sitting with the Department of Health currently provides a good template for this aspect of the proposals and should be used to inform a new regulatory and approval system for Approved Mental Capacity Professionals.

6.178 The Royal College of Anaesthetists added:

> This would ensure that there is a minimum national standard for these health care professionals; in addition it would help to increase their status as independent health care professionals in their own right.

6.179 The Welsh Government also agreed with this proposal, stating the Care Council for Wales "would be the most appropriate organisation to undertake this function".

6.180 Some consultees called for greater consistency in education and training provision. For example Vincent Duffy (DoLS team leader) called for "consistent and robust" training standards across institutions "which currently is not the case". Jill Lewis (social worker) commented that standards "should mirror each other" in both England and Wales "to facilitate cross border work" and added that "for a variety of reasons, people are placed in either country and far from where they ordinarily resign".

6.181 Many consultees (including those supporting the proposal) were concerned about resources, with some suggesting training for Approved Mental Capacity Professionals would have to be more extensive than that provided for best interests assessors. Several local authorities pointed out that they would be unable to afford any to finance anything beyond that which is currently provided.

6.182 Consultees who disagreed with the proposal were often critical of the current regulators. Anneliese Hillyer-Thake (safeguarding lead) described the Health and Care Professions Council as the "least mature of the registration bodies" and was concerned "as to how

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[54] 152 consultees expressed a view on this proposal: 114 agreed, seven disagreed and 31 held equivocal positions.

they will support, review, standardise, audit and review the work of either the best interests assessor or the new proposed role".

6.183 Belinda Schwehr (consultant and legal trainer) added:

> I wholly disagree with this suggestion, because there is no legitimacy in those bodies to justify their being in control of who can provide training of this nature. The same problem arose for the Care Act. Accreditation that has to be bought by organisations who focus on process rather than content is not worth having and makes no commercial difference to the value of the training. Reputation and qualifications should be enough, in my view.

6.184 Several consultees took the opportunity to provide general comments in response to this proposal. Rachel Griffiths (consultant) suggested an equivalent body to Health Education England should be established to monitor and oversee quality in training. Chris Lucas (best interests assessor) suggested that, since nurses become Approved Mental Capacity Professionals, "standards should have reference to the Nursing and Midwifery Council as well as the Health and Care Professions Council".

6.185 Roger Laidlaw (best interests assessor) commented that:

> For occupational therapists, nurses and psychologists there are England and Wales professional bodies. Members of these professionals can therefore practice in England or Wales. For social workers there are two professional bodies: for England, the Health Care Professions Council; in Wales, the Care Council for Wales. I therefore believe that unless social workers are registered with both bodies, they would be ineligible to practice "over the border". The majority of best interests assessors are social workers so this is an issue about the portability of qualifications that is a serious operational issue for Welsh Supervisory Bodies which have assessment responsibilities in England. This could be tackled easily by the relevant secondary legislation for both England and Wales saying that a best interests assessor being registered either the Care Council or the Health Care Professions Council is acceptable in either jurisdiction

VIEWS OF THE REGULATORS

6.186 Both the Health and Care Professions Council and Care Council for Wales supported this proposal. The Health and Care Professions Council noted:

> We already have a statutory responsibility to set criteria for the approval of Approved Mental Health Professional training and to quality assure ('approve') Approved Mental Health Professional programmes against those criteria. We consider that there is a similar case for Best Interests Assessor programmes in England to be approved by us. If the legislation was changed to give us this statutory responsibility, we anticipate that we would approve the programmes which are already running. We would consult with the sector to develop criteria for approval (similar to the structure of that in place for Approved Mental Health Professionals) and then use our education approval process to confirm the ongoing approval of programmes against those criteria.

“APPROVED MENTAL CAPACITY PROFESSIONAL” TRAINING

6.187 Several consultees commented upon the level of training that would be required to practice as an Approved Mental Capacity Professional.

6.188 The Chief Social Worker’s Practice Reference Group for Adult and Mental Health Social Work suggested:

> If the Approved Mental Capacity Professional role is to develop in the way suggested, the training requirement will need to be developed significantly, which will require considerable resources at both local authority and Higher Educational Institution level. The current training programme for Best Interests Assessors will not yield sufficient expertise for practitioners to manage the new requirements of the Approved Mental Capacity Professional.

6.189 Many commented on the training currently provided to best interests assessors. Stephen Ward (MHA and MCA lead) highlighted that best interests assessors get five or six days training, in contrast Approved Mental Health Professionals who must undergo a five month programme which includes a supervised placement.

6.190 Andy Hill (best interests assessor) stated:

> As an Approved Mental Health Professional I am insulted that best interests assessors would be put on the same footing as Approved Mental Health Professionals… after only four or five days training … It really is devaluing the Approved Mental Health Professional.

6.191 Bedford Borough Council noted that the level of post qualifying experience must be increased to “ensure the most experienced and skilled practitioners” become Approved Mental Professionals in order to “consider the complex issues regarding deprivation and to monitor, quality assure and oversee assessments”. Luton CCG suggested five years post qualifying experience.

6.192 DoLS Leads for Bracknell Forest Council, the Royal Borough of Windsor and Maidenhead and Slough Borough Council suggested that “regular refresher training” should be “expanded from once yearly to three times a year” and “initial training should be similar to Approved Mental Health Professional’s training”.

6.193 St Helens Council queried whether the Approved Mental Capacity Professional has to be a post graduate qualification or whether it could be incorporated into social work education, and commented:

> Application of the acid test for relatively straight forward cases where there is no challenge and where individuals, whilst lacking in capacity, are in a placement of choice could be completed by qualified and non-qualified staff with appropriate in house training as specified by national guidelines and applied consistently across the country.

6.194 Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs suggested that:

> This training of Approved Mental Health Professionals to be experts in their field could lend itself to the training and development of Approved Mental Capacity Professionals and the potential to incorporate both into the role of the Approved Mental Health Professionals or a new type of Mental Health practitioner may offer the expertise and status required for the role. Both are post qualification accreditations and both consider capacity, consent and liberty.

6.195 Many consultees felt the Approved Mental Capacity Professionals should have particular expertise. For example, the Royal Hospital of Neuro-disability stressed that Approved Mental Capacity Professionals must be "suitably trained and have experience of working with people with brain injury, including severe communication difficulties". The Independent Children's Homes Association stated that those undertaking the new role must have "appropriate professional knowledge and experience of looking after children in residential child care settings". The Challenging Behaviour Foundation felt that the training must include "working effectively and in partnership with families" and "an understanding of approaches to care and support based on Positive Behaviour Support".

6.196 Roger Laidlaw (best interests assessor) argued for greater consistency training in England and Wales:

> There is no requirement for additional DoLS training for staff from the professional groups eligible to act as best interest assessors in Wales … The different requirements for best interest assessors that apply in Wales and England with differing standards of training have in my view had deeper effects. Levels of applications under the DoLS scheme were and remain lower in Wales than in England. This is in part because best interest assessor staff trained to a lower standard have been less effective in acting as local practice champions and in identifying potential deprivations of liberty in their mainstream work roles. Another issue is that the lower level of training required may have been an inadvertent signal to managers and commissioners of services that this was simply a lower priority issue.

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.

6.197 This proposal received supported from a majority of consultees.[55]

6.198 Lincolnshire County Council Adult Care Directorate and Lincolnshire Partnership Foundation NHS Trust argued that this proposal would "protect the integrity" of the Approved Mental Capacity Professional role. Camden Council and Camden Safeguarding Adults Partnership Board stated this would "contribute to a more explicit acknowledgement of the additional skills and expertise for professionals holding this

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[55] 129 consultees expressed a view on this proposal: 114 agreed, six disagreed and nine held equivocal positions.

status". Garden Court Chambers' Court of Protection Team described this as "gold-plating" the Approved Mental Capacity Professional's independence.

6.199 Hampshire County Council argued that this proposal would help local authorities determine which professionals are qualified and make it easier to remove those who failed to meet the required standard. The National Centre for Post Qualifying Social Work supported the proposal and suggested that the regulators must apply "checks to ensure that those holding the titles are maintaining their accreditations (via the continuing professional development standards and audit process)".

6.200 Lyn Romero (Chief Social Worker for Adults in England) commented:

> Appropriate use of registered and regulated social workers as Approved Mental Capacity Professionals is an effective and efficient deployment of a skilled professional workforce in delivering a more person centred and bureaucracy-light approach to supporting people to have the right care and support. It gives responsibility and accountability to Approved Mental Capacity Professionals as decision makers in authorising any required restrictions to ensure the right balance is stuck between care and protection.

6.201 Consultees who disagreed with the proposal often felt it was unnecessary. Dr Ian Leonard (psychiatrist) argued that it would be "odd" to accredit this role when other roles, such as Approved Clinicians, are not. The Royal College of Nursing also disagreed because it felt that, due to the position of nurses who would be on the Nursing and Midwifery Council register, "this proposal would need a separate register or agreed as a role on all relevant professional registers".

6.202 Some consultees raised resource concerns. St Helens Council stated:

> Social Workers currently have to finance their own registration with Health and Care Professions Council. Would, by implication, social workers be required to self-finance registration as an Approved Mental Capacity Professional? Would there be additional requirements on practitioners to provide evidence of practice? This has financial and time resource implications for individuals and organisations.

VIEWS OF THE REGULATORS

6.203 The Health and Care Professionals Council disagreed with the proposal. It argued that this currently does not occur for Approved Mental Health Professionals:

> This was principally because completion of the training is not in itself sufficient in order to exercise the functions of an Approved Mental Health Professional in legislation. Instead, approval by a local social services authority (LSSA) is required. In order to approve an individual to act as an Approved Mental Health Professional, the LSSA has to satisfy itself that the requisite training has been completed, but also has to be satisfied of other criteria, including that refresher training has been undertaken. Approval to act as an Approved Mental Health Professional can also be withdrawn by a LSSA. As there is not a direct link between completion of approved training and the legal ability to exercise the role, we decided that we would not annotate the qualification on the Register. We were concerned that to do so might be misleading for members of the public and others.

6.204 The Care Council for Wales supported the proposal. Following the implementation of the Regulation and Inspection of Social Care (Wales) Act 2016, the Council shall be renamed as Social Care Wales as of April 2017. The Act also extended the powers of the regulation body to "show" other qualifications such as Approved Mental Capacity 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?

6.205 A majority of consultees agreed that there should be additional oversight of the Approved Mental Capacity Professional role and a right to request an alternative assessment.[56]

6.206 Bedford Borough Council agreed and commented that:

> There needs to be oversight to ensure consistency in approach. Currently this would be difficult to manage given the high level of independent assessors currently commissioned by local authorities. This may result in inconsistencies as they work across more than one authority.

6.207 Some argued that because the Approved Mental Capacity Professional role was more extensive than the best interests assessor role, the need for an additional safeguard is heightened. Steve Chamberlain (best interests assessor) commented that if the new role "becomes as powerful and wide-ranging as is proposed, then there must be very careful consideration of governance and oversight of the role". As a result, Voiceability (advocacy provider) suggested that:

> At least one other social care or health professional (of an appropriate level of training) should be required to support that assessment. We also feel that there would be merit in that professional being from a separate social care / healthcare team in order to provide a further level of independent scrutiny. Without further oversight in this area we are concerned that too much power is being concentrated into the hands of a single professional who is both assessing and deciding upon levels of care that are likely to breach that person's Article 5 and/or 8 rights without a proportionate level oversight.

6.208 There were a variety of suggestions as to which bodies could provide additional oversight. Bury Council and Bury CCG wanted local authorities to retain oversight as they would remain vicarious liability for the new role. Others suggested an independent body or person, such as the Health and Care Professions Council or the CQC. For example, the Tri-Borough Councils felt that if Approved Mental Capacity Professionals were run by the CQC, they were much more likely to be independent. Barchester

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[56] 163 consultees responded to this question: 106 answered "yes", 34 answered "no" and 23 held equivocal positions.

healthcare also suggested a role for the CQC. East Cheshire NHS Trust commented that in “complex cases” a section 12 doctor should be considered for a second opinion for an Approved Mental Capacity Professional. Other suggestions for increased oversight included greater continuing professional development, an accreditation scheme, a national audit tool and increased supervision and monitoring of assessments.

6.209 Some disagreed with additional oversight, arguing that it was unnecessary and already covered by existing procedures such as access to the Court of Protection / tribunal and advocacy, peer support and supervision, professional regulation and training. Tameside Metropolitan Borough Council argued there was no need for further regulation of professionals, but scrutiny of supervisory bodies was required and should be undertaken by the CQC.

6.210 The CQC commented that discussion will be needed before any decisions are taken with regard to any oversight role that it may have over the new Approved Mental Capacity Professional role.

6.211 A number of consultees also commented on a right to request an alternative assessment. The Law Society’s Mental Health and Disability Committee stated:

> This may assist in resolving disagreements and assist complaint and conflict resolution processes within the local authority. It gives the opportunity to appoint an independent Approved Mental Capacity Professional to assess the situation and may avert the need for a costly application to the Court of Protection.

6.212 The Challenging Behaviour Foundation suggested that any alternative assessment be provided by someone from a neighbouring authority.

6.213 A number of consultees suggested limits on the operation of any new right. Essex County Council felt that the right to request an assessment should be limited in order to prevent the system being overwhelmed with requests and apply on the basis of flaws in the assessment process. Similarly, Jill Lewis (social worker) suggested that it should arise only if the Approved Mental Capacity Professional has not considered some aspect of care or has failed to consult someone.

6.214 Others were concerned that a right to request an alternative assessment would be misused. Paul Greening (MCA manager) commented that he would be concerned “if the local authority could ‘shop around’ for an assessment they like”. St Andrews Healthcare stated:

> The issue is that P’s advocate, relevant person’s representative or family member could keep requesting alternative assessment in the hope that they eventually get the answer they are looking for. If there is no agreement about the assessment undertaken by an Approved Mental Capacity Professional it would be more efficient to have the assessment / decision reviewed by a tribunal.

6.215 Some consultees argued that a right to request an alternative assessment was unnecessary. Wakefield Council argued that such right already exists “with the right to request a second opinion which most health and social care public bodies have within their policy and procedures" and is also "enshrined within the *Mental Capacity Act Code of Practice* as the right to seek a second opinion".

6.216 Several consultees raised resource issues. Sefton Council referred to the "possibility that all assessments will have alternative assessments requested" and if so, "the volume will simply be unmanageable". St Andrews Healthcare felt it would be more efficient to have the assessment reviewed by a tribunal.

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.

6.217 A majority of consultees agreed with this proposal.[57]

6.218 A group of BIAs from East Sussex argued that conditions and recommendations are "a well-used and very useful part of the authorisation of less restrictive care and working towards that on behalf of the person deprived of their liberty". Sheffield Citizens Advice commented that "conditions can be good for ensuring article 8 rights are protected". In support of the proposal, Berkshire Joint Legal Team stated that:

> This allows the Approved Mental Capacity Professional to take a more holistic approach to a client's care and treatment within the context of restrictions. Improving a person's life can often require wider more flexible changes to be applied.

6.219 South Gloucestershire Council agreed with the proposal, but added that there should be clear guidance "to ensure that conditions set do not conflict with the overall direction of the proposed care plan and the intentions of the care team(s) involved". The Royal College of Anaesthetists supported the proposal and commented that:

> With regard to decisions around the person's treatment, we are not sure how appropriate recommendations from the Approved Mental Capacity Professional would be, as making these recommendations falls outside of their remit and training … to suggest that they would have the knowledge to offer advice on specialist areas would be beyond the intended scope of their role.

6.220 Vocal Advocacy agreed with the proposal and reported that:

> As independent mental capacity advocates we sometimes find that conditions attached to authorisations are beyond the power of the managing authority to fulfil without assistance, for example, from the deprived person's care manager.

6.221 Some consultees disagreed with the proposal. For example, Caroline Pomeroy (best interests assessor) argued that the role of supervisory bodies in setting conditions is a valuable safeguard that should be retained. . Steve Chamberlain was not convinced

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[57] 153 consultees expressed a view on this proposal: 109 agreed, 17 disagreed, 27 held equivocal positions.

that the current best interests assessor workforce "possesses the range of skills and competencies" to undertake this aspect of the role. Buckinghamshire local authority, CCGs, independent mental capacity advocate providers and Healthcare staff and the Service User and Carer Organisation stated that recommendations in respect of the person's care and treatment:

> Should be done by other professionals in the person's life, unless these are linked to a restrictive care plan. Otherwise we are in danger of making Approved Mental Capacity Professionals all things to all people. They should be independent and impartial, with a view to what others are doing; there should be other professionals involved already. There is a danger of too many people becoming involved.

6.222 A number of consultees provided general comments. Richard Rook (former Department of Health policy manager) commented that:

> To impose a condition which is not necessary to secure what is best for the person among the available options is to get into the realm of attempting to enforce demands on behalf of a person which the person themselves would not be able to enforce if they had capacity. An attractive idea, but beyond what the Mental Capacity Act is for.

6.223 Belinda Schwehr (consultant and legal trainer) argued that:

> It is not correct to suggest that councils can simply disagree with recommended conditions from a best interests assessor. If the condition is not imposed the best interests assessor is able to say that they would not conclude that deprivation of liberty is necessary, and if it was not necessary, it would not be able to be authorised.

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 noncompliance with conditions.

6.224 No overall majority view was reached, but the largest number of consultees disagreed with the proposal.[58]

6.225 Many of those who disagreed with the proposal cited resource issues. For example, the LGA and ADASS stated that:

> We consider that the volume of people likely to fall into the restrictive care and treatment category will be such that this proposal is simply not practical (or resourced). It is also difficult to see the need to extend such measures beyond those who are

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[58] 176 consultees expressed a view on this proposal: 58 agreed, 72 disagreed and 46 held equivocal positions.

> deprived of liberty. This proposal also has the potential to lead to tension in the system and affect other aspects of social work or other health and social care functions.

6.226 A number of consultees argued that the proposal would change the nature of the role from a part-time to a full-time one:

> Like many local authorities, Kent County Council still operates a rota system of best interest assessors as we believe in the importance of building and developing this expertise within our existing workforce. It would be impossible for these rota best interest assessors to fulfil the Approved Mental Capacity Professional role of monitoring compliance with conditions, on top of their assessment duty. This may mean we have to recruit more full-time best interest assessors / Approved Mental Capacity Professionals, which will again have significant resource implications for local authorities.

6.227 Similarly, West Sussex County Council argued that the proposal would not be achievable "for Approved Mental Capacity Professionals who would be on a rota and doing other jobs for most of their working time". It also argued that "delegation would surely defeat the object of the independent Approved Mental Capacity Professional's responsibility".

6.228 A number of consultees were concerned about the position of freelance best interest assessors. The Yorkshire and Humberside MCA DoLS Regional Forum explained that:

> This would be unworkable in the case of freelance Approved Mental Capacity Professionals. There are currently many freelance best interests assessors who complete specific assessments for local authorities. It would be difficult to organise a payment system for them where it is not clear when their involvement in the case would end. In the case of in-house Approved Mental Capacity Professionals (most of whom will also carry other caseloads alongside their Approved Mental Capacity Professional work) it is highly unlikely that they would have the time to maintain ongoing contact to monitor compliance with conditions. Monitoring of conditions should be done by other local authority staff (e.g. reviewing officers).

6.229 The College of Occupational Therapists were concerned that any move towards making the role full-time would restrict the ability of occupational therapist to be Approved Mental Capacity Professionals.

6.230 Some consultees were concerned that monitoring conditions would compromise the independence of the Approved Mental Capacity Professional. For example, Oxfordshire County Council argued that such an ongoing role for the Approved Mental Capacity Professional would mean their "objectivity would be lost". It suggested that responsibility should be placed with care management teams as part of the review cycle.

6.231 Some consultees disagreed with the power to delegate in this context. Hywel Dda University Health Board stated that:

> Delegation of the responsibility for monitoring compliance with conditions to the people who are responsible for complying with the conditions is inappropriate. Whilst many professionals would "do the right thing", such monitoring could not be

> considered as independent or reliable and would risk making monitoring a “rubber stamp” exercise.

6.232 A number of consultees suggested the responsibility for monitoring compliance with conditions should be placed on others, such as the appropriate person, independent advocate, care provider, local authority, commissioning body or the CQC. West Midlands Regional DoLS Leads Group argued that “conditions should automatically become part of the care and support plan and be monitored by the health and care professionals allocated to the case”.

6.233 Some consultees supported the proposal. For example, Maxwell Gillott Solicitors welcomed the proposal and commented that:

> Currently there is insufficient effective monitoring of compliance with conditions. This leaves individuals in unsatisfactory circumstances where non-compliance is raised but not acted upon promptly.

6.234 The Court of Protection Practitioners Association considered that the potential costs of the proposal would be outweighed by the benefits. It stated that:

> Compliance monitoring must not be left to the local authority, internally, without oversight or scrutiny from the Approved Mental Capacity Professional. We prefer a model on which the Approved Mental Capacity Professional is responsible for monitoring compliance with conditions. Whilst we recognise this would add to the work load; it may also make finding the most suitable professionals more difficult. However, we consider the obvious benefits to P to outweigh this. If funds need to be diverted to anywhere in this new system a priority ought to be given to the structure of the Approved Mental Capacity Professional role and management, their remuneration and remuneration for advocacy services for P. These are the three essential tenets of the scheme.

6.235 Cambridgeshire County Council agreed with the proposal, while suggesting possible ways of easing the burden on the Approved Mental Capacity Professional:

> The monitoring of compliance of conditions has been lacking in the current schedule A1 and we would welcome this proposal provided sanctions are at the disposal of the Approved Mental Capacity Professional for continuous non-compliance. Maybe this monitoring role for compliance could be shared between the Approved Mental Capacity Professional and the Independent Mental Capacity Advocate depending on the circumstances. Perhaps an Independent Mental Capacity Advocate could be used in the monitoring of conditions relating to care management as they will provide more independence than that of the Approved Mental Capacity Professional who is employed by the local authority.

6.236 The Bar Council agreed with the proposal, but was concerned about the use of delegation:

> Delegation of responsibility for monitoring and compliance with conditions however does present the real risk that such monitoring either does not take place or is superficial. It is suggested that if delegation does take place to other health and social care professionals the “Approved Mental Capacity Professional” must at some stage

> during the duration of any restrictive care and treatment undertake an audit to ensure that compliance in relation to conditions is taking place.

6.237 Devon County Council argued that delegation would be permissible only if the Approved Mental Capacity Professional is liable only for "information that is known to them or ought to have been known to them". It argued that this is necessary to protect the Approved Mental Capacity Professional from the failures of others.

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?

6.238 A majority of consultees agreed that the new scheme should allow for conditions or recommendations to be made that are more restrictive of liberty than the application is asking for.[59]

6.239 Warrington Council argued that this approach might allow for restrictions which "enhance the person's life and are in their best interests", and was necessary because in its experience managing authorities are poor at explaining why they need an authorisation and the full extent of restrictions.

6.240 Brent Safeguarding Adults Board argued that:

> Any proposed regime must be heavily reliant on the professional judgment of the Approved Mental Capacity Professional and as such must give that person flexibility to determine what is in the best interests of the individual even if that is more restrictive than previously requested. The other safeguards built in (advocacy, right to appeal etc) should ensure powers are not used arbitrarily.

6.241 The Old Age Faculty of the Royal College of Psychiatrists agreed with the question and suggested that the scheme should refer to "good quality health care and procedures" rather than to "restrictions".

6.242 A number of consultees emphasised the need for safeguards. Maxwell Gillott Solicitors stated:

> Yes, albeit they will need to give reasons for those more restrictive recommendations or conditions and, as with everything, if there is disagreement, it should be referred to the Court of Protection. There could be a process to refer back, even if rather informally, for discussions about possible more restrictive recommendations or conditions, before they are imposed, so that the person subject to them, has a chance to be involved in discussions and they, and their advocate, can voice concerns at an early stage.

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[59] 140 consultees responded to this question: 74 answered "yes", 43 answered "no" and 23 held equivocal positions.

6.243 Leeds City Council agreed, and commented:

> We would be concerned if assessors were to increase restrictions without having to provide a very solid rationale as to why. Risk aversion could play a part in such a scenario, thus going against the spirit of the Mental Capacity Act, regarding less restrictive options. However, we agree that there are scenarios where P's behaviour and the risks it poses are not truly discovered until after the assessment process is nearly complete.

6.244 Medway Council was concerned that the qualifications of the persons making such recommendations should be appropriate, and in particular noted that it would be "questionable" to allow for a non-medically qualified person to make recommendations relating to psychiatric medication.

6.245 Some consultees raised resource concerns. For example, Kent County Council pointed out that:

> Recommendations which are more restrictive of liberty will often have funding implications, which may be difficult to be implemented due to resource constraints for both social and health care. Independent decisions, free from operational constraints, will be hard to achieve.

6.246 A number of consultees argued that conditions and recommendations should not be more restrictive than the application is asking for. Dimensions (learning disability care provider) argued that allowing more restrictive conditions "compromises the idea of authorisation being a safeguard and could lead to more restrictions being in place than is necessary". The Official Solicitor stated that "the purpose of conditions should be to make the deprivation of liberty the least restrictive as is compatible with P's best interests not more restrictive".

6.247 DAC Beachcroft LLP commented:

> This would be contrary to the ethos of the Mental Capacity Act and the least restrictive principle. If the care plan has identified a less restrictive regime then this should be applied. If the purpose of the question is to identify circumstances where the restrictive care assessment identifies risks which the Approved Mental Capacity Professional does not consider the care plan (including any risk assessment) has addressed then the Approved Mental Capacity Professional should refer the plan back to the care team to review.

6.248 Durham County Council (Children and Adult Services) suggested than an alternative to more restrictive conditions would be that the Approved Mental Capacity Professional should be able to require, as a condition, a reassessment of the person's care needs "to include consideration of the care arrangements that are appropriate and sufficiently restrictive to protect the person from harm". Tim Wilson (workforce development manager) proposed that the Approved Mental Capacity Professional should list their concerns and ask for a review of care with a focus on addressing the concerns.

6.249 North West ADASS argued that:

> This essentially causes the Approved Mental Capacity Professional to become a care planner above and beyond both their role and that role of the provider / commissioner. This should be resisted as there is a worry that the Approved Mental Capacity Professional will be seen as the care planning safety net for providers, rather than the independent professional ensuring that care planning decisions already made by the provider are lawful. It is perhaps a subtle distinction but nonetheless a very important one.

Question 7-23

Should there be specific sanctions for a failure to comply with a condition, and if so, what should they be?

6.250 A majority of consultees agreed that there should be specific sanctions for a failure to comply with a condition.[60]

6.251 A number of consultees argued that non-compliance should be reported to the CQC. Kent County Council argued that the CQC could then "keep records and note any patterns or recurring issues with particular establishments". Mencap argued that sanctions should be built into regulation by the CQC, albeit that the conditions must be "achievable" and that adequate funding has been provided for the condition to be complied with.

6.252 The Alzheimer's Society argued that care providers could be put into "special measures" if they failed to comply with conditions. It explained:

> This would mean that a care provider would then have to do a number of things to show how they will change, such as training in the safeguards, Mental Capacity Act training or similar. There could also be further inspections and "surprise" visits during this time to monitor progress and changes. A further sanction could be similar to the CQC current inspection regime where they must now advertise their inspection outcomes, and failure to comply could be something that a care provider must publicise until they are deemed as complying again.

6.253 On the other hand, Jonathan Nash (legal academic) argued that such reporting to the CQC was "inadequate and untimely". He argued that sanctions should include a written warning that the DoLS authorisation will be removed if the provider does not comply with the condition, which would allow the individual to seek damages for the unlawful deprivation of liberty.

6.254 Some consultees suggested financial penalties. For example, Lucy Sasse (best interests assessor) stated that:

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[60] 156 responded to this question: 84 answered "yes", 27 answered "no" and 45 held equivocal positions.

> Conditions, to be really effective and change lives, need to have teeth; long experience with the private sector says they don't listen to words but financial penalties would be taken seriously.

6.255 The Law Society's Mental Health and Disability Committee argued that:

> One possible sanction could be the suspension or termination of contracts for care provision. Approved Mental Capacity Professionals could record conditions and details of any non-compliance on a register. Significant breaches or consistently poor performance by managing authorities could lead to termination or further conditions on the contract to provide care. Clearly, the terms and conditions of contracts would need to be reviewed in order to achieve this.

6.256 The Mental Health Lawyers Association argued that there already exists a sanction for breach of a condition, namely an action of damages for unlawful deprivation of liberty. It argued, further, that this is an inadequate mechanism as there are "insuperable barriers" to bringing a claim. It suggested that Approved Mental Capacity Professionals could have a role in enforcing conditions, although noted that "this will have significant resource implications".

6.257 Some consultees expressed concern that conditions may be onerous and unrealistic, and it would be unfair to impose sanctions in these situations. For example, Barts Health NHS Trust stated that it had experienced unrealistic conditions being imposed which could not be met in a hospital setting. Similarly, South Gloucestershire IMCA Service reported that very often managing authorities do not feel equipped to meet particular conditions, "for example, getting a medical review is not something that the managing authority could guarantee to achieve".

6.258 Some consultees raised concerns that care providers would be held liable for non-compliance with conditions for which they were not provided adequate funding by the local authority. For example, Dimensions (learning disability care provider) stated:

> If the conditions are dependent on funding, the local authority must be held to account also. If conditions are imposed adequate resources and timescales must be provided.

6.259 A number of consultees argued that no specific sanctions are needed. The Court of Protection Practitioners Association argued that existing remedies by way of judicial review and under section 8 of the Human Rights Act are adequate. It was concerned that specific sanctions would lead to "expensive additional litigation" which would outweigh the benefits.

6.260 Brent SAB argued that any new sanctions were unnecessary because the person or their representative already have a right to complain and seek legal remedy through the courts, and regulators can already impose sanctions on providers who fail to adhere to care standards or contractual obligations.

6.261 Professor Peter Bartlett (mental health law academic) differentiated between "positive" and "negative" conditions. He argued that negative conditions, such as "don't let P out alone", can already be enforced using tort law. On the other hand, positive conditions, such as rights to specific forms of recreation, have no obvious enforcement mechanism.

Professor Peter Bartlett stated that “the risk is that these get shunted under the carpet”. As a remedy he suggested that an ombudsman system would help with enforcement.

6.262 A number of consultees argued that if there are sanctions for non-compliance with conditions, there must be an appeal or review mechanism for providers.

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.

6.263 No overall majority view was reached, but the largest number of consultees disagreed with the proposal.[61]

6.264 Consultees who disagreed with the proposal frequently raised resource concerns. Steve Chamberlain (best interests assessor) noted:

> Taking into consideration the expectation that the Approved Mental Capacity Professional will be a highly skilled and experienced professional (mainly social workers), this will risk placing a considerable skills drain on local authority adult social care teams, which have duties to undertake Care Act assessment, care planning, reviewing and safeguarding functions.

6.265 Nottingham City Council’s Adult Social Care Department added:

> Currently we will have at least 500 people subject to this scheme so it would completely clog up the availability of Approved Mental Capacity Professionals to take on any new work at all. We believe this proposal is based on outdated notions of all service users having an allocated social worker when the reality is very different and based on a model of “assess, intervene and close”.

6.266 Some consultees felt that the proposal would make the role of the Approved Mental Capacity Professional too elaborate and unattractive for many. Liquid Personnel (social work recruitment consultancy) stated that “independent Approved Mental Capacity Professionals would not be able to undertake this role and would thus vanish”. Best interests assessors from Bradford argued that the proposal would turn the best interests assessor “from a role to a full time job” which would make it unattractive and difficult to recruit and retain staff.

6.267 A number of consultees disagreed that the allocated Approved Mental Capacity Professional should be different to the professional who authorised the restrictive care and treatment. Dr Jonathan Waite (psychiatrist) argued that:

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[61] 158 expressed a view on this proposal: 56 agreed, 71 disagreed, and 31 held an equivocal position.

> It's not fair on families who have committed themselves to establishing a relationship with one professional to have that connection severed and to have to start all over again with a stranger to satisfy some vague legal notion of "perceived independence".

6.268 The Royal College of Anaesthetists argued that the Approved Mental Capacity Professional who authorised the restrictive care and treatment should also be responsible for ongoing monitoring. Gateshead Council felt that ongoing monitoring should be undertaken by health and social care professionals "within care planning and care management" in order not to duplicate roles. The Old Age Faculty of the Royal College of Psychiatrists argued "a loving and caring wife, husband or child" could undertake this role in some cases.

6.269 Consultees who agreed with this proposal often argued that it would help to remove potential conflicts of interest, ensuring the person is safeguarded. Worcestershire Health and Care NHS Trust commented that the proposal would ensure "a semi-independent oversight and the power to review / discharge would be useful" Garden Court Chambers' Court of Protection Team argued that "close monitoring of the care of a person lacking mental capacity is to be welcomed". The British Association of Social Workers commented:

> It would make sense to the British Association of Social Workers that there is a role for Approved Mental Capacity Professionals to oversee practice in an area – a monitoring / inspectorate role. This of course would have to be resourced. If monitoring included on-going case monitoring, as opposed to overseeing and monitoring the quality of processes the resourcing would need to be even greater.

6.270 The London MCA / DoLS ADASS Network agreed with the proposal but commented:

> Some members felt that this was not necessary where the person is not demonstrating verbally or in other non-verbal ways, that they were other than content with the care / treatment regime and where there family and friends seem content with the care / treatment regime.

6.271 Many consultees who supported the proposal also raised resource concerns or stated that it would need to be adequately funded.

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.

6.272 No overall majority view was reached, but the largest number of consultees disagreed with the proposal.[62] Consultees commented on both aspects on the proposal: the requirement for the Approved Mental Capacity Professional to keep person's care and

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[62] 176 consultees expressed a view on this proposal: 57 agreed, 76 disagreed and 43 held equivocal positions.

treatment under review generally and the Approved Mental Capacity Professional's discretion to discharge.

KEEPING THE PERSON'S CARE AND TREATMENT UNDER REVIEW

6.273 Of those who disagreed, many noted the resource implications of keeping the person's care and treatment under review. ADSS Cymru and the WLGA stated:

> This has major resource implications. These proposals give the Approved Mental Capacity Professional / best interests assessor a role over and above that currently held by the best interests assessor. The resource implications are considerable, but also imply that normal care and review arrangements will be insufficient. This is the opposite of the supportive care arrangements proposed. There needs to be a well-funded Approved Mental Capacity Professional programme, with appropriate support, training, and a duty placed on supervisory body's as there is for Approved Mental Health Professional staff.

6.274 Some consultees noted that the proposal reflected an out-of-date view of social care. Kirklees Council commented:

> There is an implicit assumption throughout the consultation paper that citizens remain on established caseloads. The norm we experience is that at key times reviews are undertaken with reference to best interest then a case is closed with good contingency planning until the next review. We have concerns that the throughput of modern social care could likely not meet some of the specific aspirations identified in the proposals.

6.275 Similarly, Integritas Supported Limited (training provider) further added that "regrettably, the role you have ascribed for the Approved Mental Capacity Professional no longer exists within local authorities" and "they do not have sufficient resources to recreate that role in a different guise".

6.276 A number of consultees argued that the proposal conflates the role of an independent assessor with a "care manager". Chris Lucas (best interests assessor) noted it would result in a "doubling up of oversight" and "will lead to confusion regarding roles in actually managing a case". Bury Council and Bury CCG felt that the "review of the cases should be done by social work teams who would carry the responsibility of raising any issues / significant changes should they arise".

6.277 A number of freelance best interests assessors were also concerned that their role would no longer be viable. For example, Caroline Pomeroy stated:

> This is not viable in my situation nor is it possible because I carry out assessments for many different authorities all over the country, should this occur I will no longer be able to retain my role as a best interests assessor, it is my understanding that the workforce of independent best interests assessors is growing rapidly and to lose this workforce would have a dramatic impact on timely assessments being possible.

6.278 A number of consultees agreed with the proposal, and frequently argued that it would provide additional and independent oversight. For example, Independent Age supported the "greater independence into the process of how restrictive care orders are authorised and kept reviewed over time". It also argued that it is not appropriate for a local authority to oversee authorisations while remaining responsible for commissioning of care services. Several consultees noted that at present reviews are not taking place and some additional structure was needed to safeguard this vulnerable group of patients. Worcestershire Health and Care NHS Trust commented that the proposal would put the Approved Mental Health Professional on a similar footing to the Responsible Clinician under the Mental Health Act 1983.

6.279 Of the consultees who agreed with the proposal, many raised the issue of resources. For example, Devon County Council agreed with the proposal "as long as the demand upon the Approved Mental Capacity Professional time is adequately resourced" and Swindon Borough Council was "apprehensive about the level of staff required".

DISCRETION TO DISCHARGE

6.280 Several consultees argued that Approved Mental Capacity Professionals should not have the power to discharge people from an authorisation. It was frequently argued that this would concentrate too much power in the hands of a single individual. Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs considered that this decision should be "considered consensually" and "made as a corporate group, recorded as such and underwritten by the Approved Mental Health Professional". A group of BIAs from East Sussex suggested that future Approved Mental Capacity Professionals should "rely on others already involved in daily care" and respond to requests for discharge. ADSS Cymru and the WLGA stated:

> Care needs to be taken to ensure that if the Approved Mental Capacity Professional is able to discharge P from the restrictive care and treatment scheme, there is clear responsibility for directing an alternative placement and / or bringing the case to court for an urgent review; otherwise there is a significant risk that P will simply be deprived of the safeguards in the scheme.

6.281 The Old Age Faculty of the Royal College of Psychiatrists was concerned that "an untrained non-doctor or non-nurse person would, in effect, be responsible for deciding someone is fit for discharge".

6.282 Many consultees suggested any decision to discharge is referred to a tribunal. Stoke-on-Trent City Council, Staffordshire County Council and North Staffordshire Combined Healthcare Trust, suggested that an internal panel should be established to consider discharge. Similarly, Leeds City Council proposed "a local panel which could include a higher manager and one Approved Mental Capacity Professional" or alternatively a panel where a number of people consider discharge, as with Guardianship under the Mental Health Act. Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs put forward a similar process to that of section 23 of the Mental Health Act 1983 whereby the Approved Mental Health Professional would be required to present their case to a "management forum or panel".

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.

6.283 A majority of consultees agreed with this proposal.[63]

6.284 Of the consultees that agreed with this proposal, many felt it reflects the current situation. In addition, consultees, such as EKHUFT, agreed it would "keep the process quick and simple". Garden Court Chambers' Court of Protection Team stated that the proposal "builds in flexibility and ability to act promptly". Calderdale Adults, Health and Social Care felt "it would also save unnecessary paperwork and speed up the process".

6.285 The National Centre for Post Qualifying Social Work agreed, and added that it wanted to see "Approved Mental Capacity Professionals deployed in undertaking a statutory review role". The Tri-borough Councils supported the proposal "as long as this was the same Approved Mental Capacity Professional who had carried out the initial best interests assessment". NHS Sheffield CCG agreed but only if he Approved Mental Capacity Professional was "a direct employee of the CCG or local authority".

6.286 Consultees that disagreed were concerned this would hinder safeguarding. Bury Council and Bury CCG noted "[our] initial reaction to this was to say 'no' as full exploration of the 'facts' needs to be considered". Nottinghamshire County Council was concerned that the proposal would "not fulfil the requirement for an objective assessment" and "allows the potential for arbitrary decision making made by a single practitioner".

6.287 Belinda Schwehr (consultant and legal trainer) commented:

> If the conditions are about making the deprivation proportionate and the least restrictive possible so as to satisfy the Approved Mental Capacity Professional that nothing else is workable or able to be secured, then if the position changes there will always be [a] … specific reason for the change, in which case I do not know how the Approved Mental Capacity Professional could come up with new conditions without it being carefully considered and recommissioned for.

6.288 Other consultees raised resource concerns and felt there would be no capacity for the Approved Mental Capacity Professional to take on this role.

6.289 The Patients Association suggested an alternative model whereby the Approved Mental Capacity Professional could review and vary conditions "towards greater liberty for the person concerned", or alternatively "to return to the original conditions agreed, after a period of 'loosening' conditions has proven to be unsuccessful or unsustainable". But if

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[63] 128 consultees expressed a view on this proposal: 91 agreed, 25 disagreed and 12 held equivocal positions.

conditions needed to be changed in favour of greater deprivation of liberty, this should automatically trigger.

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.

6.290 A majority of consultees agreed with this proposal.[64]

6.291 Many consultees supported a local authority power to discharge as they felt this would be a useful additional safeguard for the person (as well as the power of the Approved Mental Capacity Professional to discharge). The British Association of Social Workers noted that the proposal was "is in line with the current review arrangements for the DoLS". It added that consistency on how this power was discharged would be "helpful", and suggested that "a multi-disciplinary panel might be the most effective and might be able to link to similar arrangements for Mental Health Act, section 7 Guardianship".

6.292 The Court of Protection Practitioners Association argued that the local authority should continue to be responsible for those falling under the restrictive care and treatment scheme and carry out reviews at "reasonable intervals (at least once a year is suggested and at least bi-annually for those under the most restrictive regimes)".

6.293 Consultees who disagreed with the proposal frequently argued this would undermine the role of the Approved Mental Capacity Professional. Belinda Schwehr (consultant and legal trainer) did not think this proposal was "consistent with the idea that the Approved Mental Capacity Professional should be the be all and end all of the system (which is what I hope your view is, in fact)". In addition EKHUFT felt this proposal was inappropriate in an acute hospital setting, stating "clinical staff need to make that decision in that environment". The Disabilities Trust was concerned that the power to discharge "could be open to misuse by local authorities who no longer wish to fund people held under restrictive care".

6.294 Some consultees provided general comments in response to this proposal. Lancashire Care NHS Foundation Trust questioned:

> Would this work in a similar way to "hospital managers" panel's within the Mental Health Act to offer an independent review? As this is not a "court of law", does it lack real safeguards of Article 5(1)(e)?

6.295 However, Richard Rook (former Department of Health policy manager) commented:

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[64] 120 consultees expressed a view on this proposal: 75 agreed, 20 disagreed and 25 held equivocal positions.

> Hospital managers’ hearings in the Mental Health Act are a relic of a less judicialised past, which I cannot believe will survive any future review of that Act. It would be strange to use them as a model for contemporary legislation.

6.296 Sharon Thompson (MCA and DoLS project lead) asked:

> Who would be held accountable if the local authority wished to end a particular regime of care and the hospital / health did not agree that was appropriate?

6.297 UHL Adult Safeguarding Team and BIAs noted:

> We would like, as a managing authority, to be able to lift the detention if the patient regains capacity. We have a significant number of patients who receive medical treatment and consequently regain capacity. Currently we are in a ludicrous position where we have to wait for a best interests assessor to assess the patient and then determine that P has capacity, even though we already know that.

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.

6.298 This proposal was supported by a majority of consultees.[65]

6.299 St Andrews Healthcare noted “this replicates the duties placed upon local authorities under the Care Act 2014”. The Court of Protection Practitioners Association agreed with the proposal and felt “the scheme ought to foster and continue to encourage all relevant persons to work closely together to make it effective”.

6.300 The Mental Health Lawyers Association suggested that in addition there should be “a requirement that if a request for a review is refused, written reasons should be provided”.

6.301 Peter Scanlon, whilst agreeing to the proposal, suggested:

> There ought to be a right to an automatic review if no review has been requested within six months. This would be particularly beneficial to persons placed out of area where contact with home authority is tenuous or where no family of informal carer exists.

6.302 The National Centre for Post Qualifying Social Work commented:

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[65] 120 consultees expressed a view on this proposal: 75 agreed, 20 disagreed and 25 held equivocal positions.

> We support this proposal and believe it should mirror the responsibilities of the Approved Mental Health Professional and local authority when responding to a request for assessment by the Nearest Relative under the Mental Health Act.

6.303 Some consultees wanted clarity on what would constitute a "reasonable request" and suggested this be included in the code of practice. Steve Chamberlain (best interests assessor and trainer) added there would need to be "clarity whether there is an absolute duty to formally review or just a duty to consider a review (as is currently the case)".

6.304 Of those who disagreed, some felt the Approved Mental Capacity Professional should not be responsible for reviews. Bill McMellon (best interests assessor) suggested this should be the role of the social worker or care manager.

6.305 Steve Broach (barrister) disagreed with using the concept of reasonableness:

> A review should be triggered on any request by any of the above persons, unless perhaps a review has been undertaken recently (say within three months), in which case the Approved Mental Capacity Professional and local authority could refuse on the basis of unreasonableness (e.g. if nothing had changed in that time). If the basic right to request a review is subject to a reasonableness qualification this will simply lead to disputes as to whether a particular request is reasonable.

6.306 Central Bedfordshire Council argued that "the responsibility should lie with the relevant care commissioner, which may not be the local authority". Gateshead Council noted "this is already within the current best interests assessors remit now" and questioned the need to change.

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.

6.307 This proposal was supported by a majority of consultees.[66]

6.308 South Gloucestershire Council argued that the proposal would "provide a stronger link between the restrictive care and treatment scheme and Care Act functions". EKHUFT emphasised the importance of providing "clear documentation of how to care for the person". Worcestershire Health and Care NHS Trust stated that "identifying the restrictions that comprise the deprivation of liberty in the care plan would focus the minds of the care providers".

6.309 Several consultees supported the use of statutory and/or standardised forms. The LGA and ADASS commented:

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[66] 158 consultees expressed a view on this proposal: 95 agreed, 16 disagreed and 44 held equivocal positions.

> The proposal to include the authorisation of a deprivation of liberty within the care plan is welcome. However, we strongly recommend that this has a statutory format. Given the lead role it has played in the review of DoLS forms nationally, ADASS feels ideally placed to make strong recommendations in this respect. The form of recording often influences the quality of decision making and the quality of the outcome, and practitioner input (supported through the ADASS DoLS networks) will be needed throughout the formation of final proposals and draft legislation.

6.310 Hertfordshire County Council also argued it would be beneficial "for a universal DoLS care plan be developed and standardised so that documenting and identifying people under the scheme is clear for all". Devon County Council suggested the use of a document similar to the current standard authorisation and a requirement that the care plan must take into account anything contained within that document.

6.311 Some consultees disagreed with the proposal. Many raised concerns that currently care plans are not of sufficient quality. For example, Health and Social Care Commissioners and Providers in North East Lincolnshire argued that there were few care plans that "would easily stand the scrutiny by tribunal and / or court". Hywel Dda University Health Board were concerned that the proposal would create an expectation that authorisation can be managed within normal care planning processes, which created "a risk that staff will not take on board the significance of these new requirements".

6.312 A number of consultees made further suggestions in respect of the proposal. For example, London Borough of Newham stated that:

> Care home care plans are variable, some can be badly written, not specific enough, sometimes out of date. There needs to be guidance as to who is responsible for writing the care plan for authorisation- provider or care manager. There will need to be a requirement that the care plan to be authorised is robust and comprehensive.

6.313 Camden Council and Camden Safeguarding Adults Partnership Board highlighted that there are a number of care plans in existence for individual, including care plans from local authorities under the Care Act and care plans drawn up by care homes and domiciliary care providers, and there must be clarity "on how and where the authorisation of deprivation would be located".

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.

6.314 A majority of consultees agreed with this proposal.[67]

6.315 Amongst those supporting the proposal, it was frequently argued that requiring a court authorisation in such cases was unnecessary and too costly. ADSS Cymru and the WLGA argued that:

> This would make sense. Deprivations continue to occur in the domestic setting, but it would seem unnecessary to manage this through the Court system. In practice this could more usefully be managed by the Approved Mental Capacity Professional and using care planning documents, where the state is involved, in order to ensure safeguards are adhered to.

6.316 Bury Council and Bury CCG stated that:

> Bringing supported living, shared lives and domestic accommodation to the scheme will reduce the need to approach the Court of Protection therefore reducing the cost and stress to “P” and their families – particularly for cases where there are no issues / objections or mitigating circumstances. We have been extremely concerned about the cost to “P” where cases are taken up to the Court of Protection when everyone is in agreement with and happy with arrangements.

6.317 We received responses from a number of family carers, and organisations representing family carers. For example, the National Family Carer Network stated that:

> We are pleased that a proportionate approach is proposed … involving the Approved Mental Capacity Professional and the care and support planning process. Approached empathetically, we can envisage this being experienced as supportive by many families, who may be worried about whether they are providing care in the best ways possible. We know from what families tell us now that the character of the relationship with the main professional(s) involved is key to a satisfactory experience. When the Mental Capacity Act is explained properly, most families understand its empowering ethos. Unfortunately some families have experienced a more frightening approach and talk about the Mental Capacity Act and safeguarding being used as “weapons” against them. The values and training of Approved Mental Capacity Professionals will be critical to changing this.

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[67] 158 consultees expressed a view on this proposal: 95 agreed, 16 disagreed and 44 held equivocal positions.

6.318 Sone consultees had concerns about the intrusion into family and private life, whilst agreeing in principle to the proposal. For example, West Berkshire District Council argued that:

> Officers within Children's Services report a particular concern that many families see no necessity for an extension of the DoLS regimes to their family environments, and there is a perception that state control should not extend into family life. This perception is critical for consideration in any new scheme in order to ensure that scheme is fair and proportionate to the circumstances that exist, with a clear rationale that can be easily explained to those families who may be affected.

6.319 Vocal Advocacy agreed with the proposal in principle, not recognised that "families and carers may feel threatened and overwhelmed and that this may result in an unjustifiable intrusion into family life.

6.320 A number of consultees disagreed with our proposal. Many of those focused on the impact on the right to family and private life. Charlotte Peters Rock commented that "the new scheme should stop at the door to any person's own home, since there is already far too much state interference in individuals' lives". A group of BIAs from East Sussex argued that:

> Such a huge issue involving professional ethics, right to family life, privacy, liberty and keeping care and its impact proportionate cannot be undertaken in a private domestic setting by a lone Approved Mental Capacity Professional at the behest of a local authority. The law in the form of the judicial process must take precedence. If right to liberty is incorporated into assessment of care needs then this alerts care provider teams to raise concerns about liberty alongside other care needs to the Court.

6.321 Paul Bowen QC, in disagreeing with the proposal, distinguished between "type I and type II cases" in relation to article 5 of the ECHR.[68] He argued that deprivation of liberty is unlikely to arise in a purely domestic setting, as it is a type II case, and that "to impose the restrictive care regime in such settings is an unwarranted interference with article 8 rights". He added:

> In those (probably rare) cases where an individual P is placed in a domestic setting in circumstances giving rise to a type I measure (such as P in the *Cheshire West* case, who was placed with foster carers in a domestic setting having been removed from her parents), if the restrictions cannot be reduced then authorisation for the deprivation of liberty will need to be obtained from the Court of Protection.

6.322 Garden Court Chambers' Court of Protection Team suggested that:

> To the person concerned and to family members, the suggestion that their loved one has to be subject to formal state intervention requiring assessments and authorisations, formal appointment of an advocate, automatic referral to a court or tribunal (if that is to be applicable) may be experienced as intrusive and could be distressing. We suggest that, where there is not already state involvement, there needs to be a flexible scheme that responds with different degrees of intervention to

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[68] For more on the distinction between type I and type II cases, see *P v Cheshire West and Chester Council* and *P v Surrey County Council* [2014] UKSC 19, [2014] AC 896 at [43] - [44].

> recognise the difference between cases that do not involve actual physical confinement in the classic sense although they may count as deprivation of liberty due to the width of the concept following *Cheshire West,* and situations where a person is subject to physical confinement

6.323 Other consultees disagreed on the basis of resource concerns. For example, Harrow Council's social care practitioners argued that the proposal "will increase the volume of work significantly and will be difficult to implement and oversee".

6.324 Some consultees commented more generally on aspects of our proposal. Several consultees were unclear why the state should be responsible for a deprivation of liberty in a private setting. Belinda Schwehr (consultant and legal trainer) noted that in domestic settings "there is no-one to report this state of affairs proactively" and no duty to report being proposed, and therefore the problem arises that "the domestic situations that come to the attention of the local authority will be likely to be those where neighbours or day care providers have concerns".

6.325 A number of consultees questioned how the Approved Mental Capacity Professional or the CQC would inspect the deprivation of liberty in domestic settings. Some suggested that the Approved Mental Capacity Professional would need new powers of entry to make their job achievable. For example, Luton Borough Council stated that:

> There are no powers of entry for assessors to carry out the assessments on the person in the domestic setting unlike the regulated care homes; hospitals etc. This may prove a stumbling block as carers may not allow access to carry out assessments' and may take offence etc. What would the fall-back position be in such circumstances – application to the Court?

6.326 Other consultees warned against granting powers of entry. Voiceability (advocacy provider) felt that the proposal raises "significant questions around rights of access for practitioners, monitoring and regulation" and noted that "carers have fed back that this would place an additional burden on the family / carer at a time when they are already under considerable stress".

6.327 The Department of Health and Ministry of Justice made a the following comments in response to this proposal:

> The Department is sensitive to the fact that many citizens will be keen to avoid what may be perceived as unnecessary and obtrusive state involvement in their private and family affairs. The Law Commission's scheme is proposed to cover domestic settings. In some cases, this option may indeed be preferable to for example, Court of Protection applications. But clarity is needed as well as reassurance that the scheme does not extend the reach of the state unnecessarily into private affairs.

6.328 Whilst stating that they would not support any proposal which acts as a disincentive to people providing informal care, they added:

> We suggest that wider context is important. The Law Commission's scheme would certainly not be the only mechanism to protect individuals in domestic settings. We would suggest that consideration be given to whether existing legal and criminal law frameworks do not already provide a robust safety net.

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.

6.329 A majority of consultees agreed with this proposal.[69]

6.330 Many consultees who agreed with the proposal criticised the current requirement for a fresh medical assessment. Bill McMellon (best interests assessor) noted that "it is already perfectly plain from the existing evidence that there is a mental disorder" and therefore completing a further medical assessment annually is frequently unnecessary. Peterborough City Council reported that it currently spends approximately £135,000 on doctors assessments for the purpose of DoLS applications and "this has been historically underfunded by central allocations for DoLS". The London Borough of Lambeth's DoLS Service stated that currently DoLS doctors get a minimum of £173 plus travel per assessment, "often for an assessment which gives no extra information than was already available and on record".

6.331 Several consultees stressed the importance of a fresh assessment in some cases. The Court of Protection Practitioner's Association suggested a fresh assessment should be required "where there is a reasonable belief that the extant assessment is inadequate". Vincent Duffy (DoLS team leader) felt that a fresh assessment should be required "if there is a suggestion that the person's condition may change of fluctuate".

6.332 Several consultees supported the idea that a broader range of practitioners should be allowed to provide the medical expertise. DoLS Leads for Bracknell Forest Council, the Royal Borough of Windsor and Maidenhead and Slough Borough Council agreed this was a positive change, as this would mean "we are more likely to have an opinion from medical professionals who know P". Many consultees argued that for some conditions, such as an acquired brain injury, autism or dementia, a psychologist opinion could be more appropriate than a doctor, and provide greater insight into whether restrictions could be reduced. Allowing assessments to be completed by general practitioners was also supported, as consultees felt they would be more likely to know their patient's situation and have on-going involvement. The British Psychological Society in particular welcomed the proposal and recommended that psychologists should be registered with the Health and Care Professions Council as a clinical or counselling psychologist, as well as have expertise in relation to those they are assessing, such as people with dementia or learning difficulties.

6.333 Some consultees wanted our proposal to go further still, with Flintshire County Council suggesting a community psychiatric nurse could provide evidence, and Barchester

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[69] 173 consultees expressed a view on this proposal: 118 agreed, 15 disagreed and 40 held equivocal positions.

Healthcare proposing “widening of the role of medical assessor to take account of competencies rather than simply qualifications”.

6.334 Of the consultees who disagreed with the proposal, many felt the Approved Mental Capacity Professionals would be unable to secure medical assessments. Steve Chamberlain (best interests assessor) stated:

> I believe this will cause considerable problems and dispute, unless there is a duty placed on the NHS to ensure that the relevant evidence is made available. I am concerned that a non-medical professional is unlikely to be able to direct a medical practitioner to provide a report (objective medical expertise) where that is needed, as the assessment and report will be outside the doctor’s contract.

6.335 NELFT NHS Foundation Trust doubted whether psychologists would want to take on this role and felt the proposal may not be compatible with ECHR case law. Dr Jonathan Waite (psychiatrist) argued:

> Psychologists do not have competence to make diagnoses, they are unable to provide “objective medical evidence”. If they have attained the necessary competencies to be appointed Responsible Clinicians they may apply for renewal of Mental Health Act detention, but so can nurses, social workers and occupational therapists. They cannot furnish an application to detain a patient under the Mental Health Act and should not be able to authorise deprivation of liberty under the Mental Capacity Act.

6.336 Rae Hughes (social worker) argued that GPs should not be able to provide the objective medical expertise, “having witnessed the ‘assessments’ of some GPs of those who are being assessed under the MHA”.

6.337 The Tri-Borough Councils also questioned why the medical assessor needs to be independent of the detaining institution, unless the person is disputing their diagnosis. Brent SAB felt that it would be “difficult in practice to find a professional with the relevant expertise who isn’t employed by the same organisation responsible for the detention”. Dr Hugh Series (psychiatrist and academic) added:

> Independence of the detaining institution may be desirable, but will be a difficult criterion to implement. It will mean creating a new register of independent doctors who are trained, able and willing to do the assessment, and no doubt will expect a fee. This would be parallel to the register of section 12 approved doctors for Mental Health Act assessors, a system which already involves considerable time, expense, and difficulty to maintain. In that system the arguments over when you may and may not claim a fee have been going on for as long as I can remember. This will create a new bureaucracy and involve significant costs.

6.338 The Old Age Faculty of the Royal College of Psychiatrists argued that due to the large numbers of people who would need to be assessed for an authorisation “any cost for medical assessments would be substantial and unfeasible”. In addition, the Disabilities Trust felt that the proposal was “unworkable in emergency situations or rehabilitation settings where conditions fluctuate rapidly”.

6.339 Some consultees made further suggestions. High Harland’s Homes felt that the proposal “could link-in with the annual Cardiff Health check, which is carried out by the general practitioner”. Several consultees suggested that the cost of the assessment should be met by the NHS. Marie Rose P.E.A. suggested the medical assessment should be more comprehensive, rather than light touch, recommending “three individual doctors who assess the individual’s mental capacity” who would be “chosen randomly from a panel of doctors”. Brian Gathercole (social worker) suggested that the best interests assessor could initially do a light touch medical assessment, with discretion to request a medical assessment should they be in any doubt about mental capacity. Barts Health NHS Trust suggested incorporating the two roles into a single role, “requiring a best interests assessment by an independent doctor or clinical psychologist in the case of hospital patients”.

6.340 Several consultees commented that the proposal must be accompanied by a change of culture within the NHS. Swansea City and County Council felt that implementation must involve “a deep change in the relative ethos of social and medical models”, and argued that “doctors do not understand the ethos and principles of the Mental Capacity Act.

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.

6.341 A majority of consultees agreed with the proposal.[70]

6.342 Hywel Dda University Health Board noted, in particular, that it is appropriate to broaden the diagnosis to disability or disorder of mind or brain as “this avoids the risk of excluding some people from the safeguards”. Similarly, Barchester Healthcare welcomes the “proposed shift to the gateway definition to the use of the Mental Capacity Act definition, which is clearer and better understood”.

6.343 Nottingham City Council’s Adult Social Care Department agreed with the proposal and commented that:

> Experience suggests that the assessments undertaken by mental health assessors are not always very detailed or of good quality and may not be robust enough for the scrutiny of a tribunal. We believe the decision should focus upon where the person is accommodated for their care and treatment.

6.344 A number of consultees who disagreed with the proposal argued that the capacity assessment should not always be carried out by a medical practitioner. For example, Cambridgeshire County Council stated that:

> This assessment requires both time and patience to not only build up a rapport with the relevant person concerned but also to establish what practical supports are to be

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[70] 117 consultees expressed a view on this proposal: 75 agreed, 27 disagreed and 15 held equivocal positions.

> given appropriately to assist them in the decision making. Hence, we do not think such objectives are practicable for the medical practitioner to achieve in practice.

6.345 Similarly, Peterborough City Council argued that:

> The current model does not require the medical assessment to include a mental capacity assessment and there may be a further training requirement if this is to be made mandatory. It is important to ensure that mental capacity assessment remains holistic and person centred and does not lose its emphasis to a medical model.

6.346 Nikki Mardell (MCA and DoLS lead) suggested that the medical professional should just confirm that the person is suffering from a disability or disorder of mind or brain. Essex County Council argued that the Approved Mental Capacity Professional should confirm whether the person lacks capacity, and that "the medical professional should also be able to express an opinion", and differences of opinion should be automatically progressed to the Court of Protection.

6.347 Paul Greening (MCA manager) argued that the capacity assessment should be undertaken either by an Approved Mental Capacity Professional. The West Midlands Regional DoLS Leads Group argued that the social worker should undertake the capacity assessment, as they are "the professional best placed to make this determination as they will often know the person better".

6.348 The need for training of medical professionals was noted by many consultees. For example, Sheffield Citizens Advice commented that:

> As advocates, we encounter many medical professionals who are not able to undertake proper mental capacity assessments. There would be a significant training need here. If this was done, it would have very positive implications for better compliance with the Mental Capacity Act. In the current financial climate, such training is unlikely and could lead to poor quality assessments.

6.349 Nottinghamshire County Council called for doctors to have the same training as Approved Mental Capacity Professionals, and highlighted the "dearth of understanding of Mental Capacity Act amongst doctors and other medical professionals".

6.350 Some consultees questioned whether there needs to be a causal link between the mental disorder and the lack of capacity. Dr Jonathan Waite (psychiatrist) argued that under the DoLS there is no requirement for a causal link, and argued that "it should be made clear in new legislation whether the causal link is necessary". Bury Council and Bury CCG argued that there should be a causal link between the lack of capacity and the disorder of the mind or brain.

Question 7-33

Should the medical assessment address other matters such as providing a second opinion on treatment already being provided or proposed?

6.351 No overall majority view was reached in response to this question, but the largest number of consultees agreed that medical assessment should address other matters.[71]

6.352 St Andrew's Healthcare argued that a second medical opinion might be useful in cases where P's family does not agree with the treatment that is being provided and "be an additional check and balance to ensure that the care and treatment that is being provided is in P's best interests".

6.353 The British Geriatrics Society commented:

> Given that very junior staff in hospitals administer many of the current DoLS, there may also need to be a requirement that only medical staff above a particular training grade can undertake the medical assessments required for restrictive care and treatment. This may of course generate significant resource impacts on medical time at a more senior level.

6.354 A number of consultees emphasised the need for flexibility. For example, the Alzheimer's Society stated that:

> In some cases the medical professional will have insufficient knowledge to comment usefully and in other cases they may have serious concerns. In the latter situation, a second opinion could act as an additional safeguard. It should therefore be an option but not something that is compulsory.

6.355 Bracknell Forest Council commented that:

> Where there is an issue in dispute then obtaining a second medical opinion does seem sensible. However, routinely requesting medical professionals to provide a second opinion would result in delay, additional costs and potentially subjecting the incapacitated adult to further unnecessary assessments. There is already widespread reluctance on behalf of treating medical practitioners to provide medical assessments as a part of their on-going contractual duties. The cost of this additional requirement will therefore fall on the local authority.

6.356 Brent SAB suggested that second medical opinions should be integrated with existing processes:

> Any proposed reform must build on the statutory safeguards which already exist and shouldn't look to duplicate. Currently the NHS constitution requires medical practitioners to offer choice, including a second opinion. There is also a duty of care on any medical practitioner to challenge colleagues if they think the care or treatment

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[71] 139 expressed a view on this question: 65 said "yes", 39 said "no" and 35 held equivocal positions.

> proposed is inappropriate. NHS trusts have whistleblowing policies, escalation procedures and, most importantly, a duty of candour to report when this is the case. Any code of practice should reemphasise these duties rather than duplicate under another statutory power. Consideration could be given to giving the medical expert powers to advise the Approved Mental Capacity Professional if s/he thinks there is a less restrictive course of treatment or care available, but it shouldn't be required in every case as this could lead to conflict between professionals or render obsolete the rights of appeal/ challenge.

6.357 A number of consultees answered "no" to the question pointed to resource concerns. For example, Newcastle City Council Legal Services stated that:

> There could be no guarantee that any medic assessing P would be suitably qualified to express an opinion. The ability to give a second opinion would require the medic to undertake a review of P's medical records, requiring disclosure and perhaps an inordinately long period of reading, with attendant cost to the local authority for the vastly increased length of the assessment and would have the effect of the local authority funding NHS functions.

6.358 Robert Robinson (solicitor for HL) argued that a second medical opinion goes beyond the requirements of article 5 and suggested that the medical assessor should communicate any concerns to the Approved Mental Capacity Professional "as they may be relevant to whether restrictive care is appropriate and justified".

6.359 Derbyshire County Council argued that a second medical opinion would "create confusion of roles, and legal disputes". Peterborough City Council reported that there is currently a shortage of mental assessors and commented that "expanding the scope and hence time taken to undertake the medical assessment might further impact of availability".

Question 7-34

Should doctors be eligible to act as Approved Mental Capacity professionals (currently Best Interests Assessors)?

6.360 No overall majority view was reached in response to this question, but the largest number of consultees agreed that doctors should not be eligible to act as Approved Mental Capacity Professionals.[72]

6.361 Several consultees argued that a social care perspective is required. For example, the Human Rights Implementation Centre at Bristol University raised concerns about "over-medicalisation", and emphasised the need for a "blend of expertise and competencies in the decision-making process". It stated that "the social care perspective is important

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[72] 158 consultees expressed a view on this question: 59 said "yes", 72 said "no" and 27 held equivocal positions.

and social care professionals are well qualified to make decisions with a focus on patient rights". Steve Chamberlain (best interests assessor and trainer) stated that:

> The purpose of the current assessment process is to provide a combination of medical expertise and social focus. This is in parallel with the Mental Health Act, dating back to 1983, requiring an assessment with a medical practitioner and a non-medical professional. If doctors became eligible to act as Approved Mental Capacity Professionals, this would potentially remove the non-medical expertise from the process. This would be a retrograde step.

6.362 Swan Advocacy argued that "clinicians are trained to treat specific conditions and can overlook the bigger picture", which can run counter to the best interests of the individual. Similarly, Derbyshire County Council stated that doctors "do not reliably understand what alternatives may be available in the community, since this is typically outside of their already broad range of expertise", and that "culturally, it can be harder for doctors to challenge each other, than it is for social workers to do so".

6.363 Rachel Ward (advocate) argued that "doctors have a general lack of knowledge and understanding of the Mental Capacity Act let alone the deprivation of liberty legislation". Mencap was concerned that doctors would not have sufficient knowledge of community-based support for people with learning disabilities. Some consultees queried whether doctors would want to take up this role. Flintshire County Council suggested that it would require doctors to be paid an "additional reimbursement".

6.364 A number of consultees argued that doctors should be eligible to act as Approved Mental Capacity Professionals. For example, Sharon Thompson (MCA and DoLS project lead) argued that "the more diverse the disciplines for being an Approved Mental Capacity Professional the better".

6.365 Professor Peter Bartlett (mental health law academic) argued that there are situations "where a better linkage between disability or environment and the skills of the assessors might have had a real and beneficial effect on the situation":

> There will be some cases where the key restrictive elements of the care plan may turn on medication or medical aspects of the disability, and for those it seems to me we really do want input from somebody who understands the medications available and the other options … The key point, of course, is that the people assessing have the relevant skills (medical or social or both) for the individual case.

6.366 Steve Broach (barrister) argued that in principle doctors should be eligible to act as Approved Mental Capacity Professionals but added:

> The practical concern would be whether doctors are sufficiently informed as to the social model of disability to conduct a holistic best interests assessment. It may be that it is valuable for a non-medical professional to carry out the best interests assessment in cases relating to medical treatment precisely to ensure that a wider perspective is taken.

6.367 Luton CCG argued that acting as Approved Mental Capacity Professionals would improve doctors' awareness of the Mental Capacity Act. Similarly, Bill McMellon (best interests assessor) argued it might mean that "more doctors might receive good training on the Mental Capacity Act".

6.368 A number of consultees commented on the remuneration of doctors acting as Approved Mental Capacity Professionals:

> It is difficult to imagine a doctor wanting (even if practically able) to take up an Approved Mental Capacity Professional role, unless they have the same level of financial incentives as they do in relation to undertaking mental health and eligibility assessments under the current regime. The Approved Mental Capacity Professional role as described is much more demanding, and if paid on a similar basis this would be even more unaffordable and provide for a system where Approved Mental Capacity Professionals are paid different amounts to do the same work according to the status and contract, creating further professional inequity within the system.

6.369 Nottingham City Council's Adult Social Care Department argued that doctors were "unlikely to want this role for the remuneration currently on offer" and pointed to "the negligible take-up of Approved Mental Health Professional responsibilities by psychologists". But it also suggested that speech and language therapists should be eligible to act as Approved Mental Capacity Professionals.

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.

6.370 This proposal was supported by a majority of consultees.[73]

6.371 East Sussex County Council argued that the proposal would "reduce the pressure on staff and gives recognition that it takes time to do a comprehensive assessment". We do not believe however that a 14 day limit would be achievable with the broad scope of the proposed new scheme. Barchester Healthcare supported the proposal and added that it must be sufficiently well-resourced "to prevent providers being unable to carry out their duties lawfully as the result of the lack of availability of an Approved Mental Capacity Professional". Other consultees emphasised the process would need to be simple and quick.

6.372 The Mental Capacity Act Project suggested that:

> This authorisation should be extended to all registered professionals, this would reduce the burden on Approved Mental Capacity Professionals for short term restrictions and add parity to the hospital setting. It may be prudent to increase this timeframe to 28 days to ensure it "fit" with the timescales for assessment - so no-one is left outside of the law whilst waiting for assessment.

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[73] 162 consultees responded to this proposal: 84 agreed, 35 disagreed and 43 held equivocal positions.

6.373 Some consultees disagreed with our proposal. Many disagreed because of the resource constraints facing local authorities. For example, Kent County Council stated that:

> The proposed changes for Approved Mental Capacity Professionals, instead of providers, to authorise in urgent cases, will have significant resource implications on this skilled workforce. We already have difficulty in recruiting and developing this workforce, considering competing demands from other areas of work for local authority social care.

6.374 Hywel Dda University Health Board argued that the proposal would put "considerable pressure on the Approved Mental Capacity Professional" which would impinge on their other responsibilities. It commented that:

> We believe that there is nothing wrong with the managing authority making an urgent authorisation, as long as it is followed up by the Approved Mental Capacity Professional in a timely way.

6.375 Other consultees commented on the position of managing authorities. For example, Sheffield City Council's Social Care Professionals stated that:

> Managing Authorities already feel that DoLS is something that is "done to" them, rather than something that they really buy into and work with on a day to day basis. The proposals may add to this. They are the ones who are actually implementing deprivations and restrictions through the work they do with those who lack capacity every day and any new procedures should really focus on supporting their day to day understanding and practice.

6.376 Some consultees commented on the timescales involved in urgent authorisations. For example, the Old Age Faculty of the Royal College of Psychiatrists felt that in many settings seven days is too short and suggested 28 days. Chris Lucas (best interests assessor) felt that 21 days would be a more realistic timescale.

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.

6.377 A majority of consultees agreed with this proposal.[74]

6.378 Several consultees argued that the proposal would address gaps in the legal scheme which cause unnecessary bureaucracy and difficulties in practice. SARCP noted this would "remove the necessity for cancellations and reauthorisations on discharge" which would help reduce workloads.

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[74] 178 consultees expressed a view on this proposal: 137 agreed, 9 disagreed and 32 held equivocal positions.

6.379 UHL Adult Safeguarding Team and BIAs stated:

> This would be incredibly helpful if a person has a 12 month authorisation in place and they are admitted to hospital during that period. Hospital staff would then simply need to ensure that any care and treatment is in best interests, under the Mental Capacity Act.

6.380 Helen Turton (best interests assessor and Approved Mental Health Professional) described the current problems that arise for hospital patients moving to a care home:

> I am often asked to complete an in depth assessment to authorise time spent in hospital but not for any future placement. There is, as a result, a doubling up of the work as the care home will then make their application (in nearly all cases) after the person has moved there. This results in family being consulted twice but also if the family supports the placement for 24 hour support and the patient is objecting to a move to a care home but is happy to remain in hospital for treatment then they are not properly represented. All too sadly the delay results in the likelihood of them going home remote.

6.381 Several consultees noted that the proposal would need to be implemented and enforced by other agencies, such as the police or ambulance services. For example, Roger Laidlaw (best interests assessor) commented:

> Expecting provider service staff or other workers such as police officers, hospital porters and security staff and ambulance crews to consider relatively abstract issues such as whether the employment of force is reasonable and proportionate or might amount to a deprivation of liberty and to reach conclusions in a confident and uniform manner is unrealistic. A clear statement of the requirements for authorising effective detention and explicit direction as to the powers to convey and return is required.

6.382 Stoke-on-Trent City Council, Staffordshire County Council and North Staffordshire Combined Healthcare Trust suggested that we should consider granting certain professionals powers of entry.

6.383 Some consultees suggested additional safeguards such as explaining why this is necessary, proportionate and in the person’s best interests or on the recommendation of multiple professionals. Roger Laidlaw added:

> As noted above, concerns about the casual or oppressive use of such powers could be addressed by arrangements for automatic referral to the Restrictive Care Scheme or for early review by the Mental Capacity Tribunal.

6.384 East Sussex County Council supported the proposal and commented:

> Regarding authorisation in multiple settings, it could be useful to be able to authorise deprivation in certain circumstances if the person does not object for example for rolling respite in the same care home or in a day centre. We would not support blanket authorisation in any setting however. We believe that the Court of Protection is better placed to rule on such exceptional or complex cases.

6.385 A number of consultees disagreed with this proposal. Denbighshire County Council felt that allowing authorisations to apply in different settings, failed to "take into account the different settings and care provided" and was concerned by the potential resource implications of introducing powers to authorise transportation. Hertfordshire County Council was specifically concerned about enabling authorisations in multiple settings:

> Being in a different setting may present different restrictions and the person should have the right to be assessed a fresh in a new place. The concern is that if the authorisation follows the person they may be subjected to additional restrictions without the safeguard of a new assessment.

6.386 Some consultees made suggestions for how the proposal might be implemented. For example, London Borough of Barking and Dagenham Council stated:

> In relation to transfers, there will need to be a more local process for implementations a move into restrictive care. Possibly similar powers in relation to section 136 or section 135 Mental Health Act as police are often unwilling to intervene. Enable local courts to use powers rather than the Court of Protection.

6.387 Alan Capps (family carer) argued:

> Transfer should occur for a reason. That reason should appear in the care plan, and a new authorisation made to take account of the circumstances to avoid patients being shunted around for a local authority / NHS convenience.

GENERAL CHAPTER 7

6.388 In addition to responding to the provisional proposals and consultation question, several consultee provided general comments on chapter 7.

6.389 Some commented on the name "restrictive care and treatment". For example, Leeds City Council was concerned that it carried negative connotations and was stigmatising. Life Path Trust (learning disability charity) felt the name was misleading, since the scheme does not provide any authority to treat a person. Similarly Garden Court Chambers' Court of Protection Team argued that name "does not suggest a scheme that is kind and supportive of P and those interested in P's welfare".

6.390 On the other hand, some consultees were supportive of the name. Conwy County Council stated this will sound better when talking to family members, noting in particular that "care is a good word to use". Sharon Thompson (MCA and DoLS project lead) commented that the name "is not loaded with the immediately negative connotations of deprivation of liberty".

6.391 Some consultees were critical of the idea of establishing different safeguards for different settings. The LGA and ADASS argued that the proposed tiers "are artificial, will not work and should be removed". Instead they suggested the entire scheme have one name, across all settings and that oversight of restrictive care plans should be incorporated across all routine social work. Similarly the Mental Health Alliance argued that tiers could "over-complicate this new scheme" and that "arbitrary decision-making could put a person in the wrong tier, which could deprive them of the full safeguards that they are entitled to". Roger Laidlaw (best interests assessor) also noted the possibly of staff "playing the game" by downgrading cases to supportive care once a perceived power of the scheme has been used to achieve an effect.

6.392 St Helens Council suggested the introduction of a "dual process" for authorisation:

> One for straightforward cases, where there is no challenge, (these cases could potentially be completed by those involved in the care) and one for more complex cases which would require Approved Mental Capacity Professional interventions. The non-complex route could be a self-authorisation process overseen by an Approved Mental Capacity Professional.

6.393 The Equality and Human Rights Commission noted that, in order to ensure compliance with article 5 of the ECHR, care plans must record that a deprivation of liberty has been authorised, that it is necessary and proportionate, in the person's best interests and is the least restrictive option. In order to ensure compliance with article 14 of the UN Disability Convention, it suggested an additional step of ensuring reasonable accommodation "must have been considered, and, if appropriate, taken so as to obviate the need for a deprivation of liberty or to minimise the level of restriction".

Chapter 7: Hospital scheme

Provisional Proposal 8-1

A separate scheme should be established for hospitals and palliative care settings.

7.1 It was agreed by a majority of consultees that a separate scheme should be established for hospitals and palliative care settings.[75]

7.2 For example, the Bar Council agreed that the "'single approach irrespective of setting' model has failed", and that the position of hospital patients was materially different because of the likely or anticipated timescale of the deprivation of liberty; hospitalisation is indicative of physical ill, health that requires treatment; a deprivation of liberty in a hospital ward is highly restrictive; and clinicians are available to carry out assessments, on site, relatively frequently.

7.3 Stephen Ward (MHA and MCA lead) noted that a separate hospital scheme makes sense as the issues in hospitals are different to the issues in care homes; for instance, hospitals are under pressure to discharge patients as soon as possible and compliance with a full DoLS scheme in such cases could be disproportionate and unnecessarily elaborate. Bury Council and Bury CCG also argued that "an acute setting is completely different to that of a care / nursing home, admission of a patient tends to be due to some type of emergency / acute episode".

7.4 David Flood (adult safeguarding nurse) described the current situation in hospital settings as "unworkable", "ill defined" and "not patient centred", and added:

> The scenario of deprivation of liberty within an acute hospital inpatient stay is very different to both the original Bournewood case and the [*Cheshire West]* Supreme Court cases. Patients (and I use this word intentionally) are not resident here, it is not their home and we do not in general "keep" patients in hospital longer than is necessary.

7.5 Those who disagreed with the proposal believed that adding a separate hospital scheme would be too complex and create further confusion, especially when people are moved between services.[76] Some consultees felt that the proposed hospital scheme offered insufficient safeguards.[77]

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[75] 223 consultees expressed a view on this proposal: 159 agreed, 34 disagreed and 30 held equivocal positions.

[76] For example, the Huntercombe Group.

[77] For example, Rita Panayides (best interests assessor).

7.6 Several consultees who opposed the proposal felt there is a lack of understanding of the Mental Capacity Act amongst health staff. For example, Integritas Support Ltd (training provider) argued:

> It is extremely risky to allow the medical model to prevail, to deprive a person of their liberty for up to 28 days without any independent scrutiny. Some of our most harrowing experiences as best interest assessors have been in acute and mental health hospital settings. In our experience of being both best interest assessors and trainers of thousands of staff on the Mental Capacity Act and DoLS, healthcare practitioners have demonstrated the least amount of knowledge and appreciation of this Act.

7.7 CQC argued there would be "significant challenges" in deciding whether a care setting should fall into the scope of the hospital scheme or not.

7.8 A number of consultees (including those who supported the proposal) raised resource concerns. City and Hackney SAB, which generally welcomed the proposal, argued that considerable resources would be needed to implement a robust system of safeguards. Similarly, Cambridge House (service and advocacy provider) commented that in the light of current levels of non-compliance in hospital settings it was difficult to imagine how hospitals would facilitate and fund a stand-alone scheme. Averroes (think tank) were concerned that, at a time when many NHS trusts are in financial deficit, it would be difficult to apply the reforms.

THE ACID TEST IN HOSPITALS AND HOSPICES

7.9 Several consultees commented about the impact of *Cheshire West* in a hospital setting, or made general points about when article 5 would be engaged. Many expressed confusion about whether the judgment applied in general hospitals and whether the acid test needed to be adjusted to take into account the reality of hospital inpatients (intensive care settings were mentioned frequently in this context). Alwyn Davies (best interests assessor and Approved Mental Health Professional) referred to the "dearth of adjudication, explanation and guidance" issued since the judgment, and there were many calls for greater elaboration of the "acid test" set out in *Cheshire West* to make it more relevant to hospitals.[78]

7.10 The Law Society's Mental Health and Disability Committee, which broadly welcomed the proposal, commented on the situation of those based in hospitals with long-term illnesses:

> Not all deprivations of liberty are of short duration. In certain circumstances, patients may remain for some time in hospital while arrangements are made for them (together with social services) to be discharged into suitable care and accommodation when their own accommodation is no longer available or suitable for their needs. There are many long-stay wards that care for people with Alzheimer's or dementia. These are the very patients who will satisfy the acid test and will not be "free to leave" the hospital.

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[78] For example, Paul Harper (MCA and DoLS Lead).

7.11 It also questioned whether it is necessary for the scheme to cover all those in an intensive care unit who are technically deprived of their liberty, but are not resisting treatment, or actively attempting to leave the unit.

7.12 According to Paul Bowen QC (Brick Court Chambers), the majority of hospital admissions are emergencies lasting a relatively short period and would not engage article 5. He also argued that in other cases a deprivation of liberty will arise "only if the restrictions are imposed for an improper purpose or are not normal in the circumstances (for example, they continue for an extended period)".

7.13 There were many calls from consultees for the Law Commission to provide a clear definition of how the "acid test" applies in hospitals and hospices. Francis House Children's Hospice commented that:

> It would be extremely helpful if clarification and elaboration could be provided within any new legislation regarding the "acid test" particularly the "not free to leave" aspect of the test. The young people who use our services are unable to physically leave our care and often are unable to express a wish to do so. They could however be removed from our care by family members or carers without objection from ourselves in appropriate situations as all the care we provide at Francis House is with the agreement of parents and carers.

7.14 St Helens and Knowsley Teaching Hospitals NHS Trust commented that the acid test is not appropriate in respect of intensive care and should only apply to those patients who are not sedated to facilitate mechanical ventilation.

HOSPICES

7.15 There was some discussion amongst consultees on whether or not the proposed hospital scheme should apply to hospices. East Anglia's Children's Hospices argued that hospice, palliative care and end of life care should require specific attention:

> Whilst we agree to some degree with the view that there are similarities with care being provided in a hospital, the outcomes are different for a hospice where quality of life and a good death are the desired outcomes rather than cure. There are specific issues relating to hospice, palliative and end of life care which would benefit from greater clarification.

7.16 Alwyn Davies felt it was a mistake in the consultation paper to link hospitals and hospices together. He argued that whilst they may share some similarities the intended outcomes of each were "fundamentally different and distinct":

> Hospitals will invariably have a purpose of therapeutic optimism whereas the hospice is primarily focused on end of life care where the outcome is invariably the death of the person.

7.17 The National Care Forum, which broadly agreed with this proposal, had the following to say on the issue of hospices:

> Whilst it may be logical to extend this approach to hospices we wonder whether the average length of stay of people in hospice settings warrants this additional burden

> being placed on providers and we are concerned about the potential intrusion on families supporting a loved-one at the end of life. The use of the term palliative care in this context is in our view unhelpful as most nursing homes, although not hospices, are nevertheless providing palliative care on a routine basis.

7.18 The differences between children and adult hospices were also emphasised by East Anglia's Children's Hospices, who told us that:

> Children's hospices are not the same as adult hospices, in particular in relation to short break care provision. Children's hospices provide more short breaks and less end of life care than adult hospices given the nature and prevalence of children's palliative care conditions. Hospices staffing models vary, and not all have 24 hour medical cover, so the role of other senior clinical staff in relation to decision making should be considered.

7.19 University College London Hospital NHS Foundation Trust was "unsure" whether hospices should be clustered with hospitals "as the client groups have different needs and pathways"; in a hospice setting, advance decision-making may operate as best practice and be "treated with more sensitivity and with minimal distress to patient and their families". Hospice UK and the National Council for Palliative Care suggested the implementation of a separate "end of life and palliative care scheme", that allowed for in-house authorisation by a multi-disciplinary team.

PSYCHIATRIC HOSPITALS

7.20 A number of consultation responses commented on the position of psychiatric hospitals. DAC Beachcroft LLP considered that a separate scheme in relation to general hospitals and psychiatric hospitals could "indirectly reinforce the stigma which is associated with treatment for mental disorder", and would mean that the use of the Mental Health Act could be ignored altogether in a general hospital setting since this Act "is generally poorly understood in general hospitals".

7.21 The Royal College of Psychiatrists also described proposal not to include psychiatric patients from the scheme proposed for hospitals and palliative care as a "retrograde step for parity of esteem between mental and physical health".

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).

7.22 There was no overall majority in the response to this proposal, but the largest number of consultees disagreed.[79]

THE 28 DAY TIME LIMIT

7.23 Responses from consultees who disagreed tended to focus on the 28 day time period. For example, Dr Caroline Barry (palliative medicine) argued that 28 days was too long for the following reasons:

> I think the danger is that the system will work backwards; that patients who are non-compliant with medication or treatment DoLS will be sought to ensure that an individual stays in hospital. A 28 day detention in an acute unwell person with terminal illness is likely in many cases a de facto decision for them to die there.

7.24 The Court of Protection Practitioners Association commented that the 28 day limit did not pay sufficient regard to "cases where restrictions are increasing to high level interventions by way of movement control such as tying them down to a hospital bed, binding of hands or sedation". Professor Richard Beale (Chair of the London Adult Critical Care Operational Delivery Networks' Steering Group) commented that in practical terms the need to notify the local authority at 28 days would create "an unnecessary paper trail which will be challenging to administer".

7.25 Some consultees suggested shorter periods of time: 23 consultees suggested up to 14 days; 20 consultees suggested up to seven days; and 15 consultees suggested up to 72 hours. For example, South West London and St George's Mental Health NHS Trust argued that a 72 hour time limit would mirror the powers of section 5(2) of the Mental Health Act and allow for further assessment to be carried out.

7.26 Some consultees considered that 28 days was an appropriate length of time before an assessment by an Approved Mental Capacity Professional was required. According to King's College Hospital NHS Foundation Trust:

> Currently, the period of seven days for the "self-issue" by way of an urgent authorisation is too short, and does not reflect the reality of a significant number of acute admissions. The Trust is also confident that such a proposed system has adequate in-built safeguards:

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[79] 287 consultees expressed a view on this proposal: 86 agreed, 119 disagreed and 82 held equivocal positions.

7.27 David Flood (adult safeguarding nurse) argued:

> Clearly there is the possibility that at some point an extended stay with significant restrictions would benefit from (external) scrutiny but these cases are rare and usually highlighted to parties such as myself due to their complexity.

7.28 Some consultees, whilst having concerns about the 28 time limit, agreed that it could be utilised alongside a robust review process. According to Kent Community Health NHS Foundation Trust:

> Self-authorisation to deprive a patient of their liberty in the hospital setting is a useful tool in order to effectively care for some categories of patients. Such authorisations are required for a relatively short period of time. 28 days may be too many days in a lot of cases and therefore the guidance should clearly set out review dates within the 28 day period to ensure that the deprivation of liberty is still required and proportionate.

THE ROLE OF HEALTH STAFF

7.29 Many consultees who disagreed with this proposal were concerned about the lack of understanding of the Mental Capacity Act amongst health staff. Hertfordshire County Council argued that capacity and best interests in these circumstances will be poorly recorded and relate solely to medical decisions. It suggested a very short authorisation be available to medical practitioners only for the time when the person is receiving medical treatment and that, at the point at which they become medically fit for discharge, an Approved Mental Capacity Professional become involved in their case.

7.30 Wakefield Council Adults Health and Communities disagreed with the proposal in the following terms:

> Previous experience has been that medical staff can misunderstand their role and have difficulty in differentiating between clinical / treatment decisions and consent / compliance and capacity issues. For example, they think that as they have prescribed something for a person, the person should accept it and as they wouldn't suggest an intervention unless it was in the person's best interest, they see the person's refusal to accept the treatment proves a lack of capacity. Thus their assessment of capacity is flawed.

7.31 Derek Boothby (MCA lead) stated that he had:

> Experience on an almost daily basis of medical staff misunderstanding their role, doctors in particular would have a great deal of difficulty differentiating between the clinical / treatment decisions and the consent / compliance and capacity issues, 28 days is too long a timeframe in which this could be wrongly applied.

7.32 Similarly, the response submitted from a conference for service users at Croydon Council and Croydon CCG told us that health professionals are just as open to make errors of judgement as others and should not have additional authority in this way.

7.33 Paul Greening (MCA manager) suggested a role for a named person in each hospital (with a similar standing to an Approved Mental Capacity Professional) who would have to “sign off” any deprivation of liberty approved by a doctor, alongside “a clear statutory duty for both the hospital trust and the CCG to oversee the new process”:

> This might ensure medical practitioners would be challenged if not performing the role effectively. The model often used for “psychiatric liaison” services within general hospitals might be helpful here – as they are part of the hospital and so can respond quickly and flexibly yet independent from the ward and immediate clinical team – with separate supervision and management structures.

SUPPORT FOR A HOSPITAL SCHEME

7.34 Consultees who supported this proposal tended to focus on the practical benefits. For example, the NUTHFT MCA and DoLS steering group stated:

> We welcome the proposed approach for hospitals, which would essentially reduce the bureaucratic burden generally and specifically reduce the case load of what we perceive to be unnecessary DoLS authorisation applications in relation to patients who are in hospital because they are ill and temporarily (in most cases) lack mental capacity to agree to remain in hospital. In these cases the discussion around DoLS does not add to their care management, and does not appear necessary in relation to protecting them from being deprived of liberty in a meaningful sense.

7.35 The Royal Hospital for Neuro-disability noted that currently the majority of its patients were not being assessed by a best interests assessor within the statutory time limits for the DoLS. Similarly Queen's Hospital, Burton, Staffordshire argued that the proposed scheme would be more appropriate than the current situation where patients currently have unauthorised DoLS due to a lack of best Interest assessors being available.

7.36 The Royal College of Anaesthetists supported this proposal, and commented that further guidance would be needed as to the minimum qualifications required of the registered medical practitioner and that it “would be useful for all medical personnel to have a template for the assessment and also a standardised letter to hospital managers”.

GENERAL COMMENTS

7.37 Several consultees raised general points in response to this proposal. For example, the Old Age Faculty for the Royal College of Psychiatrists agreed that safeguards are needed but felt that “focusing upon freedom to leave is the wrong target”. It went on to suggest that:

> Acknowledgement is needed that mental and physical illnesses can impair mental capacity and that medical treatment and care are priority rather than restrictions or deprivations. If a time period is needed, 90 days rather than 28 days more accurately reflects recovery from conditions that can cause acute and temporary confusion.

7.38 The British Geriatric Society questioned:

> whether an uncontested hospital stay for the express purposes of medical investigation and treatment for up to 28 days constitutes a true deprivation of liberty,

> and whether such an otherwise uncontested hospital stay is simply an inevitable consequence of acute medical illness.

7.39 Dr Kezia Lange (psychiatrist) informed us about how the DoLS are implemented on the ground:

> Our hospital has a pragmatic guidance which suggests that if the incapacity is likely to continue (or has continued) for seven days, then an urgent DoLS authorisation must take place. Most patients will have regained capacity long before seven days.

7.40 Dr Lange called for this to be enshrined in the code of practice, and explicitly extended to psychiatric hospitals.

7.41 An anonymous consultation response pointed to the specific issues that can arise in hospice care:

> In hospices it will not be feasible to have one medical practitioner who certifies a deprivation of liberty and one who is the responsible clinician. Most hospices have a small number of consultants and it would not be possible to have a distinction between the two. They would need to be the same person. The responsible clinician (the consultant responsible for the patient during their inpatient stay) will know the patient best and will be best suited to ensuring appropriate deprivation of liberty decisions are made. Decisions should be reviewed through the hospice governance structures. It would not be effective to routinely have reviews by a consultant from another hospice, but these colleagues would be available in cases where clear second opinion needed.

7.42 Dr Jonathan Waite (psychiatrist) reported that:

> It is distressing to report that in acute hospitals extreme levels of restraint (sometimes employed by security guards with minimal training in capacity issues) are not uncommonly used. Other techniques employed include shackling, the use of “boxing glove” dressing to prevent patients removing drips, the forcible insertion of naso-gastric tubes to a resisting patient and other invasive medical techniques may be employed without the staff involved having adequately considered human rights issues.

7.43 Bristol City Council commented on the need for CQC regulation of any hospital scheme:

> There should be robust regulation by CQC of the scheme in hospitals. There are serious concerns about CQC’s track record of monitoring the use of the Mental Health Act and in terms of general regulatory practices in health settings. In addition to the regulation, there needs to be quality control mechanisms by the commissioners.

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)?

7.44 There was no overall majority in response to this question, but the largest number felt that an advocate should always be appointed.[80]

ADVOCACY

7.45 Voiceability argued that it is crucial that an advocate should be available to support the person:

> In our experience the window of opportunity whereby a vulnerable person might return home from hospital is small and is increasingly being missed. Faced with huge pressures to speed up the discharge process vulnerable adults are often being placed in residential settings without due consideration being given to supporting their return home. This is resulting in unnecessary deprivations of people's liberty and costly subsequent legal challenges. Advocates and family members play an essential role in ensuring this life changing moment in someone's care pathway is centred around them. They provide a significant safeguard to that person's rights and play a critical role in scrutinising a care planning process that is under significant pressure.

7.46 There was some discussion as to whether advocacy was "always" appropriate. For example, in a response from a Croydon Council and Croydon CCG conference for health and social care professionals it was suggested that an advocate should be appointed where there is conflict or questionable scenarios or for those without a next of kin. Similarly North West ADASS considered that, given the scarcity of advocacy resources generally, "we do need to make sure we're ensuring 'always' is applied where advocacy is absolutely essential".

7.47 Bracknell Forest Council, however, told us that family advocates are not always aware of their rights and responsibilities and often find it difficult to challenge professionals particularly consultants and doctors. They continued:

> Patients in hospital are routinely subjected to various assessments by professionals involved in their care and treatment and careful consideration about introducing an additional person into the individual's situation would need to be undertaken. Where there is no family or friends to advocate on behalf of the individual an advocate or second medical opinion may provide a sensible safeguard.

7.48 PASAUK told us that:

> An advocate is always appropriate and should only be replaced by a second opinion where there is convincing evidence that an advocate was not suitable. Such a

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[80] 179 consultees expressed a view on this proposal: 83 agreed, 32 disagreed and 64 held equivocal positions.

> situation might be where the treatment is so complex that it would be unreasonable for a competent non-medical professional to understand and make a decision on.

7.49 In the context of end of life care, Francis House Children's Hospice were concerned that an advocate would not be able to play any real role on behalf of a young person for such a short stay. It also pointed to a local shortage of suitably qualified advocates and questioned whether this need could be met, noting that "if an advocate had to be appointed each time a respite visit takes place then the costs involved could be significant".

7.50 Dr Stephen Brett (President of the Intensive Care Society), who disagreed with the question, commented:

> With regard to the […] critical care perspective, I do not believe the addition of some external advocate will provide any real benefit or additional safeguard to patients. It is likely to lead to a cumbersome and potentially disproportionate administrative workload.

7.51 Passing comment on the issue of resources, London Borough of Sutton told us that they supported the appointment of an advocate in all hospital cases, but were not clear how this will be funded and particularly if local authorities are expected to fund the costs of advocacy.

SECOND MEDICAL OPINIONS

7.52 A number of consultees supported the idea of a second medical opinion. EKHUFT Trust stated:

> A multi-professional second opinion would be far better. In an acute hospital setting it may not be immediately clear whether it is the Mental Capacity Act or the Mental Health Act being required.

7.53 Paul Greening (MCA Manager) was in favour of a second opinion as part of the authorisation process but did not think that this necessarily needed to be from another medic. He suggested that this could be a role for a specialist professional akin to an Approved Mental Capacity Professional (possibly in line with the current psychiatric liaison role) employed by the hospital but independent of the ward.

7.54 Other consultees called for flexibility and a case by case consideration of appropriate safeguards. According to Bedford Borough Council:

> A second medical opinion could be appropriate in some cases and CCGs may wish to appoint or identify a person or system that could provide this additional safeguard. The key however is to ensure that medical opinion is informed by the Mental Capacity Act and best interests process.

7.55 St Helens and Knowsley Teaching Hospitals NHS Trust had concerns regarding the resource implications of obtaining a second medical opinion:

> Obtaining a second medical opinion is likely to incur very substantial costs as currently the system is optimised to ensure maximum efficiency from senior medical staff. An

> advocate alone should be sufficient. If 14 intensive care patients will require a second medical opinion then there is nothing like the available resource to facilitate this.

7.56 The response from the Law Society's Mental Health and Disability Committee supported a requirement of a second medical opinion in intensive care units:

> The purpose we would suggest is to keep under consideration whether the deprivation of liberty is still necessary in order to carry out the treatment in the patient's best interests. If, for example, a patient continually pulls out 'lines' or intravenous feeding tubes, it may be necessary to restrain the patient for a considerable length of time in order to ensure the patient receives the necessary treatment. Only a medically qualified person will be able to review the care plan and confirm that the treatment is necessary and in the best interests of the patient and can only be delivered if the patient is deprived of his or her liberty.

GENERAL COMMENTS

7.57 We received a variety of responses which did not address directly one of our provisional proposals or questions in this chapter but nevertheless were relevant to the proposed hospital scheme.

7.58 Many reported existing problems faced by hospitals under the DoLS. UHL Adult Safeguarding Team and BIAs told us that a new DoLS application would have to be completed when an individual is transferred across different sites within the same Trust, which they described as "unhelpful". Helen Turton (best interests assessor and Approved Mental Health Professional) pointed out that currently there is a "doubling up" of the work when an application for a DoLS authorisation is made by a hospital for a patient who is in receipt of medical treatment but waiting future placement in a care home. An in-depth assessment is undertaken to authorise hospital stay, but it does not address the future placement, and consequently the family are consulted twice.

7.59 Several responses focused on the situation in intensive care units. Paul Harper (MCA and DoLS Lead) noted that by definition patients in these settings are very unwell and that the DoLS "seems an unhelpful and insensitive intrusion" in these settings and "in practice few applications are made". He suggested that:

> If all relevant parties including family, friends and advocate agree that the deprivation of liberty is in the person's best interests and that no less restrictive options are available then an application should not be required.

7.60 The Faculty of Intensive Care Medicine and Intensive Care Society's Legal and Ethical Policy Unit felt that intensive care units should be included in the broader hospital scheme, since this would allow the movement of patients within a hospital without the need for an entirely separate process.

7.61 On the issue of terminology, Dr Stephen Brett (President of the Intensive Care Society) thought that we should change the term "intensive care" to "critical care" as the term "critical care" is now used to encompass what used to be called high dependency or level 2 care:

> Many of the issues of relevance also occur in high dependency units and in fact often many disturbed patients after head injury or neurological disease are cared for in what would be termed as a level 2 manner.

7.62 Several consultees commented on the need for training, generally, of health staff. For example, Camden Council and Camden Safeguarding Adults Partnership argued that many doctors, including senior clinicians, have limited knowledge of the Mental Capacity Act and needed to become “considerably more competent in issues of mental capacity”. Wakefield Council commented that there are “questions around the availability and requisite level of knowledge of the doctors needed for the scheme as the majority will not be specialists in the field”.

7.63 We also received some several comments about the challenges clinicians face in hospital when patients have fluctuating capacity.[81]

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[81] We have prepared a separate consultation analysis document on this issue. Consultation analysis, para 16.10.

Chapter 8: 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.

8.1 A majority of consultees agreed with our proposal.[82]

8.2 Consultees generally agreed that advocacy is an important and necessary safeguard. For example the National Autistic Society noted that "well-trained advocates have a vital role to play in ensuring that individuals' needs and wishes are fully considered at every stage of care planning". Voiceability (advocacy provider) argued that the important of advocacy is highlighted in cases where local authorities have breached human rights law such as *London Borough of Hillingdon v Neary*.[83] The Advocacy Centre North considered that the proposals are an "ideal opportunity to strengthen individual's rights to access independent advocacy and that further actions need to be taken to make this right a reality".

8.3 Many consultees raised concerns about the funding necessary in order to provide an effective advocacy service. For example, Independent Age welcomed the proposal and argued that as the new scheme places such high importance on provision of advocacy, "relevant Government Departments will need to make adequate resource provision for advocacy at a time of severe financial pressure on local government".

8.4 Many consultees pointed out that the current provision of advocacy is under-resourced. For example, Sarah Rochira (Older People's Commissioner for Wales) stated that the "lack of referrals to Independent Mental Capacity Advocacy services by professionals is an issue my casework and scrutiny team has identified too often". Sunderland City Council reported that at present advocacy services cannot meet demand and are operating waiting lists.

8.5 Professor Julian Hughes (psychiatrist and academic) and Charlotte Emmett (law lecturer) supported our proposal, whilst also noting that:

> Our experience suggests that the quality of the support offered by advocates can vary considerably case by case. Without uniform standards applicable to advocates the appointment of an advocate may well not improve a person's outcomes.

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[82] 198 consultees expressed a view on this proposal: 124 agreed, 16 disagreed, whilst 58 held equivocal positions.

[83] *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584.

8.6 Joanna Burton (solicitor and trainee advocate) argued that a person who lacks capacity to make health and well-being decisions should have a statutory right to an advocate irrespective of whether they have friends or family who may be appropriate:

> Having an independent advocate ensures that the individual's autonomy is fully acknowledged and respected and their wishes and feelings brought to the table untarnished by the views or opinions of others however benign or well meaning. It also removes the issue of the family member or friend from feeling rebuffed or "not chosen" or considered "inappropriate".

8.7 There was some support for an automatic right to advocacy. For example, Voiceability argued that an "opt in" service would leave "the very people who most need [help] – and cannot "opt in" – without support". However, the Department of Health and Ministry of Justice stated that:

> The benefits of advocacy are potentially great for some but the Department does have concerns of the imposition of advocacy. The role of support from family and friends may be more appropriate and beneficial for some individuals.

8.8 A small number of consultees disagreed with our proposal. For example, Bury Council and Bury CCG did not support "blanket advocacy" in all cases as "this could be seen to disempower friends and family who are more than capable of acting as an advocate". Dr Jonathan Waite (psychiatrist) argued that:

> In the real world there is a limited local authority budget for care. The resources for advocacy will have to come out for this finite budget, so any resources for providing advocacy will result in less being available to fund care provision, resulting in worse care facilities.

8.9 Esther Hack (mental health workforce development officer) noted that:

> Consideration should be given to whether it is really helpful for the person involved. Another interview asking questions may be a burden. It is important that our concern with human rights does not get in the way of listening to the person … There is an argument that organisations such as local authorities should be able to properly listen to people's views and take them on so that advocacy should be unnecessary. If the money spent on advocacy were spent on creating a good service this might be a more effective way of meeting people's needs. With a responsive service, advocacy should only be needed in a small minority of cases.

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.

8.10 A majority of consultees agreed with our proposal.[84]

8.11 For example, SEAP (advocacy provider) argued that referrals will be made easier under our proposals, because:

> Professionals will know to refer to an advocacy provider without having to decide which specialism to use. This currently causes confusion and wastes valuable time for the person as referrers and providers debate whether a referral is appropriate. If inappropriate then the referrer has to look for another provider who could potentially advocate for their client. The new system will make things easier and would improve the use of advocacy by ensuring that there is one point of contact for referrers, referrers knowing their client will be dealt with by experienced advocates and increasing the opportunity for the person to make changes to their lives more swiftly.

8.12 Glenn O'Halloran (advocate) argued that "it must be best practice for the person to have one multi skilled advocate rather than a possibly two, three or four" and that advocates "should be able to support the client through the process from start to finish". Living Options Devon (advocacy provider) argued that the proposal would "ensure a smoother and more consistent service for the client, enabling them to build a relationship with one advocate rather than two (or more)". An anonymous response from an independent advocate noted that:

> Sometimes I find people are passed like a "hot potato" from one advocacy service to another because they don't meet the criteria of a particular service. This can mean a delay in the help. There are too many types of advocacy service at the moment and it can get confusing with regards to who does what.

8.13 The Older People's Advocacy Alliance argued that:

> A streamlining of statutory advocacy could result in older people having a better experience of access to advocacy and advocates could benefit from greater clarity of roles. A big positive from our reading of these proposals relating to advocacy particularly is that they are supportive, person centred and they are in tune with human rights, this is very encouraging.

8.14 Some consultees pointed out that many advocates were already combining roles. For example, Glenn O'Halloran noted there are already some advocates working as both

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[84] 202 consultees expressed a view on this proposal: 121 agreed, 41 disagreed and 34 held equivocal positions.

independent mental health advocates and independent mental capacity advocates, whilst Bill McMellon (best interests assessor) noted:

> In practice the same advocates are likely to be carrying out the different roles anyway, because their employers will have contracts covering both areas of work so it might just as well be streamlined in some way.

8.15 Some consultees agreed with our proposal, while emphasising the need for advocates to retain specific competencies and skills in relation to each statutory role. For example, the London Borough of Barking and Dagenham Council argued that within our proposal "all advocates must reach a common standard of competence and skill, and all must be Mental Capacity Act – compliant". Similarly the PASAUK stated that there is still the need for specialist advocacy services and it "would not support the loss of such services as the Independent Mental Capacity Advocate and the Independent Mental Health Advocate".

8.16 Your Voice Counts (advocacy provider) agreed with our proposal, while also emphasising the resource implications:

> Advocates will need to be expert in and be multiply qualified in different roles and legislation and able to challenge health and social care professionals whom we know often have very poor understanding of, or willingness to adhere to, that legislation. Already under-resourced advocacy services would need to be in a position to recruit sufficiently and to put their staff through various costly qualifications.

8.17 A number of consultees disagreed with our proposal. For example, Manchester Think Quality and Partnership Board Group stated that:

> We are concerned that the proposal for one type of advocacy only will limit the amount and the choice for people. An advocate needs to be able to spend time getting to know someone. Some people might prefer a peer advocate or a citizen advocate instead of a strange woman with glasses. Life is messy so why can't advocacy be messy too. There is too much standardisation of the lives of people with disability. The advocacy movement has been curtailed since the Care Act.

8.18 Pohwer (advocacy provider) felt that "well trained, qualified, specialist advocates provide a safeguard for clients which would be lost in a more generic, potentially less focussed, role". Similarly, Devon and Torbay Independent Mental Capacity Advocacy Service argued that the proposal would undermine specialist roles and knowledge:

> Independent Mental Capacity Advocates have been gaining valuable experience of acting as litigation friend and are ensuring that their clients have access to the Court of Protection. Independent Mental Capacity Advocates must keep abreast of case law around the Mental Capacity Act and DoLS as part of their everyday advocacy work and, essentially, due to their involvement in court proceedings.

8.19 A number of consultees pointed to a concern that local advocacy providers would lose contracts as a result of our proposals. For example, Tom Hore (director of Bristol Mind) argued that:

> There is also a risk that if all these roles are subsumed under one title, then they will be packaged to be delivered under one contract. The awarding of single contracts for all types of advocacy has been shown to favour the larger national (non-local) providers, which would have the effect of reducing the diversity in the field.

8.20 A number of consultees argued that the Care Act is recent legislation and has not fully been embedded, and therefore our proposal was premature. Dorset Advocacy further argued that Care Act advocacy is not based primarily on a best interests model and advocacy under the Mental Capacity Act was therefore “a wholly different conceptual framework”.

8.21 Some consultees took the opportunity to make more general comments. For example, a number of consultees (including the Care Council for Wales) noted that the role of advocacy under the Social Services and Well-being (Wales) Act 2014 needed to be considered. A number of consultees were concerned that in Wales the role of advocacy had been “watered down”.

8.22 A number of responses pointed out that, whilst the legislative provisions were different, in practice most advocates undertook a similar role of representing and supporting the person.

8.23 Voiceability (advocacy provider) argued that family members should be able to approach advocacy services directly when their relative is subject to protective care and questioned whether this proposal would improve people’s access to advocacy. They noted greater access:

> Would be in line with the House of Lords MCA Select Committee recommendation 24: “We recommend that the Government consider the establishment of a form of self-referral for IMCA services to prevent the damaging delay that occurred in the case of Mr Steven Neary”.

Question 9-3

Should the appropriate person have similar rights to advocates under the Care Act to access a person’s medical records?

8.24 A majority of consultees agreed that the appropriate person should have similar rights to advocates under the Care Act to access a person’s medical records.[85]

8.25 For example, East Sussex County Council argued that:

> In principle an appropriate person should have similar rights to an advocate because they have either been chosen by the person or appointed by [the local authority]. We believe that these rights should relate to all relevant personal records and in particular the provider’s records. We don’t agree that it should just be about medical records.

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[85] 147 consultees expressed a view: 93 said ‘yes’, 15 said ‘no’, whilst 22 held an equivocal position.

8.26 The National Family Carer Network supported the appropriate person having access to medical records, noting that:

> We have heard of “data protection” and “confidentiality” being cited as reasons not to allow family carers to see records; sometimes this may be justified of course, particularly for example where an individual has made an advance statement about not wishing certain people to have access. However, we think that staff do not always think through how to apply “best interests” principles to information sharing. In particular we are aware that it is sometimes necessary to remind staff of the important Caldicott principle about the dangers (to the individual and / or others) in some circumstances of not sharing information.

8.27 Pohwer (advocacy provider) argued this:

> Allows the appropriate person to have access to all relevant documentation to allow them to more adequately support “P”. Family and friends are often of the view that they are disadvantaged in their representation of “P” by not having access to the same documentation as an advocate. This proposal is empowering for the appropriate person and is therefore by definition empowering for “P” too.

8.28 Several consultees emphasised that safeguards should be put in place. For example, London Borough of Barking and Dagenham Council argued for “a clear mechanism to identify conflicts of interests between the individual and the appropriate person”. Hywel Dda University Health Board stated that the appropriate person should only be able to access relevant information and should not have “unrestrained access”.

8.29 Some consultees (for example, n-compass advocacy) argued that the appropriate person should also have access to social care records.

8.30 A small number of consultees argued that the appropriate person should not have similar rights to access a person’s medical records. South Gloucestershire IMCA service argued that:

> We do not see that it would be a good idea for a family member to have these sorts of untrammelled rights to access a person’s medical records. There can be a huge amount of conflict for a family member in this position. There is a danger, when there is a right enshrined in law, that the holders of such records simply give unfettered access. This may mean that a family member gains access to information that they do not want to see; that the relevant person does not want them to see; or that it is not in the relevant person’s best interests for that person to see.

8.31 Some consultees argued that the existing legislative framework for information sharing is sufficient. For example, the Court of Protection Practitioners Association argued that:

> We cannot see the need for changes or additional legislation given the Data Protection Act and Mental Capacity Act enable the sharing of information with others when it is in their best interests, where the person has the capacity to consent to the sharing of information, they can stipulate this themselves without additional legislation required.

8.32 Some consultees made comments on the question without taking a firm view. For example, Brent SAB argued that:

> Family members are already able to access information under current mechanisms within the Mental Capacity Act (e.g. Lasting Power of Attorney or deputyship). It is important to ensure any new statutory scheme builds on those mechanisms rather than duplicate or dilutes these because they contain important safeguards for individuals. Ideally family members acting in the role of appropriate person would have legal authority to make decisions on behalf of the person. If they are unable/ unwilling to apply or the individual has indicated that they would not wish for them to act in this capacity, then they must still be consulted on the proposed treatment / care as a best interest consultee, but might not be best placed to act as the appropriate person.

8.33 Some consultees highlighted the position in Wales under the Social Services and Well-being (Wales) Act 2014. For example, the Welsh Government noted that:

> The right of an Advocate to access medical records does not exist in Wales as this is not prescribed in the Social Services and Well-being (Wales) Act 2014. It was not felt necessary to legislate in respect of this issue but views on this from the wider consultation would be welcome.

Question 9-4

Should Independent Mental Health Advocacy be replaced by a system of Care Act advocacy and appropriate persons?

8.34 No overall majority view was reached on this question, but the largest number of consultees thought that Independent Mental Health Advocacy should be replaced by a system of Care Act advocacy and appropriate persons.[86]

8.35 For example, the CQC stated that:

> We are aware that in some services the roles are already combined and, provided that sufficient training is given and there is sufficient capacity, this can work successfully. The advocates have a greater understanding of how the two Acts interface, and the advantages and disadvantages of both regimes. Individuals, their carers and staff benefit by only needing to be in contact with a single service, and there may also be the potential for some cost-saving by pooling resources.

8.36 Some emphasised the need to retain expertise if Independent Mental Health Advocacy is replaced. For example, West Berkshire District Council stated that:

> Streamlining makes sense providing the capacity and skill set is available in sufficient quantities. We recognise that Independent Mental Health Advocates and Independent Mental Capacity Advocates fulfil very different roles and require precise knowledge of very different legislative frameworks. Any streamlining must ensure the very specialised roles of advocates in varying settings are considered and accommodated.

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[86] 156 consultees expressed a view on this question: 43 said “yes”, 33 said “no” and 24 held equivocal positions.

8.37 Halton Borough Council expressed qualified agreement with the question:

> In principal, to reduce the shortfall in available advocates, the proposal to create Care Act Advocates, who work across Mental Health and Mental Capacity, is a good one. In the short-term however there would be an increased training need for these individuals and it is not clear how this is to be met. The Independent Mental Health Advocate provides a key role under the Mental Health Act and we would not want to see this role diluted.

8.38 One third of consultees argued that Independent Mental Health Advocacy should not be replaced. For example, Tom Hore (Director of Bristol Mind) stated:

> I feel that it also conflates two differing types of advocacy role; the Independent Mental Health Advocacy role is set up as a safeguard for people subject to legal provisions allowing for their detention, or significant restrictions to their liberty; whereas the Care Act advocacy role is more of an empowering role supporting decision-making within the realm of access to services. Whilst it may be that advocates may be able to deliver both types of service, having one single role may dilute expertise, and create a confusion for others involved.

8.39 Aaron Lohan (advocate) argued that appropriate persons may lack knowledge of the Mental Health Act, and:

> An appropriate person may take the opinion that the patient needs to be detained and that it is in their best interests to remain detained, whereas the patient may want to appeal his detention, this would create a conflict of interest.

8.40 Some consultees queried whether access to an advocate when detained under the Mental Health Act would be restricted if Independent Mental Health Advocacy were replaced. For example, Empowerment Matters stated that:

> Independent Mental Health Advocacy is currently the only statutory advocacy that does not consider having family or friends or whether the person may lack capacity as a criterion … Access to an Independent Mental Health Advocacy currently is purely based around the individual’s detention and whether they wish to access the support of an Independent Mental Health Advocacy or lack capacity to instruct one which therefore affords them further rights under the Mental Health Act regardless of issues of capacity.

8.41 A number of consultees took the opportunity to make wider comments about the role of the Independent Mental Health Advocate. For example, the CQC stated that:

> There is little regional or national oversight of the Independent Mental Health Advocacy role, as no common activity reporting is required. We would suggest that any new system of advocacy should come with the introduction of a centralised data collection to enable such oversight.

8.42 Some argued that rights to advocacy in England should be extended along the lines introduced by the Mental Health (Wales) Measure 2010. For example, Empowerment Matters argued that:

> We would support a change that was in line with the role of Independent Mental Health Advocate in Wales that recognises the right to advocacy for a person that has a mental disorder regardless of their status under the Mental Health Act as this would be more inclusive and enable contracts, where there are restrictions on who advocates can work with, to be more flexible and achieve greater equality.

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.

8.43 No overall majority view was reached, but the largest number of consultees agreed with our proposal.[87]

8.44 A number of consultees highlighted the importance of the relevant person's representative. For example, Judy Weiner (independent mental capacity advocate) stated that:

> The relevant person's representative (or paid representative) currently can have the most effective role in changing a restrictive situation for a person in a care or hospital setting. Following a DoLS authorisation, many managing authorities do not pay heed to conditions set until a new review is required. Regular visits by a paid representative or relevant person's representative ensures that improvements have been made for that person if they were stated necessary or notes if a situation has changed. Unlike the Independent Mental Capacity Advocate 39A the ongoing relationship over several months duration by the regular visits of the paid representative or relevant person's representative gives more insight into a person's needs and if they are met in their placement.

8.45 Voiceability (advocacy provider) agreed with our proposal, and went on to highlight the value of the section 39D advocate who is appointed to support the relevant person's representative. They reported that when a section 39D advocate becomes involved "it is often the first time someone has taken time to explain the Mental Capacity Act to them", including the DoLS process, the assessment process, and how to request a review and make an appeal.

8.46 A number of consultees disagreed with our proposal. For example, Vincent Duffy (DoLS team leader) stated:

> I believe the family's views will in most cases be essential in balancing a best interests decision and I firmly believe this to be an ongoing requirement of the process. However, I do not believe that they should require formal appointment under the title

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[87] 142 consultees expressed a view on this proposal: 71 agreed, 24 disagreed, whilst 47 held equivocal positions.

> of “relevant person’s representative”, their views in the process should be a requirement. Remove some of the bureaucracy where possible.

8.47 Some consultees disagreed with our proposal because of perceived duplication of roles with our proposed system. For example, Thames Valley Safeguarding Network argued that “it would make more sense to appoint an advocate in each case and remove the role of the relevant person’s representative”. Brent SAB argued that it would be more logical to replace the relevant person’s representative “with a similar scheme of an appropriate person so that this mirrors the provision available to those who qualify for support under the Care Act”.

8.48 Some consultees argued that the role of the relevant person’s representative should be altered. For example, South Gloucestershire IMCA service argued that currently the role of the relevant person’s representative is “inherently conflicted” given that the family member (or friend) is highly likely to have been heavily involved in the planning of the relevant person’s care and accommodation arrangements, but as a representative they must “adopt a rights based approach and take action to enforce these rights, even if they believe this is not in the person’s best interests”. It argued that the role should be reformed so that the representative still has a right to challenge the authorisation if they think there is reason to do this.

8.49 Some consultees took the opportunity to comment more generally on the role of the relevant person’s representative. For example, a group of BIAs from East Sussex stated that:

> Family members too often feel scared to raise a challenge with the care home / ward for fear of making the situation worse for their loved one. They also report that they prefer to be the husband / wife, not the representative responsible for challenge and scrutiny. That said, many family members who do decide to take on the role do so remarkably well and work hard to ensure the home / ward uphold freedom by lesser restriction for the person. The home / ward see and respond to the relative in a new light with the title of representative.

8.50 Kelvin Skidmore (best interests assessor) stated that:

> Within the current *DoLS Code of Practice* when a relevant person’s representative is identified it is a “singular person”. I have had requests from families in the past that both parents would like to share this role but within the current regime this is not strictly possible. I also feel there would be no harm in “P” having two different family members as joint relevant person’s representative for instance. It would seem an oversight in the original code of practice as within other legalities such as “Power of Attorney” courts are able to grant joint representation.

8.51 A small number of consultees commented that the term “relevant person’s representative” should be changed. The Tri-borough Councils argued that the current name is “a bit of a mouthful and too much like jargon”, so suggested that they should be called the “protective care representative”. PASAUK suggested that the name should be either “protected person’s representative” or “restricted person’s representative”.

8.52 Camden Council and Camden Safeguarding Adults Partnership Board stated that many relevant person’s representatives are not aware of their current powers, and were concerned that they were “not fully utilised as a safeguard to individuals”. It argued for clear guidance to be given as to the expectations of regular contact and the support given to the relevant person.

8.53 Some consultees took the opportunity to comment on other issues, such as on the appointment of the nearest relative under the Mental Health Act. For example, Brent SAB argued that the appropriate person should be appointed following the principles of the Mental Capacity Act based on the person’s wishes and best interests. They stated that:

> The Law Commission might take this opportunity to look at amending the Mental Health Act so that the nearest relative role is determined along the same principles, rather than (as is now required) assume an individual can be supported, during a time of mental health crisis to apply to the courts to displace the nominated nearest relative if they do not wish for them to act.

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.

8.54 It was agreed by a majority of consultees that where there is no suitable person to be appointed as the representative, the person should be supported by an advocate or appropriate person.[88]

8.55 For example, Pohwer (advocacy provider) noted that the effect of the proposal would be the removal of the paid representative role, and stated that the proposal would allow for:

> Continuity of service where there is already an advocate in place and also ensures that the same safeguards are in place for clients at all stages of the proceedings. The paid representative role has been quasi advocacy (many would argue that it is advocacy) and there is no good argument to continue it when robust advocacy provision will be in place.

8.56 N-compass Advocacy Service reported that the paid representative role is in many areas taken up by the Independent Mental Capacity Advocacy service, and that:

> Removing this role would see a more streamlined process and more robust safeguards for the relevant person and would ensure continuity with no “break” in appointment of these roles resulting in an unlawful deprivation.

8.57 A number of consultees questioned whether there could be circumstances where there is no suitable person to be appointed as the representative, yet there is someone

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[88] 128 consultees expressed a view on this proposal: 84 agreed, 15 disagreed and 29 held equivocal positions.

suitable to be appointed as the appropriate person. For instance, Oxfordshire County Council stated that:

> It is very unclear what the difference is between an appropriate person and a relevant person's representative and why would someone not be suitable to be the relevant person's representative but be suitable to be an appropriate person.

8.58 A small number of consultees disagreed with our proposal. For example, West Berkshire District Council stated that:

> We believe this should be a paid representative as per the current system. The current system is fair and would not be enhanced or improved with these proposals.

8.59 A multi-agency response from Buckinghamshire argued that:

> In Buckinghamshire, we have a significant number of these and they have proved to be very successful. They have built up an excellent knowledge and skills base around the role and it would be detrimental to lose them. It is hard to see how an advocate or appropriate person would fulfil that role.

8.60 Vocal Advocacy stated that:

> We see the paid representative role as a necessary safeguard for many extremely vulnerable people. However, we recognise that there has always been an anomaly between the training required to act as a paid representative and the powers afforded to them, such as to access records, and that of Independent Mental Capacity Advocates. We would welcome any proposal which addressed this anomaly while continuing to ensure ongoing support for clients.

8.61 Cambridge House (service and advocacy provider) stated that:

> It is disappointing that the Law Commission proposals fail to acknowledge the work of a paid representative and their role in overseeing and monitoring conditions attached to a DoLS and, where necessary, challenging the DoLS review process.

8.62 Some consultees commented more generally on the role of the relevant person's representative and the paid representative. For example, Amanda Colclough (best interests assessor) stated that:

> I think that the use of paid representatives has lacked guidance under the current scheme and the code of practice gives very little guidance for the role beyond challenging the authorisation and requesting review. I believe that the use of a paid representative for each person subject to the safeguards would be welcomed with a clear role in supporting the person and in monitoring the safeguards and any conditions or recommendations made. This is often something which is not followed through as there is no mechanism for this in place. Sometimes best interests assessors set short timescales for authorisations which mean that there are more frequent assessments, which is incredibly time consuming and resource heavy. Instead it would be preferable for a representative to monitor the conditions and recommendations and be able to have some redress if they are not followed … In my experience relatives have found the role of the relevant person's representative

> confusing and have rarely exercised their rights or supported the person to unless they disagree themselves, which is quite rare.

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.

8.63 A majority of consultees agreed with our proposal.[89]

8.64 For example, South Gloucestershire Council felt that there would be situations where the appropriate person is unable or unwilling to perform all of the representative functions, for example facilitating an appeal. PASAUK stated that the proposal should be extended to require appointment "if there are safeguarding issues involving the person's family or care provider when no family member is available or able to represent them".

8.65 Rachel Ward (independent mental capacity advocate) suggested that:

> There should be strict guidance on who can be appointed or refused appointment in this role. Frequently Supervisory Bodies request paid representatives because family members not approve of the placement. They frequently try and restrict family involvement in order to achieve their own goals.

8.66 Those who disagreed with the proposal frequently argued the appointment of both a representative and an appropriate person would be duplicative. For example, Hywel Dda University Health Board argued that:

> If the person is appropriate to be the appropriate person, then why would someone else be needed as a representative? If the Approved Mental Capacity Professional feels an additional representative is needed, then that would seem to indicate that the appropriate person is not appropriate to be the appropriate person. Too many people would be confusing for all concerned.

8.67 The Bar Council disagreed with our proposal because they believed it was not appropriate for an Approval Mental Capacity Professional to make this decision, and instead it should be made by an independent body or person. Similarly the Law Society's Mental Health and Disability Committee felt that this decision should be left to a "more senior person who is not involved in the delivery or monitoring of a [person's] care".

8.68 The Court of Protection Practitioners Association argued that:

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[89] 106 consultees expressed a view on this proposal: 55 agreed, 23 disagreed and 28 held equivocal positions.

> This proposal is akin to that of the 39D Independent Mental Capacity Advocate role and the discretionary element of that has led to problems. Best practice guidance and the Department of Health have always stated that the 39D Independent Mental Capacity Advocate role should be an automatic referral to at least afford P and their representative with the opportunity to understand it further as well as the Mental Capacity Act itself. Where this has not been an automatic referral, issues have arisen such as P wishing to challenge their deprivation of liberty but where the representative does not think they should, they have been unable to. This proposal therefore does not change that. We do however believe that if representatives are given specific responsibilities and there is a level of accountability overseen by the Approved Mental Capacity Professional then P is ultimately afforded more of a safeguard.

8.69 Some consultees took the opportunity to comment more generally on the relationship between the relevant person's representative and the appropriate person. For example, Durham County Council stated that:

> There needs to be clarity regarding the role of the relative person's representative and how this links to the appropriate person and Care Act advocate. Consideration needs to be given to the appointment of a relative person's representative if the person who is the appropriate person would not be able to fulfil the necessary function.

8.70 A number of consultees believed that too many individuals were involved in representing the person. For example, Denbighshire County Council pointed out that the person could be represented by, for instance, an advocate, "relevant person's representative" and appropriate person, which could become "complicated for the practitioners and professionals involved but even more so for the relevant 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.

8.71 No overall majority view was reached, but the largest number who expressed a view agreed with our proposal.[90]

8.72 For example, Pohwer (advocacy provider) stated that:

> There have been instances (notably "AJ"[91]) where the representative has not acted in the person's best interests. Pohwer would argue that the proposals should go further and should insist that the Approved Mental Capacity Professional monitor the performance of the representative, not just their level of contact.

8.73 N-compass Advocacy Service stated that:

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[90] 129 consultees expressed a view: 55 agreed, 44 disagreed and 30 held equivocal positions.

[91] *AJ v A Local Authority* [2015] EWCOP 5, [2015] 3 WLR 683.

> Without this additional responsibility within the process there would be a gap that would need to be addressed to ensure protection for the relevant person in the process.

8.74 Some consultees agreed with our proposal, while suggesting modifications. For example, Paul Greening (MCA manager) stated that this role should be able to be delegated to others at the discretion of the Approved Mental Capacity Professional.

8.75 A number of consultees disagreed with our proposal. Frequently resource considerations were cited. For example, Vincent Duffy (DoLS team leader) argued:

> This would be taking a specialist resource and over loading it with long-term responsibility regarding the case. The impact this would have is that the Approved Mental Capacity Professional would not be able to consume the volume of assessments as currently.

8.76 The MCA / DoLS London Network pointed to the existing shortages of trained best interests assessors and argued:

> Rather the ongoing monitoring of the relevant person's representative should be reviewed by the care team allocated to the person. These cases should be reviewed more regularly, perhaps every six months than just once a year according to local authority annual care reviews.

8.77 The Tri-borough Councils argued that a monitoring role "would be far too onerous for the Approved Mental Capacity Professional and might be intrusive", and suggested that:

> The advocate is well-placed to report back on any issues with the representative (if the representative is paid then no monitoring is needed). The Approved Mental Capacity Professional can also check on this at the reviews they schedule.

8.78 West Sussex County Council argued that, in the light of the resource implications, the duty should be on the provider to contact the local authority if a representative or advocate is not fulfilling their role. Similarly, Bury Council and Bury CCG argued that the managing authorities should monitor the relevant person's representative and ensure that they maintain contact. Nottinghamshire County Council suggested that the CQC should be able to impose sanctions if the managing authority failed to monitor the representative adequately.

8.79 Safeguarding Adults Board National Chairs Network stated that:

> Whilst the Law Commission are correct to highlight that managing authorities do not often realise that this is their role under the current regime it would be counterproductive to require the Approved Mental Capacity Professional to proactively monitor contact …[The] CQC have reported that the changes they have made in the last year to their inspection regimes has afforded them greater opportunity to scrutinise providers' understanding of their duty of care in respect of deprivations of liberty and this should be encouraged by ensuring any new regime places continued emphasis on the duty of care. On a practical level care providers should also be required to monitor contact and report any concerns regarding the representative to

an Approved Mental Capacity Professional who could then re-evaluate whether a particular person continues in that role.

Question 9-9

Does the role of relevant person's representative need any additional powers?

8.80 The majority of consultees argued that the role of relevant person's representative does not need any additional powers.[92]

8.81 A significant number of consultees who argued against additional powers suggested that other changes could be made to bolster the role. For example, Stephen Ward (MHA and MCA lead) stated that:

> I do not think the role of relevant person's representative needs additional powers – what is needed is a simpler appeals process and better support for relevant person's representatives to ensure that, where required, appeals are made on behalf of the relevant person.

8.82 Many felt that more training, information and support is needed. For example, Bill McMellon (best interests assessor) stated that:

> I don't believe they need additional powers, but they certainly need additional training and support. In an ideal world, with an unlimited supply of advocates, I would have a paid representative for every authorisation. It seems to me that the role can only be carried out properly by someone who understands both DoLS and the Mental Capacity Act well. Such people are in short supply.

8.83 The London Borough of Barking and Dagenham Council suggested that:

> The relevant person's representative will need additional support and information, not additional powers, in order to enable them to access the judicial process when necessary.

8.84 A number of consultees argued that the role of relevant person's representative does need additional powers. A range of additional powers were suggested, but the most common were:

(1) the right to appeal against the deprivation of liberty;

(2) the right to access health and social care records;

(3) the right to request a review of the placement; and

(4) the right to discharge the person from the new scheme.

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[92] 122 consultees expressed a view: 30 said "yes", 75 said "no" and 17 held equivocal positions.

8.85 Other suggestions for additional powers were made by consultees. For example, Brent SAB argued that:

> The appropriate person should be able to apply, on the person's behalf, for legal aid where appropriate. Where they take on the role as litigation friend and act reasonably within proceedings mechanisms should be in place to protect them from costs.

8.86 Mencap argued that the relevant person's representative should have the power to challenge decisions of the Approved Mental Capacity Professional and the right to seek a second opinion.

8.87 The Court of Protection Practitioners Association argued that:

> Where there is a relevant person's representative in place there should be a duty of ensuring that they consent to their role, that they are fully informed as to what it entails, the rationale for it and what the rights of the person are as well as how to ensure they are achieved. Whilst in theory this is no different to existing expectations, it is clear that this does not occur.

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?

8.88 The majority of consultees held an equivocal view.[93]

8.89 Some consultees argued that only advocacy should be provided, and that the role of the relevant person's representative is not necessary. For instance, Vincent Duffy (DoLS team leader) argued that the representative role should be removed and instead family members and close friends should be routinely included in the process.

8.90 Dr Kate Dean (geriatric medicine) argued that:

> Advocacy is extremely important but I am not convinced of the need for a dual system - this has both resource implications and risks "muddying the waters" with multiple opinions regarding what is in a patient's best interests. A single voice speaking for the patient would be better - less confusing for patients with cognitive issues, more powerful and more likely to be listened to.

8.91 Brent SAB felt that "given the scarcity of resources, not least individuals to undertake the roles, it is important that full consideration is given to streamlining the roles".

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[93] 135 consultees expressed a view on this question: 47 agreed, 25 disagreed and 63 held equivocal positions.

8.92 Some consultees noted that case law, in particular the decision in *AJ v A Local Authority*[94], means that local authorities are increasingly unlikely to appoint family members as a relevant person's representatives.[95]

8.93 Some consultees argued that the roles of advocates and relevant person's representative should remain separate. For example, Jill Lewis (social worker) felt that this would maintain the involvement of the family. Rita Panayides (best interests assessor and trainer) highlighted the different nature of the roles as an argument for keeping the roles separate:

> The relevant person's representative is generally someone, who knows P well and more importantly has that emotional connection with them. However, this person also often finds it difficult to challenge care providers because they are concerned that this may impact negatively on how P is perceived and maybe how P is treated. An advocate although lacking the emotional connection is nevertheless often more able to challenge the care provider as they are seen as another professional. This would seem to me to point to them being complementary roles.

8.94 Paul Bowen QC (Brick Court chambers) also argued that the roles fulfil distinct functions:

> The relevant person's representative is concerned with what is in P's best interests, and acting in accordance with that; the advocate's task is to ensure that P's wishes and feelings are communicated effectively. Although these are likely in many cases to pull in the same direction there is considerable scope for conflict between these two functions.

8.95 Some consultees commented on the circumstances in which both an advocate and a relevant person's representative should be appointed. For example, Devon County Council argued that people should not automatically receive both, only where the Approved Mental Capacity Professional and the detaining authority feel it "necessary and appropriate" to instruct both.

8.96 Other consultees were concerned that advocates would be instructed in every case. For example, West Midlands Regional DoLS Leads Group stated that:

> We do agree that people should have support that is independent of the local authority or care provider. However, we do not believe that support should be mandatory. Many people will have family who are willing and able to support and they may not want another person involved. We would also be extremely worried about how this would be funded and resourced.

8.97 Other consultees stress the importance of advocacy provision. For example, Ncompass Advocacy Service argued that:

> It needs to be recognised that true independence and upholding an individual's rights cannot always be achieved with family and friends acting alone as relevant person's

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[94] *AJ v A Local Authority* [2015] EWCOP 5, [2015] 3 WLR 683.

[95] For example, Ceredigion County Council.

> representatives. There is now national recognition enshrined in case law that working to the “best interests” of the individual does not uphold their human rights. N-compass’ experience of supporting relevant person’s representatives through the section 39D Independent Mental Capacity Advocate DoLS role identifies that the majority of work with relevant person’s representatives is supporting, identifying and addressing their lack of knowledge and action when a relevant person’s authorisation is not in keeping with the relevant persons views (either verbally or behaviourally).

GENERAL COMMENTS

8.98 We received some general comments on the issue of advocacy which were not related directly to our proposals and questions on this topic.

8.99 Averroes (think tank) recognised the importance of independent advocacy, and highlighted that advocates must understand the religious and cultural needs of the individuals on whose behalf they are advocating. It argued that:

> The proposals generally make little mention of the specific needs and problems that might arise in patients from ethnic minorities. Given that this group of individuals is especially vulnerable, the proposals must include guidance in addressing the needs of such individuals, including adequate equality and diversity training for independent advocates involved in the assessment and advocacy process.

8.100 Some consultees made general comments on how advocacy provision happens in practice. For example, SEAP (advocacy provider) stated that:

> There is a concern that although advocacy is an important part of the legislation, local authorities do not always place the same value on the importance of independent advocacy, leading to regional variations in provision, which is clearly unacceptable for a statutory service and the person requiring an advocate. Having advocacy money “ring fenced” would ensure that no matter where you were in the country you could expect the same quality service.

8.101 A number of consultees highlighted the strain which advocacy provision is under due to resource constraints. For example, Advocacy Focus stated that:

> The current difficulties are that there are not enough staff to meet the demand in all sectors, and specifically for our organisation Independent Mental Capacity Advocates and relevant person’s representatives, and the “appropriate person” … There are currently and will continue to be funding issues with advocacy providers. For example we have found that since the *Cheshire West* ruling, we have provided the proposed advocacy hours to the value of contracts significantly before the end of the contract date and have found it very difficult to obtain additional funding to continue with the service provision or to recruit more Independent Mental Capacity Advocates and relevant person’s representatives to meet demand.

8.102 Some consultees made general comments about the training required for advocates. For example, People First (Self Advocacy) noted that:

> Advocates are there to support people to understand what is happening as well as to protect people’s legal rights. We think that having an advocate will make things much

> safer but we are worried about what training they will get so that they can do their jobs properly, especially when working with people with learning difficulties. They need training to make sure they listen to the wishes of people with learning difficulties and support them to make their voices heard.

8.103 Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs stated that:

> The issue here is the level of scope, training and accreditation of advocates. This needs to be addressed across the board for advocates in all settings, ensuring that issues of consent and capacity are thoroughly explored.

Chapter 9: 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.

9.1 A majority of consultees agreed with this proposal. Of the responses from mental health stakeholders (including service users and carers) there was no overall majority view, but the largest number agreed with the proposal.[96]

9.2 Consultees who agreed with this proposal felt it would improve current practice. The National Autistic Society noted:

> We hope that this will bring to an end the practice of admitting people who lack capacity, but who do not appear to object to admission to inpatient units as an authorised deprivation of liberty (aka "informal sectioning"). This is a wholly inappropriate use of DoLS and leaves vulnerable individuals without access to the rights under the Mental Health Act.

9.3 Paul Bowen QC (Brick Court Chambers) added:

> The interface between DoLS and the Mental Health Act is unnecessarily complex. Leaving clinicians with a choice as to which regime to use would lead to the differing regimes with different levels of protection being applied on the basis of arbitrary distinctions. It is preferable that the Mental Health Act provides the legal framework for all informal admissions of incapacitated patients admitted to a psychiatric hospital for treatment for mental disorder.

9.4 Some argued that the proposal would offer greater safeguards. The Mental Health Tribunal's Members' Association Executive Committee stated:

> We believe that the principles enshrined within the Mental Health Act offer a high level of protection for people detained under that Act, and consequently would welcome a simplification of the law to permit all patients who lack capacity to agree to their care plan or any aspect of it, even if they do not object, to be detained under the Mental

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[96] 224 consultees expressed a view: 143 agreed, 28 disagreed and 53 held equivocal positions. Of the 38 responses we received from mental health stakeholders: 15 agreed, 10 disagreed and 13 held equivocal positions.

> Health Act when receiving care and treatment for a mental disorder in a hospital licensed to provide such treatment.

9.5 Many consultees felt the proposal would remedy the current legal “lacuna” where patients are left “in limbo” between the two pieces of legislation, where they are “sectionable” but the mental health team decides not to initiate formal powers under the Mental Health Act, and they are therefore ineligible for the DoLS.

9.6 Richard Rook (former Department of Health senior policy manager) agreed with the general policy intention behind the proposal, but disagreed with the need for a new admission procedure:

> I think it would be a great mistake to establish a whole new detention procedure in the Mental Health Act just for this purpose. That is not necessary and is likely to replace one set of legal complexities with another. It would be far preferable to rely on the existing detention procedures in Part 2 of the Mental Health Act.

9.7 Similarly, Neil Allen (barrister and academic) noted that our proposal would create a “hierarchy of power” based on objection:

> Where a person lacks capacity to consent to admission for mental health purposes, it is submitted that the same “business-class” safeguards should be afforded, irrespective of whether the person complies or objects. This would simplify the law and ensure that those lacking capacity received the same quality of safeguards as those with capacity. It would also ensure equal recognition before the law in article 12 UN Disability Convention terms.

9.8 Of those who disagreed, many were concerned that the use of the Mental Health Act would be stigmatising for these patients. For example, Professor George Szmukler (emeritus professor of psychiatry) felt that the proposal may add to the discrimination faced by mental health patients, and suggested that all non-objecting hospital patients, psychiatric and general, should be treated under the Mental Capacity Act. Mind stated that, whilst it welcomed that the proposal was trying to introduce certainty, it would prefer our general hospital scheme to be used for compliant incapacitated persons. The Royal College of Psychiatrists also favoured this option.

9.9 Some consultees argued that as a matter of principle non-objecting and objecting patients should have access to the same safeguards. The Law Society’s Mental Health and Disability Committee stated:

> It must be the case that vulnerable patients who are not objecting to being detained (or are incapable of articulating objections) require the same protections that objecting patients receive. To do otherwise would be discriminatory.

9.10 Some felt the proposal would be used to bypass the statutory duty to provide after-care under section 117 of the Mental Health Act, due to resource constraints. Paul Gantley (mental health tribunal member) argued that it was “indefensible and unworkable to suggest that an objecting patient has a right to section 117 but a compliant, incapacitated patient does not”.

9.11 Dr Tania Gergel (visiting research fellow in psychiatry) felt there should be greater emphasis on “informal” treatment:

> It seems that there is a gap between the perception of formally sanctioned treatment / detention by human-rights activists and by service users themselves. The former seem increasingly committed to the notion that formal status covering any restrictive treatment is advantageous to the service user, given the added legal protection and e.g. processes for appeal. However, some psychiatric service users themselves may well prefer to accept hospitalisation under certain restrictive conditions on an informal basis, if this means they can avoid what they perceive as the greater degree of restriction of choice and stigmatisation which comes with formal detention.

9.12 Other consultees were concerned about how the proposal would be resourced. Natalie Turner noted:

> Passing work from the courts to the medics via a change to the Mental Health Act does little to relieve the burden on the NHS. Mental health budgets are, and have historically been, very slim to say the least. Adding the cost of section 12 doctors and others, like Approved Mental Health Professionals in the process of Mental Health legislation changes simply shifts the burden and is not helpful to already stretched resources.

9.13 Richard Rook further commented that the complexity of the interface has been exaggerated by “viewing it through the lens of those relatively few hard cases which reached (and exercised the mind of) the Court of Protection”. Several responses referred to a paternalistic and risk-adverse culture dominating psychiatry. It was suggested that any new scheme located in the Mental Health Act would soon become “infected” by this culture or “swamped by the Mental Health Act rules” (for example Steven Richards).[97]

FUSION LAW

9.14 Several consultees commented upon the concept of “fusion law” – where mental health and mental capacity legislation is merged into one scheme. Of those who responded on this issue, the majority expressed support for fusion law.[98]

9.15 For example, Dr Ben Spencer (psychiatrist and academic) made the case for fusion law in the following terms:

> The function of the brain is to produce the mind, and therefore it is a false dichotomy to differentiate between the two in this way. I consider that any condition affecting the brain that as a result leads the person to lack decision-making capacity must therefore by definition be affecting the mind, and be a “mental disorder” regardless of the cause … This dichotomy, which provides that a different legal regimen is used for disorders like schizophrenia compared to dementia is at best stigmatising and at worst discriminatory and in breach of article 14 of the ECHR.

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[97] Consultation analysis, para ###.

[98] Of the 23 fusion comments we received on this issue, 15 wanted fusion, 3 didn’t want fusion and 4 held an equivocal position.

9.16 Professor George Szmukler noted that:

> Most of the confusion and difficulties surrounding the relationship between the Mental Health Act and the Mental Capacity Act would obviously disappear if we had a single ‘fusion’ statute. This is not likely at present though I hope it will come to pass in the future. In the meantime we have to accept there are two distinct legal regimes, operating on entirely different principles that cannot be elided.

9.17 The Mental Health Foundation and the Foundation for People with Learning Disabilities referred the introduction of fusion law the Mental Capacity Act (Northern Ireland):

9.18 This unique piece of legislation is seen as vital to reduce the stigma associated with having separate mental health legislation and provide an opportunity to enhance protections for persons who lack capacity and are unable to make a specific decision in relation to their health (mental or physical), welfare or finances for themselves.

9.19 The Royal College of Psychiatrists argued that the Government should not “close down” consideration of fusion as a “long term solution”. The Mental Health Alliance also noted that it would have preferred consideration of fusion law, but understood why the Law Commission had decided not to pursue this. Mind also expressed “disappointment that the more radical reform ‘fusing’ mental health and mental capacity legislation was not pursued”.

MENTAL HEALTH ACT AND COMMUNITY POWERS

9.20 The consultation paper also asked for views on the use of dual authorisations in the community – where patients under the Mental Health Act community provisions (such as Community Treatment Orders of guardianship) are also subject to the DoLS). We received a small number of responses, but most indicated they would want the Mental Health Act to be amended to authorise community deprivations of liberty.[99]

9.21 For example, Clementine Maddock (psychiatrist and academic) stated:

> In attempting to keep patients safe in the community, and acting in their best interest, a degree of restriction, which may be defined as a deprivation of liberty is going to become increasingly common as the definition of deprivation of liberty seems to be ever expanding. If the same patient is subject to DoLS procedures and community treatment orders / safeguarding procedures, which may involve different decision makers, problems arise. Community treatment orders and guardianship patients have inbuilt safeguards and could be extended to provide a lawful procedure for deprivation of liberty in such cases.

9.22 Brent SAB also favoured this amendment, explaining:

> In practice the explicit powers to convey and return a person to their address are necessary features of guardianship because they empower practitioners to implement a rehabilitative care plan knowing they have proportionate safeguards if the patient becomes unwell or ceases to be compliant with aspects of their care plan outside the

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[99] Of the 10 comments we received discussing deprivations of liberty in the community, six agreed, one disagreed and three held an equivocal position.

> hospital setting. Those features are not present within the Mental Capacity Act DoLS procedure and it is precisely why so many cases end up in dispute or with dual authorisation under both Mental Health Act and Mental Capacity Act DoLS regimes.

9.23 The Royal College of Psychiatrists argued that:

> On balance it may be more streamlined for authorisation of deprivation to sit within the powers of the Community Treatment Order but with increased protections, for example, early recourse to a Tribunal, (currently patients cannot contest conditions) and additional scrutiny by a professional outside the clinical team at the time of making the Community Treatment Order. Professionals should be required to justify the restrictions in terms of purpose and effectiveness and describe why they are a proportionate response to risk, in line with the principles in the *Mental Health Act Code of Practice*.

9.24 Other consultees disagreed. For example, Richard Rook stated:

> I do not think it would make sense to try to avoid dual authorisation by extending the "community" powers in the Mental Health Act to include detention. That would be the tail wagging the dog, and would fundamentally change the way the Mental Health Act works, which (apart from anything else) is likely to make the passage of legislation to replace DoLS much more controversial and time-consuming. It would also inevitably be no more than a partial solution unless the powers in the Mental Health Act were to be extended so far that they could, in effect, be used to detain people for treatment for physical disorders even though their mental disorder did not warrant detention. That would be stretching the current scheme of the Mental Health Act beyond breaking point.

GUARDIANSHIP

9.25 Consultees were also asked for their views on the use of guardianship. Only a small number of consultees responded to this. Of these a majority wanted an extension of guardianship.[100]

9.26 Professor Richard Jones (solicitor and legal academic) suggested:

> My own preference would be for the DoLS scheme to be scrapped and replaced by a modified form of Mental Health Act guardianship. This was one of the options identified by the Government in its consultation following the decision of the European Court of Human Rights in the Bournewood case. When compared with the proposed scheme, this option would be much cheaper, far less complex, would utilise the existing mental health tribunal system, and would eradicate interface issues.

9.27 Roger Laidlaw (best interests assessor) suggested:

> The Guardianship regime could be adapted to satisfy the European Convention requirement to authorise a deprivation of liberty and this might be accomplished easily with simple remedial legislation. This change perhaps should be considered on its

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[100] Of the seven comments we received which discussed amending guardianship, four agreed and three disagreed.

> own merits as part of a review of the inconsistencies of the Mental Health Act but even if this were to happen it would not plausibly address the scale of the task. This would simply mean that while the legislation was "fixed", the challenge of applying it on a wide scale was likely to be refused.

9.28 Other consultees were less favourable. North East NHS London Foundation Trust stated:

> What would this achieve? To be of use such a power would have to include a power to detain and a power to treat. This would make it hard to distinguish from a section 3. Since it currently requires two medical recommendations and an application by an Approved Mental Health Professional or the Nearest Relative and consultation with the Nearest Relative it is difficult to see that it would be any less resource intensive.

9.29 Richard Rook stated:

> I strongly agree that, whatever is done, it should not be based on extension of the guardianship regime. The only possible reason for using a revised guardianship framework would be presentational – to somehow make it appear that compliant incapacitated patients were not being "sectioned" like other patients. That does not seem a good enough reason to try to graft powers of detention solely for compliant incapacitated patients onto a legal framework that currently contains no powers of detention and which applies to all patients whether or not they have capacity and whether or not they are compliant.

LEARNING DISABILITIES

9.30 The consultation paper asked for further views on whether the new scheme should extend to all those with a learning disability or whether the Current Mental Health Act exclusion ("based on abnormally aggressive or seriously irresponsible conduct) should be retained. Very few people commented on this specific point, although some made general reference to the position of people with learning disabilities.

9.31 The National Family Carer Network stated that "people with learning disabilities who also have mental health problems should have equal rights with other people who have mental health problems". Advonet IMCA team (advocacy provider) stated:

> The terms "abnormally aggressive or seriously irresponsible conduct" are subjective and hopefully would be monitored over a longer period of time if it involved someone with learning disabilities or autism before the Mental Health Act was brought in to use.

9.32 In a detailed response on this issue Richard Rook argued that:

> A much simpler solution would be to remove the learning disability qualification from section 3 Mental Health Act in respect of people who lack capacity to consent to the treatment for the learning disability (and so bring the relevant patients within the scope of that section). The qualification could still apply to people with capacity.

SECTION 117 AFTER-CARE

9.33 Some consultees commented generally on section 117 of the Mental Health Act which enables some patients to receive services free of charge. For example, Northumbria County Council stated:

9.34 In our view the best and most equitable solution would be to repeal section 117 in its current form, since its interpretation by the courts as a freestanding statutory duty with no attached charging power, which was not envisaged by Parliament at the time when it was passed, creates indefensible anomalies in the financial treatment of people with similar needs.

9.35 Dr Hugh Series (psychiatrist and academic) added:

> As a personal view, I think that free after-care under s117 for those with dementia and other conditions requiring long term care is a serious distortion of the state system for funding long term care. It creates an unfair situation in which those who happen to have been detained under s3 and need long term care are at an enormous financial advantage for the rest of their lives over those who have not been detained. Detention under s3 has little to do with anything that I can recognise as a fair basis for charging for care. Might this be an opportunity to revise s117?

GENERAL COMMENTS

9.36 As well as considering our provisional proposal on the Mental Health Act interface, some consultees raised general concerns about how the law is currently operating.

9.37 For example, Barchester Healthcare explained some of the difficulties it experiences in managing risk in its independent hospitals in a particular area:

> The commissioner responsible for residents who we believed needed DoLS also sat on the safeguarding board. It was his view that anyone managed in a mental health setting who was at risk would be better served by measures taken under the Mental Health Act. However, the responsible consultant did not agree and did not feel that the several individuals concerned warranted detention under Mental Health Act referral. Neither party would give ground. Our only option appeared to be to involve the Court of Protection to determine best interests, with the consequence that several individuals in practice had their liberty restricted without a legal basis for it over an extended period, eventually resolved by finding new care pathways.

9.38 Dr Ceri Evans (consultant psychiatrist) stated:

> It strikes me that one of the things we struggle with is when patients with severe dementia (and usually associated behaviour challenges) are admitted to a mental health ward. As we are now only admitting the most complex patients it can take months to get to the point of discharging the patient to an appropriate setting that can meet their needs. Other than the complexity of the patient’s problems, factors such as lengthy and bureaucratic continuing healthcare assessments as well as long waiting lists for care homes or continuing healthcare wards mean that patients may remain on the wards for many months. At this point if they are stable and accepting medication but at times resistive to personal care, it can be tricky to determine whether

> they are refusing “treatment for a mental disorder”. The definition within the Mental Health Act of treatment can include nursing care but there are often differing views whether mild restraint in order to provide personal care should or does constitute treatment for a mental disorder purely because it happens to be provided on a mental health ward.

9.39 NUTHFT MCA / DoLS Steering Group outlined current lack of clarity over how to deal with the following individuals:

> In our experience there is a small but significant number of patients in acute hospitals who have been brought there before a Mental Health Act section has been considered or implemented but who require medical interventions (to which the Mental Health Act section would not apply).

9.40 Jacqueline Clarke (family carer) noted:

> It has come to my attention only yesterday that a family carer of someone with autism and challenging behaviour has been told that if she disagrees with the clinician about a sectioning she risks being removed as “nearest relative” status. This threat has paralysed her ability to support her son in his direst need. There is no question about the quality of this mothers actions in his best interests, nor her willingness to work well with any professional.

Chapter 10: 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.

10.1 A majority of consultees agreed that there should be a right to apply to the First-tier Tribunal.[101] Those consultees who were in favour of this proposal focused their support around three central themes: the efficiency gains of a tribunal system, its accessibility for users and its flexibility and simplicity.

PROBLEMS IN THE COURT OF PROTECTION

10.2 Many supported the proposal due the difficulties faced in the Court of Protection currently. For example, Hill Dickson LLP reported that:

> Often these cases take many years to resolve and use up the scant resources of the NHS and patients. On many occasions, the process takes so long to resolve that patients are left in inappropriate placements or even die in such placements before the dispute can be resolved. Swift access to a tribunal which can be convened on NHS premises to allow for the attendance of key clinicians and patients with minimal disruption would be a great step forwards.

10.3 Dr Lucy Series (mental capacity academic) outlined some of the problems with the existing legal framework:

> The system was never designed to hear appeals in any significant volume: the DoLS impact assessment anticipated that only 2.5% of authorisations would result in an appeal … It is a near certainty that large numbers of people who are deprived of their liberty under the DoLS are unable to exercise their right of appeal when it would be reasonable for them to do so, that others are failing to do so on their behalf, and that therefore their article 5(4) rights are being violated. In addition to concerns about the accessibility of the appeal mechanism under DoLS, there are also concerns about cost and delay in Court of Protection DoLS proceedings, and the extent to which they facilitate the participation of the relevant person. Were the appeal mechanism under the DoLS to function as it should, it seems quite likely the Court of Protection and the wider system of the DoLS could not cope with the number of appeals.

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[101] 252 consultees expressed a view on this proposal: 188 agreed with it, 21 disagreed, whilst 43 held equivocal positions.

EMERGENCY GAINS

10.4 A number of consultees commented on the potential efficiency gains and speed of a tribunal system, compared to the Court of Protection. For example, Hertfordshire County Council argued:

> This is likely to provide more accessible and quicker access for individuals to appeal, will provide additional safeguards and hopefully make it easier for people to access their article 5(4) rights. We also believe it is likely to improve the quality of legal competence within practice and will be more efficient at dealing with the greater volume of cases. The Court of Protection route is very slow and unable to meet the article 5 requirement for a prompt judicial review of detention.

10.5 Similarly, Bedfordshire CCG felt that a tribunal system would provide "a quicker turnaround especially for appeals and fits much better with article 5(4) speedy access to appeal".

10.6 Garden Court Chambers Court of Protection Team commented:

> Article 5(4) requires a "speedy" review of the lawfulness of a deprivation of liberty. At present, the Court of Protection is not able to ensure that cases are dealt with within a reasonable time, which can lead to individuals with degenerative conditions losing autonomy during the last months in which they have capacity. The problem is particularly acute in the regions, where often the only judge with a Court of Protection ticket is also the only judge responsible for hearing urgent and complex family cases.

10.7 Paul Gantley (mental health tribunal member) noted that:

> I can see that our Tribunal, and others in the same Chamber, is / are very well placed to speedily provide a hearing, where the patient / person is, with a multi-disciplinary panel experienced in such matters and able to offer a variety of responses whether a paper hearing and a single or multi-member oral hearing as would be proportionate.

ACCESSIBILITY FOR USERS

10.8 Several consultees argued that a tribunal system would have the advantage of maximising user participation. Dr Lucy Series noted that tribunal hearings could take place in multiple settings outside of the formal courtroom:

> Even with the regionalisation of the Court of Protection, it is questionable whether hearings in a regional court room are the most appropriate and accessible place for maximising the participation of a population who are likely to have significant care needs. Whereas tribunals under the Mental Health Act take place in hospitals, those subject to the Law Commission's new framework will be located in a very diverse range of settings.

10.9 Many consultees felt that a tribunal system would provide a more regionalised and accessible forum. Conwy County Borough Council noted that a tribunal system would "provide a 'local' service and the Mental Health Review Tribunal in Wales works well". According to the Mental Health Tribunal Members' Association's Executive Committee, a tribunal system "brings the decision makers to the person involved and thus encourages their participation".

FLEXIBILITY AND SIMPLICITY

10.10 A number of consultees felt that a tribunal system provides greater flexibility and was less cumbersome than the Court of Protection. For example, Age UK noted that "the flexibility and informality of its processes would be advantageous." Dr Lucy Series stated:

> Evidence of incapacity and best interests submitted by the detaining authorities could be supplied by tribunal members, rather than having to seek directions from the court as to what evidence would be admissible, identify individuals to produce such evidence, wait for expert's to write their reports, give parties opportunities to comment on reports and potentially submit further questions.

10.11 Roger Laidlaw (best interests assessor) pointed at the current difficulties experienced in the Court of Protection:

> Congestion in the Court means that public authorities know that the chances of them being referred to the Court for other welfare matters, even including ones where are disputes are limited, effectively giving them impunity in taking actions which exceed their legal authority. For every reported case in which a local authority was criticised for such infringements, I speculate that there are many others which have not been referred to the Court. Most staff in adult services and most advocates have no experience of the Court and the idea of making a referral seems strange to most.

RESOURCES

10.12 Some consultees who supported the proposal also noted the potential resource implications of a tribunal system. South London and Maudsley NHS Foundation Trust argued that "there should be adequate resources both within the Tribunal service and health and social care providers to make this workable".

10.13 According to Wakefield Council (Adults Health and Communities Directorate):

> There are however resource implications for local authorities in having sufficient admin to run tribunals for what could potentially be hundreds of people. Report writing for tribunals is time consuming for workers. Again the burden for this appears to be placed entirely and unfairly upon the local authority. Any such tribunal should be a part of the existing Mental Health Act tribunal or a separate Mental Capacity Act tribunal, but either way a separate body, centrally funded. This would still leave the local authority with a significant resource allocation to oversee and set up appeals, though such could be provided from within existing DoLS admin teams, were they given extra resources.

10.14 In broad terms the main resource concerns centred on the large numbers of hearings, panel costs, training needs, administrative support and the diversion of resources away from front-line services.

DISAGREEMENT WITH THE PROPOSAL

10.15 A number of consultees disagreed with the proposal and felt that the role of the Court of Protection should be retained. For example, Elizabeth Batten and Margaret Glentworth (Court of Protection District Judges) argued that impact of recent reforms in the Court of Protection had already addressed many of the concerns raised in the consultation paper. These included regionalisation of personal welfare work to a more extensive network of judges, active case management to reduce delay and cost, and the involvement of P through rule 3A. The response also raised the question of whether the Re X procedure could be adapted to provide a suitable model for "review of authorisations of deprivation of liberty which do not require any investigation of the arrangements for accommodation and care".

10.16 Mr Justice Charles (Vice President of the Court of Protection and President of the Upper Tribunal (Administrative Appeals Chamber)) provided a list of what he considered to be the "right issues" to be considered in this context, including the availability of hearing rooms in supported living and other settings, whether a Mental Health Act "test shop" and a different Mental Capacity Act "test shop" is needed, the need for injunctive orders, the need to resort to an administrative law challenge or the inherent jurisdiction, and who will sit.

10.17 District Judges Batten and Glentworth commented that:

> Consideration of those arrangements by the court involves examining the extent to which they amount to a deprivation of liberty. Challenges to an authorisation of deprivation of liberty nearly always involve revisiting best interests in relation to accommodation and care. The benefits of a holistic approach to P's best interests will be lost if part of that process is re-allocated to the First Tier Tribunal – Mental Health Tribunal.

10.18 They also suggested that the present delays in the Court of Protection arise from external factors, namely "the unavailability of legal aid, representation, there being no automatic referral to court for those Ps who are deprived of their liberty and the availability of resources".

10.19 Some of those who disagreed with the proposal felt that a new tribunal system would lead to a significant loss of expertise. The Court of Protection Practitioners Association commented that:

> Whilst the Mental Health Tribunal also has a good deal of expertise, some of which crosses over with the Mental Capacity Act, such matters are not a major part of the tribunal's work and to expand its role in this respect would have resource implications, as well as risking losing the expertise that has been built up in the Court of Protection.

10.20 Some consultees were concerned by the potential emergence of a "split jurisdiction". Professor Peter Bartlett (mental health law academic) noted:

> The current arrangement has its difficulties in this regard, but at least for matters over which the High Court has jurisdiction, these have been largely overcome by the appointment of double-ticketed judges to the Court of Protection. If we move to a system of tribunals that have statutory jurisdictions, and, often, specifically defined

membership of their panels (for example, mental health tribunals that must have a lawyer, a lay person, and a psychiatrist) however, it does seem that these problems are likely to increase, since there will be less flexibility for one collection of judges / arbiters to sit wearing multiple hats. This cannot be a good thing.

ALTERNATIVE REFORMS

10.21 Some consultees, rather than a tribunal system, proposed reforms to the Court of Protection. According to Paul Bowen QC (Brick Court Chambers):

> I would prefer the Court of Protection to be simplified by (a) removing the requirement for the Official Solicitor to be appointed as P's litigation friend except in exceptional cases or where the Court of Protection considers it necessary; (b) training some or all of the judges of the Mental Health Tribunal to sit as judges of the Court of Protection; (c) enabling/ requiring hearings of the Court of Protection to take place in a hospital, care home or other residential setting where the restrictions are imposed, like a Tribunal; (d) fast-tracking the majority of cases by introducing regulations with tight deadlines for the provision of expert reports and the hearing of cases.

10.22 Professor Peter Bartlett suggested that a possible way forward may involve giving more choice to the patient:

> One possibility that might warrant consideration is to create a more flexible system, allowing litigants to select the forum that makes sense given the case. I appreciate this is an unusual solution, but some precedent for it may be found in the British Columbia Mental Health Act, which allows a challenge to detention either before a review tribunal or before a court … A certain amount of this already occurs regarding the Mental Capacity Act, with other courts occasionally referring to it when relevant to do so.

10.23 Leeds City Council made reference to local guardianship panels:

> The Court of Protection does provide an excellent level of scrutiny on cases before it but we feel that some of these could be dealt with via a more structured use of local social service authority resources. Local guardianship panels work for some local social service authorities and could be set up to consider cases that require mediation and better care planning, as well as those who may need to have their care plans (RCTS) reviewed / ended by the Local Social Service Authority.

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.

10.24 The majority of consultees agreed this proposal.[102]

10.25 Much of the discussed focused on the meaning of "particular significance" (see also responses to question 11-3). Rachel Ward (independent mental capacity advocate) suggested that challenges which relate to moving someone from the community to a care home and cases where restrictions on family contact are proposed should be included on a matter of principle. Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs felt that a definition must be provided in the legislation. Maxwell Gillott Solicitors commented that "careful guidance" should be attached to any such definition.

10.26 Some saw "particular significance" as being a low threshold. For example, the Mental Health Lawyers Association felt it is likely to apply in every case. Bill McMellon (best interests assessor) observed that:

> Being deprived of liberty, and everything associated with that, will always be of particular significance to the person concerned unless a mental disorder means that they are oblivious to it.

10.27 Bindmans LLP suggested extending the remit of appeals beyond issues of particular significance:

> In addition, the person subject to the care plan him or herself, or his or her advocate, or the appropriate person or the Approved Mental Capacity Professional him or herself should have a right to seek an oral review of the care plan first to the First Tier Tribunal, and then by way of appeal (on a point of law or fact, and not just where the issues raised are of particular significance to the person concerned, as that runs the risk of "normalising") to either the Upper Tribunal or the Court of Protection, with the Tribunal able to "divert' cases" which involve wider consideration than just the components of the care plan itself to the Court of Protection. It is considered that the Tribunal could and should make use of the Special Visitors currently maintained by the Court of Protection.

10.28 A number of consultees commented on which court should consider an appeal. The judges of the family division of the High Court stated:

> If there is to be a right of review by the First-tier Tribunal, we suggest that any appeal should then lie to the Court of Protection, with leave being required. We see difficulties

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[102] 92 consultees expressed a view on this proposal: 68 agreed, 6 disagreed, whilst 18 held equivocal positions.

> in splitting responsibility for more serious decisions between the Court of Protection and the Upper Tribunal.

10.29 Hertfordshire County Council argued that:

> There is a real need for a process to be implemented to deal with hybrid cases (e.g. those which also involve additional issues such as tenancies and contact arrangements) … there should be a clear distinction between the cases that are dealt with by the tribunal and the cases that are dealt with by the Court of Protection. For hybrid cases, Hertfordshire County Council is of the opinion that cases should be heard by the Court of Protection.

10.30 A small number of consultees disagreed with this proposal. Judge Mark Hinchliffe (Deputy Chamber President (Mental Health) First-tier Tribunal) objected to the proposal on three grounds:

> First, I consider that this would be hard to define (and would potentially cover nearly all cases); second, it would raise the question of why mental health patients do not have the enhanced right of appeal if the issues raised are of particular significance to them (as they nearly always are); and third, it is unlikely that any appellate body will have non-legal expertise on the panel which would be an anomaly if the First-tier decision-maker did have such expertise available. I would therefore recommend that any appeal should be on point of law only, and require permission.

10.31 Hertfordshire County Council commented that appeals should only consider points of law to therefore "avoid the position where individuals are afforded another bite at the cherry simply because they are unhappy with the original decision". Similarly, Peterborough City Council noted that any appeal to the Upper Tier Tribunal should be "on the basis on of point of law only or the permission criteria should be very robust to ensure that appeals to the Upper Tier Tribunal are appropriate".

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?

10.32 Consultees who answered this question[103] highlighted four general types of cases: objections to the deprivation of liberty, disputes regarding a person's capacity or best interests, interference with human rights, and decisions regarding serious medical treatment.

OBJECTIONS TO THE DEPRIVATION OF LIBERTY

10.33 Several consultees suggested that "particular significance to the person concerned" should include situations where there is an objection on the part of the incapacitated

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[103] 102 consultees answered this particular question.

person regarding their deprivation of liberty. For example, the Mental Health Tribunals Members' Association's Executive Committee noted that cases to be considered of particular significance are:

> Those where they specifically object to the deprivation of liberty or where their nearest relative … or relevant person's representative object. In such cases the individual or their relevant person's representative would almost certainly dispute the facts put before the tribunal and thus would have a basis for appeal.

10.34 Some local authorities agreed with this approach. For example, North Tyneside Council believed such cases should include situations where the person is under intense supervision by staff and he or she insists they do not want to be supervised to this level. East Sussex County Council remarked that "examples of cases include where a person is happy in their setting but the family want to remove them and where the family and the person object to the care".

10.35 Vincent Duffy (DoLS team leader) noted that:

> I would consider anything by where the individual expresses their views and beliefs strongly which goes against the care or treatment in place that amounts to a deprivation to be of "particular significance to the person concerned".

CAPACITY AND BEST INTEREST DISPUTES

10.36 Some consultees felt that "particular significance to the person concerned" should include cases where mental capacity is disputed or refuted. For example, the Yorkshire and Humberside Mental Capacity Act DoLS Regional Forum identified cases "where the person disagrees about the treatment required and there is question about whether they lack capacity or not".

10.37 The joint response from Shropshire Partners in Care, Telford and Wrekin Council identified fluctuating capacity cases. Similarly, Karen Davies (Senior Matron, Safeguarding Adults at Maidstone and Tunbridge Wells NHS Trust) argued that "particular significance" should include:

> Those cases where lack of mental capacity is refuted. Those cases of fluctuating capacity or borderline capacity. Those cases where blocks to placement from the Acute Hospital to community care are causing detriment to the placement.

10.38 According to Thames Valley Safeguarding Network CCGs, these cases should include those where there is a "dispute in relation to best interest decisions, individual or family appeals or a query relating to lack of capacity". Berkshire Joint Legal Team suggested "a dispute over what is in best interests, an individual or family member's appeal against authorisation, uncertainty over capacity".

HUMAN RIGHTS TREATMENT

10.39 Brighton and Hove City Council noted that these cases should include situations where there is any interference with rights protected under article 5 of the ECHR. The Law Society's Mental Health and Disability Committee commented that cases where there is reason to believe article 8 is engaged could be a starting point. Similarly, Leicester

County Council have noted that such cases should constitute “points of law or article 8 issues”. According to West Sussex County Council such cases might include “where being accommodated for care and treatment conflicts with a person’s long held beliefs” or “where there is significant interference with a person’s rights to a private and family life”.

SERIOUS MEDICAL TREATMENT

10.40 Some consultees considered that decisions regarding a person’s medical treatment should be considered to be of particular significance to the person concerned. According to Barts Health NHS Trust such cases should include those “where treatment may result in long term side effects or adverse consequences, separately from any benefits of treatment” such as amputation and chemotherapy. The Law Society’s Mental Health and Disability Committee identified cases where there were disputes over medical treatment (including but not limited to serious medical treatment) for mental or physical disorder.

10.41 On the issue of serious medical treatment, Steve Broach (barrister) commented:

> Serious medical treatment and significant welfare decisions should continue to be determined by the Court of Protection. In those cases the Court of Protection should also be able to discharge the tribunal review functions in relation to restrictive care and treatment generally to avoid the need for a separate review by the tribunal.

OTHER COMMENTS

10.42 A number of consultees believed that issues regarding a person’s deprivation of liberty will, by definition, always be of particular significance.

10.43 According to the Bar Council:

> It is likely that all decisions as to the person’s capacity, residence, care, treatment and / or deprivation of liberty are properly described as being of particular significance to him / her. Indeed, it is arguable that these decisions are some of the most important decisions any court, in any jurisdiction, are called upon to decide.

10.44 It was argued that the current test under the Court of Protection rules should be adopted permission to appeal is granted only where the court considers that the appeal would have a real prospect of success, or there is some other compelling reason why the appeal should be heard.

10.45 Similarly, according to the Court of Protection Practitioner’s Association, issues concerning deprivation of liberty are, by their very nature, of particular significance to the person concerned and “we would have some difficulty in identifying a subset of cases which might fall into this category”.

10.46 Maxwell Gillott Solicitors’ Court of Protection Team suggested that, given that all cases are likely to have ‘particular significance to the individual’, there would need to be careful guidance attached. The British Association of Social Workers, Nottingham City Council and Conwy County Borough Council also called for guidance on this point.

10.47 Some consultees believed that the test was too fact-sensitive. For example, according to the West Midlands Regional DoLS Leads Group "the concept of what is of particular significance to the person concerned is too subjective to be workable". Paul Bowen QC (Brick Court Chambers) also made this point: "I am not sure that I would try to define the term 'particular significance' as it will depend on the facts of each case".

10.48 According to Steve Broach:

> The test should instead be to the effect that there is a significant dispute of fact which may have made a material difference to the outcome of the appeal. This test should be applied by the Upper Tribunal on a case-by-case basis … If it was interpreted restrictively, particularly against a pre-determined list of circumstances, the proposed filter would deny a second hearing to cases which may be felt by the person concerned to matter greatly to them.

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.

10.49 A majority of consultees agreed with this proposal.[104]

10.50 For example, the Bar Council argued that:

> There is a very strong case for a system of automatic referrals to either the First-Tier Tribunal or the Court of Protection … There is a positive obligation on the state to ensure that arrangements which amount to a deprivation of liberty are properly considered by an independent court or tribunal under article 5(4) of the ECHR. In the circumstances, the public body responsible for the said arrangements ought to bear the responsibility of referring the same to the court or tribunal if no application has already been made within a specified period of time.

10.51 The Court of Protection Practitioners Association (whilst disagreeing with the establishment of an appeal to the First-tier Tribunal), agreed that there needs to be an automatic referral system:

> Whilst there has in recent years been a greater understanding on the part of local authorities, Independent Mental Capacity Advocates and family members of the need to ensure that cases are referred to the Court for review when the person objects to their care arrangements, there is still a need for a failsafe mechanism to ensure that the Article 5(4) rights of vulnerable adults are protected.

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[104] 129 consultees expressed a view on this proposal: 82 agreed, 26 disagreed and 21 held equivocal positions.

10.52 A number of consultees supported the proposal, whilst noting resource concerns. For example, Camden Council and Camden Safeguarding Adults Partnership Board stated that:

> We believe that an automatic review to a tribunal is a positive move, but are aware that this will have a significant resource implication. Local authorities are likely to be responsible for much of this system (as supervisory bodies) and therefore we suggest that adequate resources to administer and support such a system will need to be allocated for that purpose.

10.53 Some consultees suggested ways in which the resource implications could be addressed. For example, Rachel Ward (independent mental capacity advocate) suggested that tribunals could review straightforward cases on the papers. The Court of Protection Practitioners Association advocated a similar streamlined process for these referrals, albeit with the possibility of heightened scrutiny by a judge if a possible breach of article 5 or statutory duties is detected.

10.54 Some consultees argued that automatic reviews are a human rights requirement. For example, Robert Robinson (solicitor for HL) stated that the need for automatic review follows from Strasbourg case law, specifically the case of *MH v United Kingdom*.[105]

10.55 A number of consultees rejected our proposal on the basis of the resource implications. Northumberland County Council argued that:

> This proposal would create a very substantial burden on local authorities, quite aside from the running costs of the tribunals themselves. In our case, for instance, even if the specified period of time was three years, we might be required to produce hundreds of tribunal reports every year, most of them about situations in which nobody had any concerns about the person's care arrangements. We do not think that this would be a good use of resources.

10.56 Similarly Kent County Council argued that:

> It is more important that there are sufficient, effective safeguards in place for the vulnerable person through the review process and the involvement of appropriate persons / advocates. The automatic referral system would create additional and sometimes unnecessary bureaucracy, and will have significant cost implications for local authorities.

10.57 The Department of Health and Ministry of Justice raised the significant cost of automatic tribunal referrals, and pointed out that "such funding could be used for greater service-user outcomes elsewhere in the health and care system". They further argued that:

> It may be that in many cases, individuals might find such an escalation distressful. Any disagreements and concerns might be more satisfactorily addressed through greater discussions and/ or facilitated mediation.

10.58 Garden Court Chambers' Court of Protection Team stated:

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[105] *MH v United Kingdom* (2014) 58 EHRR 35 (App No 11577/06).

> Whereas it is essential that P has genuine access to the court / tribunal for the purpose of article 5(4) of the ECHR, we are not convinced that automatic referral of all cases to a tribunal as a matter of course, is useful in terms of the likely gains to persons lacking mental capacity such as to justify expenditure on this as opposed to on other areas of more direct benefit to P. We consider that there should be investment in the training of advocates and relevant person's representatives, the development of the professionalism of the role of Approved Mental Capacity Professionals and robust processes to make sure that the scheme works well on the ground and that cases that ought to be referred to the court / a tribunal, applying the established principles, are identified. The large amount of expenditure that would be required in order to provide for an automatic referral of every case to a tribunal and for each case to be processed, regardless of whether or not P objects to the care arrangements or wishes to challenge them, or the arrangements are contentious in any way, we believe, would be better directed towards providing good quality care services.

10.59 A number of consultees argued that other safeguards would be more cost-effective and secure the person's article 5 rights. For example, Dr Lucy Series (mental capacity academic) suggested that a referral to a tribunal could be triggered in certain circumstances such as where the detained person is objecting to their detention or the restrictions placed on them, the family objects to the detention or restrictions, or where the relevant person's representative, advocate or Approved Mental Capacity Professional believes that the care may violate the principles of the Mental Capacity Act or the person's human rights.

10.60 Chris Lucas (best interests assessor) suggested that local authorities should be required to apply to the tribunal "if the person is objecting / unsettled after 2 years, even if all other parties agree that the care is in their best interests". Hertfordshire County Council suggested that an annual review built into the normal reviewing of an individual's restrictive care and treatment scheme would suffice to replace an automatic review.

10.61 Others argued that representatives or advocates should be able to appeal, and if they do not, there should be a duty on the local authority to refer to the tribunal. Weightmans LLP argued that a system of automatic referral was not necessary if the advocacy and representation system works effectively.

10.62 Garden Court Chambers' Court of Protection Team suggested another alternative to automatic referrals:

> We suggest that a culture astute to article 5(4) rights should be entrenched into the scheme: by specific article 5(4) training for Approved Mental Capacity Professionals and advisors, and highly trained Approved Mental Capacity Professionals being involved in the selection of relevant person's representatives / ensuring advocates for P have the required understanding of when going to court should be initiated and what to do/who to approach in order to do so if needed. We suggest that it should also be part of the Approved Mental Capacity Professional's role to identify at the time of the assessment, whether P wants to challenge the deprivation of liberty or is indicating any significant objection to the care arrangements. In either case a challenge to a tribunal / court should be initiated, the local authority having ultimate responsibility for ensuring that this occurs promptly.

10.63 Of those who responded to this question, the largest number suggested that the timetable for an automatic referral should replicate the Mental Health Act scheme.[106] For example, the South West Yorkshire Partnership NHS Foundation Trust suggested that:

> The automatic referral system of the Mental Health Act 1983 be replicated; at six months from initial authorisation and there after every three years unless under the age of 18 in which case an annual referral should be made.

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?

10.64 A number of consultees who argued that the timescale should be in line with the Mental Health Act recognised the resource implications of this approach. For example, Hywel Dda University Health Board noted that:

> Whatever the agreed timescale, it needs to be sensible and practicable. There will be much higher numbers of patients under restrictive care and treatment (and the hospital scheme) than there are people detained under the Mental Health Act. Therefore the resource implications for such tribunals would be significant.

10.65 A number of consultees suggested that the period of time should be six months, after which an automatic referral should be made. Dr Hugh Series (psychiatrist and academic), suggested that a six month automatic referral is needed because:

> After that time it become increasingly difficult in practice to discharge a person to home or another form of care. Their home may have been sold, or they may have become so accustomed to the present care setting that a move would now be disruptive.

10.66 Other timescales proposed by consultees included 14 days, 28 days, three months, 12 months, two years and three years. The reasons for proposing the differing timescales were varied, although often centering on resources considerations. For example, London Borough of Lambeth's DoLS Service argued that automatic referrals should be every two years in order to "reduce the burden of assessment and council processes on the person themselves".

10.67 The Tri-borough Councils proposed a three month referral initially, in case the tribunal decides that the person should return home, be moved elsewhere, or that a major aspect of care and treatment should be changed. Thereafter they suggested a referral after 18 months.

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[106] 122 consultees responded to this question. The majority (70%) suggested a period of time after which an automatic referral should be made.

10.68 A sizeable number of the consultees who responded with suggestions for a timescale advocated having timescales tailored to the individual: the length of time before an automatic referral must be made will vary depending on the person's situation. For example, the Alzheimer's Society proposed that a flexible approach be adopted, with an upper limit on referrals but allowing professionals to refer cases to the tribunal earlier than this.

10.69 Bury Council and Bury CCG suggested that the timescale should vary case by case, depending on whether the person is objecting or settled. For a patient who is settled, they argued that an 18 month or two year referral to the tribunal would be appropriate. For a patient who is objecting, or whose treatment raises issues, a six month referral to the tribunal was suggested.

10.70 A number of consultees did not suggest a timetable for automatic referrals, and they highlighted their disagreement with a system of automatic referrals (see provisional proposal 11-4).

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?

10.71 This question elicited 127 responses from consultees. The responses can be split into three themes: paper reviews, single member tribunals, "straightforward cases", and other comments.

PAPER REVIEWS

10.72 Most of the consultees who took a view on whether paper reviews should be used for relatively straightforward cases thought that they would be beneficial.[107] For example, Robert Robinson (solicitor for HL) stated that:

> In my experience it is already the case that a proportion of Mental Health Act detentions do not warrant an oral hearing. The proportion would, I believe, be considerably higher in respect of non-objecting incapacitated patients in hospital for treatment of mental disorder and also in respect of the great majority of people under restrictive care who I take to be people with dementia who are residing in care homes.

10.73 A number of consultees referred to the approach taken to paper reviews in the mental health tribunal, as a possible example to follow. For example, the Law Society's Mental Health and Disability Committee explained that:

> Paper reviews are only used in the First-Tier Tribunal in mental health cases where the patient is referred rather than appeals to the Tribunal in a community treatment order case; and where the patient has capacity to consent and does consent; or if the

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[107] 127 consultees commented on this question: 58 thought that paper reviews would be beneficial, 29 thought that paper review should not be introduced, and 40 did not take a view.

> patient lacks capacity and their representative - appointed under Rule 11(7) (b) - consents. This approach could be adopted in mental capacity cases.

10.74 Some consultees thought that paper reviews would not be appropriate. For example. The Alzheimer’s Society were concerned that paper reviews would turn appeals into an administrative procedure, diluting the safeguard of the tribunal. They also made an analogy with the mental health tribunal:

> We have found that the Mental Health Act tribunal system, as it is a face-to-face system, means that people themselves and / or their representatives are able to attend and express their opinions effectively. This feeling of involvement means people are generally more satisfied with the outcome.

10.75 Steve Broach (barrister) argued that paper reviews are not legally permissible:

> In my view the decision of Mr Justice Charles in Re NRA is wrong and an oral hearing is required in every case at least initially, this requirement stemming both from common law fairness and articles 6 and 8 of the ECHR.[108]

SINGLE MEMBER TRIBUNALS

10.76 Most of the consultees who took a view on whether single member tribunals should be used for relatively straightforward cases thought that they should not be used.[109] For example, Steve Chamberlain (best interests assessor and trainer) felt that:

> It would risk watering down the access to the proper judicial system. Presumably a single member tribunal would comprise of a lawyer, as they would be the chair / judge as in Mental Health Tribunal cases. This would exclude important other perspectives.

10.77 Camden Council and Camden Safeguarding Adults Partnership Board echoed this concern:

> It is assumed that a single member tribunal would need to be staffed by a lawyer, which would considerably dilute the expertise available to consider the issues involved. We believe that when a tribunal needs to sit, it should contain members with various backgrounds, as in the mental health tribunal system.

10.78 The Mental Health Tribunal Members’ Association’s Executive Committee dismissed single member tribunals for a similar reason:

> One of the principal benefits of the tribunal system for Mental Health is the bringing together of expertise from relevant backgrounds. A single (legal) member approach to hearings would not bring such benefit.

10.79 Some consultees thought that single member tribunals should be used in straightforward cases. For example, Kent County Council thought single member tribunals and paper reviews would be a good suggestion, particularly if automatic

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[108] *Re NRA* [2005] EWCOP 59.

[109] 127 consultees commented on this question: 40 thought that single member tribunals would not be appropriate, 35 thought that single member tribunals should be used, and 52 did not take a view.

referrals are introduced. Others noted that District Judges in the Court of Protection have experience of dealing with these matters without a panel. For example, Maxwell Gillott Solicitors could not see "why a single member tribunal would not be adequate, given how Court of Protection cases are currently presided over".

10.80 A number of consultees expressed qualified support for single member tribunals, with the caveat that the single member must be sufficiently experienced. For example, Lincolnshire County Council Adult Care Directorate and Lincolnshire Partnership NHS Foundation Trust stated that:

> It may be possible to have single member tribunals but you would need to be satisfied that the person has the breadth and depth of experience to deal with the matter.

STRAIGHTFORWARD CASES

10.81 A number of consultees expressed concerns about the identification of "straightforward cases". For example, Mind argued that:

> There needs to be great caution in deeming a case to be straightforward. For example, professionals involved may think a case is straightforward and may not have noted any objections, but a tribunal might find differently. The *Neary* case[110] highlights the risk of making assumptions about how straightforward a case is. Any cases where there are objections from anyone involved or where there are viable alternatives should be brought in front of a tribunal.

10.82 The Mental Health Alliance noted the potential benefits of paper reviews and single member tribunals, but advised caution in defining which cases are straightforward:

> What we have seen in practice in relation to "straightforward cases" is that some of these cases are never as straightforward as professionals involved might have initially stated. If such a system is imposed then there should be very clear guidelines as to what would constitute a straightforward case, otherwise we risk arbitrary decision making by professionals.

OTHER COMMENTS

10.83 A number of consultees commented more generally on how efficiencies could be secured. For example, Peterborough City Council localised tribunals; streamlining applications to the tribunal to make use of existing documentation; and informality within the tribunal. St Andrew's Healthcare argued that:

> Holding tribunals at local authority offices, similar to Mental Health Act tribunals, would limit the amount of time staff have to spend travelling to regional court centres and could be slotted in around other appointments.

10.84 Some consultees were concerned that greater efficiencies would compromise the quality of scrutiny. For example, PASAUK was concerned that:

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[110] *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584.

> "Greater efficiencies" become synonymous with "financial savings"; in our view the aim is to arrive at high quality care provision, not save money. Paper reviews and single member tribunals are not guarantors of quality outcomes and we have concerns about the use of terms such as "relatively straightforward cases".

10.85 Your Voice Counts (advocacy provider) stated that:

> We strongly disagree with the suggestion of paper reviews or single member tribunals … We know from experience in mental health review tribunals that reports are often inaccurate, inconsistent or biased and that this becomes apparent only when the author is robustly questioned. This feels like a suggestion based on resources rather than rights.

10.86 Other consultees questioned whether greater efficiencies are needed if the tribunal's focus is adjusted to scrutinise a narrower set of cases. For example, the Mental Health Lawyers Association argued that:

> The system should be designed in such a way that "straightforward cases" never reach this stage. It is a poor system that simply rubber stamps deprivations of liberty. The purpose of the legislation should be to support freedoms without intrusion of law and process and at the same time to identify and support incapacitated individuals experiencing restrictions on their liberty … Therefore there should be an easy system by which incapacitated patients or their relatives / carers can make an appeal and speedy adjudication by the new tribunal / Court of Protection. This would move the focus away from relentless recording DoLS and on to actually reaching out to those adversely affected. The tribunals would then be dealing with real issues and in such circumstances it would be hard to justify paper reviews or single member reviews.

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?

10.87 This question elicited 69 responses from consultees.

10.88 An issue which was repeatedly raised was the relationship between the best interests of the individual and resource allocation by the local authority. For example, West Midlands Regional DoLS Leads Group felt that:

> Despite it being made clear that the Court of Protection cannot decide public law issues, attempts continue to be made to try and use the Court of Protection to make public law challenges. The importance of letters before claim and the chance to respond can be lost. Whatever happens in this area, public law issues must continue to be decided on public law principles of reasonableness.

10.89 Funding decisions was a concern of Roslynn Azzam (DoLS lead) who stated that:

> Difficulties arise where a person could only return home safely with a significant package of care that the public authority will not agree to fund. Challenges which are brought under 21A can be fruitless if there is no flexibility in funding decisions.

10.90 Robert Robinson (solicitor for HL) stated that difficulties arise "where it is not known what could be provided as an alternative to the current placement" and where "that depends in part on knowing what resources would be made available by the responsible public authority".

10.91 Some consultees advocated changes to the law to address the divide between public and private law. For example, the Tri-borough Councils argued that:

> The law should be amended so that Tribunal and Court of Protection judges can hear both the Mental Capacity Act and public law elements of the case. The fact that public law decisions are currently relatively hard to challenge means that the local authority / NHS body can sometimes present inadequate assessment and care planning in Court, which causes unnecessary delays for the person, and expense if the Tribunal / Court of Protection judge asks the local authority / NHS body to reconsider the options and whether they can offer something else.

10.92 This desire for the Court of Protection to be able to hear judicial reviews joined with standard Court of Protection cases was echoed by the Mental Health Lawyers Association, which stated:

> It would assist if Court of Protection cases involving judicial review challenges could be handled by the same court and judge. Financial constraints on the local authorities does create potential for a judicial review. It is of no help to the public purse for this to result in duplicate proceedings.

10.93 The Court of Protection Practitioners Association did not think that the Court of Protection's jurisdiction should be expanded to hear Care Act appeals or judicial reviews, and instead suggested that:

> More judges of the Court of Protection should be appointed as judges of the Administrative Court and that the Court rules be amended so that such issues can be heard by the same judge when they arise, without the need to issue separate proceedings in the Administrative Court.

10.94 Maxwell Gillott Solicitors expressed concern about the implications of a move to a tribunal system on cases raising public and private law issues:

> At present a judge who can deal with both Court of Protection and public law challenges in the High Court, can manage both, but if there were a move to the tribunal, we are not sure what jurisdiction the tribunal has to deal with public law disputes, or whether a referral to the High Court would be required still.

10.95 Some consultees suggested that the Court of Protection should have powers extending further than judicial review. For example, Paul Bowen QC (Brick Court Chambers) argued that:

> These problems cannot be solved unless the Court of Protection (or the Tribunal) is given jurisdiction to order for a local authority or NHS body to provide specified care where necessary to ensure P's best interests are met. There is a precedent for this – the Special Educational Needs and Disability Tribunal has jurisdiction to order the provision of services to meet special educational needs. I recognise that this would be politically very difficult to achieve but until such jurisdiction is conferred the Court of Protection is limited to cajoling and encouraging local authorities to provide care packages – itself a significant factor in the delays inherent in the system.

10.96 Other consultees were resistant to changing the remit of the Court of Protection. For example, Mills and Reeve LLP argued that:

> To broaden the Court of Protection's powers and allow them to dictate which publicly funded options should be available would be to extend its remit beyond that originally intended and ignore the fact that there are limited circumstances in which the judiciary can interfere with funding decisions of public bodies. It would also present P with recourse above that available to a patient with full capacity. This seems unfair and unreasonable.

10.97 Weightmans LLP adopted a similar stance, arguing that:

> Public authorities have to constantly make difficult decisions about the support they provide to individuals balancing their statutory duties and the resources available. We believe that it is a fundamental element of administrative law that public law decisions made by public authorities can only be challenged by judicial review and should not be changed in any way.

10.98 Leicestershire County Council pointed out that:

> There is clearly a potential tension between courts prescribing care and support for individuals which have significant resource implications for local authorities. In our view local authorities must not be effectively prevented from managing their resources by private law decisions and best interests decisions have to be considered within the context of meeting needs in a reasonable way. In our view a change of law would not address this and the correct avenue for such decisions is via the existing system of judicial review.

10.99 Some consultees suggested that more guidance was needed in this area. For example, Brent SAB argued that:

> Current mechanism in place are sufficient to address public law and private law issues, but the code of practice should clarify more carefully how these will be distinguished and what powers Approved Mental Capacity Professionals, the tribunal or Court of Protection has to request a review of a care / treatment plan and what sanctions each has if they are not satisfied that the care/treatment plan is lawful.

10.100 Bedford Borough Council suggested that confusion among professionals about the difference between public and private law could be alleviated if more training is made available to professionals to differentiate between the two.

10.101 In order to challenge public law decisions, Roslynn Azzam suggested that “access to legal aid for judicial review could be increased” so that vulnerable people and their relatives “have a realistic opportunity to challenge these decisions”. Similarly, Sheffield Citizens Advice also suggested that legal aid is too restricted for public law challenges.

Question 11-8

Should protective care provide for greater use of medication and, if so, at what stage?

10.102 A majority of consultees who responded to this question agreed that protective care should provide for greater use of mediation.[111]

10.103 Many of these consultees favoured mediation as a way of avoiding escalation to the Court of Protection. For example, John Young (best interests assessor and trainer) stated that:

> I think it would be invaluable if mediation were available. Ideally this would be used when it becomes apparent that there is conflict / significant differences of opinion. Such an approach might well prevent cases ending up in court.

10.104 The Mental Health Alliance argued that:

> Mediation would be useful at any stage where there are objections or irresolvable conflicts. We find in practice that these objections / irresolvable conflicts are often caused by parties being unable to consider a view other than their own, for example professionals being fixated on “keeping the person safe above all else” or family “wanting the person home, regardless of the risk”. There is often a middle ground and mediation can help those involved explore this in an objective way.

10.105 The Alzheimer’s Society proposed that mediation could be used at different stages of the process, depending on the case in question:

> If it would result in further delays in someone’s care when care is urgently required it may not be appropriate … in other cases mediation could be used before a formal appeal is lodged and the case moves to a tribunal or the Court of Protection. Mediation could resolve the situation more quickly and be better for those involved.

10.106 Hampshire County Council argued that mediation would be useful as a next stage after best interest decision, “as currently the next official stage to appeal is the Court of Protection, which for many people is a big leap to take”.

10.107 PASAUK felt that in particular mediation should “be encouraged and facilitated as part of any matter being referred to the Court of Protection” in order to avoid unnecessary court proceedings and to “enable the Court of Protection to have an oversight of and benefit from the knowledge of how all parties have engaged in the mediation process”.

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[111] 112 consultees expressed a view on this proposal: 68 said “yes”, 11 said “no” and 33 held equivocal positions.

10.108 Other consultees believed that mediation would more often be appropriate after the case has reached the Court of Protection. For example, Berkshire Joint Legal Team suggested that:

> Quite often, matters are urgent and need urgent judicial decision so we think medication would only have a limited part to play at the beginning of proceedings. However, once an interim order has been made it may be beneficial for parties to enter into mediation in respect of the ongoing matters to be addressed and may avoid the need for expensive expert advice / final hearings.

10.109 Some consultees did not agree with a statutory requirement for mediation. For example, Paul Greening (MCA manager) noted that he was:

> Not sure whether legislating for statutory mediation is the most productive way forward as there are situations where this is either not possible or not helpful. I would support statutory guidance that made consideration of using mediation a prerequisite of any Court of Protection application – with an explanation of why it either hasn't been used or hasn't resolved the dispute forming part of the court application.

10.110 Some consultees disagreed that the use of mediation should be increased and believed that the court is the more appropriate arena to resolve disputes in this area. For example, Steve Broach (barrister) commented that he:

> Would be concerned about the widespread use of mediation in cases which engage the fundamental rights of people who lack capacity to consent to their own care or treatment. In such cases the court or tribunal plays a vital role in imposing an independent check on the arrangements. I would not favour the extension of mediation in this area.

10.111 A number of consultees commented that mediation should already be part of good care planning. For example, North West ADASS pointed out that mediation, along with family group conferencing, should be used in good care planning, and not as an element of protective care. Central Bedfordshire Council stated that it was:

> Not clear that, overall, that greater use of mediation would be effective in respect of protective care. Care and support planning requires parties to try and work together and if this is not possible then it is not clear that mediation would assist further as the principles of mediation should be imbedded in good practice already.

10.112 Devon County Council argued that the best interests process already provides for "a mediation type forum and if this is unsuccessful it is highly likely that the case is intractable and can only be determined by the Tribunal or Court".

10.113 Some consultees took an equivocal position. For example, Paul Bowen QC (Brick Court Chambers) stated that:

> In large, intractable cases of the kind that bedevil the Court of Protection at present mediation can play a significant part in breaking the log-jam. However if the proposals for simplifying the procedure of the Court of Protection or tribunal are adopted then mediation is unlikely to play a major part, at least in "fast track" cases, although it may have a part to play in larger scale, evidentially complex cases.

10.114 The Tri-borough Councils argued that the benefits of mediation depend on the context, noting that:

> If it's about contact, or any disagreement with family or friends, then mediation is a really good idea and a good step between discussions / meetings with professionals (where relationships might be struggling) and the inevitable stress and fear of going to Court (or tribunal, although hopefully a tribunal would be less stressful). Mediation should not be obligatory but should be offered as the next step unless someone adamantly doesn't want to try it. Mediation is probably not suitable for a disagreement with the person where their cognitive impairment is stopping them from being able to understand others' concerns (when, for example, they want to return home but they would be at high risk if they did so), or for hospital treatment situations.

10.115 The Law Society's Mental Health and Disability Committee warned of possible dangers of mediation:

> Whilst mediation and other forms of alternative dispute resolution are important the problem in the protective care system is that the person at the centre of the case will almost certainly lack capacity in some domains and therefore it is hard to see how they will be able to participate in mediation, where there is a real risk that the agenda can be hijacked by other parties. Mediation will be more effective where the relevant person is formally represented by a litigation friend or accredited legal representative.

Question 11-9

What are the key issues for legal aid as a result of our reforms?

10.116 There were 98 responses to this question. The key themes were the lack of availability of non-means tested legal aid in certain cases, the need for legal aid funding for families and representatives, and the need for parity with the Mental Health Act.

LACK OF AVAILABILITY OF NON-MEANS TESTED LEGAL AID

10.117 Several consultees were concerned that non-means legal aid was only available to people subject to the DoLS (as opposed to people deprived of liberty elsewhere). For example, Maxwell Gillott Solicitors stated that:

> As now, the main concern we all have, is the lack of availability of non-means-tested legal aid to anyone not challenging a DoLS authorisation. We have never understood why any deprivation of liberty challenge should be treated differently from another, and the separation out of eligibility merely on the basis of care home / hospital versus any other location, is not logical at all. That view remains the same even were the system to change. Anyone who wants to challenge their deprivation of liberty should be able to do so, regardless of their funds, as they shouldn't have to pay from their own funds to challenge a decision made in their best interests. In fact, we believe that in all proceedings in the Court of Protection where P is challenging decisions made in his or her best interests, their representation should be non-means tested, for the same reason.

10.118 According to Steven Broach (barrister):

> The current position, whereby non-means-tested legal aid is only available to those challenging deprivations of liberty in hospitals and care homes, is in my view absurd and gives rise to a breach of the non-discrimination provisions in Article 14 of the ECHR. This must be remedied for the new scheme to operate effectively.

10.119 Bury Council and Bury CCG were also concerned about the inequality of availability of funding across different settings:

> At present we are faced with deprivations in the home, supported living or shared lives schemes having to be authorised in the Court of Protection where legal aid is both means and merits tested. This seems unfair especially when neither the family nor P want this litigation and where legal aid is available for 21A challenges. Further there is a concern that local authorities may be asked to undertake to pay costs which is something that is simply not affordable especially when budgets are tight.

LEGAL AID FUNDING FOR REPRESENTATIVES AND FAMILY MEMBERS

10.120 A number of consultees argued that family members and representatives should qualify for legal aid. For example, according to Hertfordshire County Council:

> It also seems unfair that a number of family members are now being appointed by the Court as rule 3A representatives but that they are not eligible for non means tested legal aid to represent the wishes of P. Family members should be able to properly represent their views and those of P during the court process and under the current legal aid rules, the only way this is possible is for them to either be litigants in person or to self-fund the cost of legal representation.

10.121 It was also suggested that, in order to minimise the cost implications, a list similar to that in section 26 of the Mental Health Act concerning nearest relatives is used to determine which family members should be able to receive legal aid.

10.122 Mencap argued that:

> It is very important there is legal aid not just for individuals but also families. Families are not always properly consulted by lawyers for individuals, meaning that the crucial knowledge they have is not used to inform decisions as it should.

10.123 According to the National Care Forum:

> We would like to see legal aid maintained for the relevant person’s representative and extended to include close family members (either generally or through a defined list) so that, where appropriate they have the means to challenge decision-makers.

10.124 In contrast, a multi-agency response from Buckinghamshire argued:

> For the sake of clarity we do not support extending legal aid to family members who are not representative person’s representatives because of the reason as to why they have not taken on this role – where they considered inappropriate or is it their choice not to undertake that role? A defined list would raise more questions than answers.

PARITY WITH THE MENTAL HEALTH ACT

10.125 Some consultees emphasised the importance of parity between the legal aid regime in relation to deprivations of liberty with that under the Mental Health Act. According to the National Centre for Post Qualifying Social Work:

> Legal aid support will be required for tribunal hearings to ensure parity with the mental health system and ensure that the individual is not barred from access to appeal based on the availability of resources / finances. Upper tribunal and court of protection fees and costs will also need to be considered to ensure that entitlement to legal review is exercised.

10.126 Similarly, Jill Lewis (social worker) said that:

> Legal aid should be available to the relevant person and their representatives / advocates at any stage where protective care has been applied. It should not be means tested, so that it sits more closely with the Mental Health Act rules.

10.127 The Equality and Human Rights Commission Professional Association commented that:

> It would be important to ensure that non-means tested legal aid is available, in a similar way as it is currently in the mental health tribunal, in order to ensure adequate representation of the individual affected. The need for incapacitated individuals subject to deprivation of liberty to have adequate legal representation is well recognised. Non-means tested legal aid is presently available for mental health tribunal proceedings and for reviews by the court of authorisations under the current DoLS regime. This recognises the importance of guaranteed access to legal representation when liberty is at stake. It is considered that the same principles should apply under the proposed new jurisdiction for the same reasons.

10.128 Jonathan Nash (legal academic) commented that legal aid should be granted on exactly the same basis as for Mental Health Act tribunals. He argued that there can be no justification for any departure whatsoever from that position.

OTHER ISSUES

10.129 Many consultees also made general comments about the importance of legal aid. For example: Paul Greening (MCA manager) said:

> Without a replication of the non-means tested right to legal aid available to P under the DoLS, any right to appeal against protective care decisions will be largely theoretical for many people. I think that it is essential that the right to have their appeal heard in court, regardless of their financial situation, is too important a safeguard against arbitrary detention to be risked due to the unavailability of legal aid. There will be a significant cost of maintaining legal aid in all protective care cases, but this will depend largely on the cost of the Tribunal service – which should be significantly cheaper than using the Court of Protection for all section 21A appeals.

10.130 Lincolnshire County Council Adult Care Directorate and Lincolnshire Partnership Foundation NHS Trust noted that some cases are being artificially squeezed into a section 21A Mental Capacity Act challenge in order to qualify for legal aid. Similarly, the judges of the Family Division of the High Court said:

> On the question of legal aid, we can report that the existing rules on eligibility cause a distortion whereby parties struggle to present what is essentially a welfare question as a DOL issue so as to retain legal aid. This is unhelpful to the welfare of P and to the properly focused presentation of the issues.

10.131 Robert Robinson (solicitor for HL) made a similar point in arguing for a fixed fee regime for lawyers acting in deprivation of liberty cases:

> In my opinion DoLS has been exploited by lawyers, for example by running best interests cases under the guise of deprivation of liberty challenges. The Court of Protection is a poor critic of itself. The atmosphere, which one readily picks up from judgments, is of lawyers doing something which is of great value and that, accordingly, they are to be congratulated for their hard work and concern for the vulnerable people involved - and paid handsomely. How different is the world of the First-tier Tribunal (Mental Health)! A fixed fee regime should be introduced, as for the tribunal under the Mental Health Act. I do not know what can be done about the interminable and costly best interests cases under the Mental Capacity Act, but they need to be kept apart from Article 5-type cases (restrictive care) to be heard by the new tribunal.

10.132 Paul Bowen QC (Brick Court Chambers) stated that:

> Legal aid must be provided to P where article 8 is engaged having regard to the importance of the issues at stake, the complexity of the law and evidence and P's inability to represent himself: see R (Gudanavicience) v Director of Legal Aid [2014] EWCA Civ 1622. Where what is at stake is the individual's detention then there is a presumption that legal aid is provided: Megyeri v Germany (1993) 15 EHRR 584, para 29.

10.133 The Court of Protection Practitioners Association commented:

> The current regulations could also be improved by allowing for non-means tested legal aid to be granted where an urgent authorisation is in place, and not just when a standard authorisation is in place.

GENERAL COMMENTS

10.134 Several consultees provided general comments on the role of the courts in our scheme. For example, Care England commented:

> This is an opportunity to widen what we do with a tribunal: it would be a mistake in practice terms to model these tribunals slavishly on those relating to detention under the Mental Health Act. Hence we would like to see provider representation on tribunals. Managers' and senior nurses' knowledge of specific types of care and of people they provide services to is, in this context, perhaps comparable to that of a doctor. Also, there might be different members of the tribunal for, say, older and younger people: the issues are so different.

10.135 South Tees Hospitals NHS Foundation Trust noted:

> We think that there should first be an internal panel / process to hear requests for discharge and consideration for reviews of certain elements of the assessments, then a tribunal system.

10.136 According to Roger Laidlaw (best interests assessor):

> I must note those judges who have troubled to use language and to explain carefully to make the reports of cases accessible have performed an important service in illustrating the principles of the Act and modelling conscientious decision making. Honourable mentions should go to Mr Justice Jackson and District Judge Eldergill for producing particularly helpful and effective reports. Other judges have sometimes seemed to positively revel in the obscurity of the legal language they have used and to many staff in adult services this would seem to confirm the commonly held perception that the law is a closed world that does not intersect with their area of responsibility.

10.137 Joanna Burton (solicitor and trainee advocate) commented that:

> I agree with the Court of Appeal that P who lacks capacity to make the decision in question and / or to litigate should be joined as a party to any proceedings in whatever Court or Tribunal the matter is being heard. Not to do so would be a breach of P's Article 6 rights.

10.138 The Equality and Human Rights Commission commented that the new scheme "must have regard to the requirement of Article 5 of the ECHR that there must be a right to compensation in the event of unlawful detention", which could be achieved either by granting the tribunal the power to award compensation or by permitting such a claim to proceed by another route.

10.139 The response from Mr and Mrs E, and HL, commented:

> The ability of a court appointed deputy, advocate or appropriate person to make a robust challenge to decisions made by professionals in a timely manner, such as at the point of decision making, is absolutely necessary otherwise the delay in trying to put things right after the event by accessing a tribunal or court system will put the person at an extreme disadvantage.

Chapter 11: 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).

11.1 A majority of consultees agreed with the proposal.[112]

11.2 Consultees who agreed with the proposal recognised the benefits of formalising the role of a supporter. For example, Lucy Series (mental capacity academic) remarked:

> I concur that where individuals and families wish to use supported decision making, some may find it useful or otherwise attractive to have formal recognition of the role (and responsibilities) of supporters. In particular, this may help families who have experienced being shut out decision-making or have had limited access to information where they are the person's chosen supporter. The Commission's proposals are based on the consent of the individual and the supporter; this is vital if formalised supported decision making arrangements are to be viewed as a welcome tool for individuals and families for addressing particular problems and not more state imposed bureaucracy.

11.3 The National Family Carer Network felt that "it would be very helpful to strengthen the support available to people to make decisions for themselves" or "to contribute as much as they can to the decision-making process". Eleanor Murphy (best interests assessor) noted examples of cases where the capacity assessments do not evidence how a person was supported to make the decision, what information they were provided with in terms of the valid options or even if there are any options on the table.

11.4 The Centre for Law and Social Justice and Centre for Disability Studies, University of Leeds and CHANGE, Leeds argued that:

> Whilst there are some aspects of the current Mental Capacity Act that reflect the ethos of supported decision-making, these are not sufficiently robust or holistic and portray a very narrow view of what is required to support somebody to exercise legal capacity in a broader sense.

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[112] 173 consultees expressed a view on this proposal: 91 agreed, 34 disagreed and 48 held equivocal positions.

11.5 The Centre for Disability Law and Policy at the National University of Ireland, Galway submitted a detailed response on this proposal and advocated a choice-orientated framework for supported decision making. It noted:

> It should be possible to develop a robust system of supported decision-making which does not rely on assessments of mental capacity to determine who is in need of, or entitled to, support. For example, all adults should be able to choose one or more trusted supporters who provide assistance with decision-making, and determine the scope and limits on that assistance. Where an individual wishes to use support, a low threshold for the creation of a valid support agreement could be used, along the lines of that proposed by the Law Commission:
>
> (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.
>
> We would however advocate that in certain circumstances, a different formulation of these criteria may be required to ensure that those who are in need of more intensive support can be found eligible for a legally binding support agreement.

11.6 It also suggested detailed guidance on the instances in which a local authority can refuse to provide a care advocate where the person also has a support agreement.

11.7 Many consultees made specific suggestions in respect of this proposal. For example, the Old Age Faculty of the Royal College of Psychiatrists felt that:

> We think that in most cases a “supporter” should be the person who acts as an advocate. To appoint an advocate over and on top of a supporter such as a loyal and loving wife / family member would be an abuse and wrong.

11.8 The Law Society’s Mental Health and Disability Committee noted:

> We would have serious concerns if financial decisions were included in the supported decision arrangement, for example, decisions relating to gifts, the making of wills, dealings with land or securities, or entering into contracts. The risk of undue influence and financial loss would be too great.

11.9 There was some discussion on whether or not an Approved Mental Capacity Professional should have the power to displace the supporter. The Devon and Torbay Independent Mental Capacity Advocate Service questioned the circumstances in which the Approved Mental Capacity Professional would be able to exercise this power. Hertfordshire County Council commented that when a supporter is appointed, there must be a safety mechanism to replace the supporter or change a decision they have made akin to the applications that can be made currently under section 29 of the Mental Health Act 1983 to displace a nearest relative.

11.10 Some consultees focussed their comments on the eligibility of the supporter role. For example, Stephen Ward (MHA and MCA lead) noted:

> I do not think the law should restrict who can take on this role, as each case is unique and a suitable person could be a family member, a friend, or a professional, with the safeguard that an Approved Mental Capacity Professional could make an application to displace someone thought to be not acting in the person's best interests.

11.11 Kingwood (learning disability service provider) noted that there needs to be consideration that the person appointed is not directly linked to the persons care or would have views that would not be in the persons best interests, as this would be a conflict of interest. Hertfordshire County Council noted that there must be clear parameters outlining what the supporter can do within this role.

11.12 Dimensions (learning disability care provider) felt it was important that non-professionals should be vetted just like professionals, whilst also recognising that this "could cause issues with family and friends if they are deemed inappropriate".

11.13 The Centre for Disability Law and Policy at the National University of Ireland, Galway argued that the requirement for qualifications should only apply to professional supporters, rather than natural supporters chosen by the person, and suggested that the elaboration of a set of values for supporters, based on principles of ethics and human rights:

> In our view, the need to safeguard those using support from exploitation or abuse could be better achieved through independent monitoring, flexible and accessible complaints processes, and the availability of alternative support if the individual so chooses, than the imposition of requirements for professional qualifications on potential supporters.

11.14 West Sussex County Council called for any supporter role to have parameters to avoid opening up a formal role to vexatious positions or cause conflict within families, where those involved do not all agree on the position of what is in the person's best interests or the current care arrangements.

11.15 Several consultees asked for further details on how any new scheme might operate or how existing schemes worked in practice. In particular, many questioned how a supporter would differ from other representative roles under the Mental Capacity Act, and what forms and costs would be required in order to appoint a supporter.

11.16 Some consultees did not agree that a new legal process was necessary. For example, Hywel Dda University Health Board argued that the focus should be on moving professional attitudes away from protection and paternalism. Similarly, Halton Borough Council argued that good person-centred care should already take the wishes and feelings of the service user into account and effective care planning should reflect the decision-making process. Nikki Mardell (MCA and DoLS lead) felt that supported decision-making is adequately provided for through the appointment of an advocate or a donee under a Lasting Power of Attorney.

11.17 South West Yorkshire Partnership NHS Foundation Trust suggested that there be a legal requirement on health, social care, legal services and financial institutions to discuss with the person who may have decision-making difficulties the option of an advocate to support the person with their decision-making. With the person's written consent the health, social care, legal service or financial institution could make the referral to the advocacy service for the purpose of accessing supported decision-making.

11.18 A number of consultees disagreed with the proposal on the basis that it would add complexity, and lead to disputes. For example, Bindmans LLP was concerned that too many roles may lead to confusion for the person in question and a blurring of roles. Professor Peter Bartlett (mental health law academic) thought that the field was getting "crowded" with relevant person representatives, appropriate persons, advocates, the Official Solicitor and lawyers. He noted that the list has grown organically "with a bit of a sense that adding in more has no down sides".

11.19 Some consultees (including those supporting the proposal) raised questions regarding the costs of any new scheme. For example, the Department of Health and the Ministry of Justice mentioned the potential cost to the public purse of providing a new statutory form of support for people in all aspects of their lives.

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.

11.20 The proposal was supported by a majority of consultees.[113]

11.21 For example, the Equality and Human Rights Commission stated that:

> We think that the approach that a person's wishes and preferences, where reasonably ascertainable, should be given effect to in so far as practicable, gives better effect to Article 12 of the United Nations Convention on the Rights of Persons with Disabilities by moving away from best interests decision making rather than merely promoting the persons wishes and feelings within the hierarchy of best interests decision making.

11.22 Similarly, the Alzheimer's Society argued that the proposal would ensure "that the person is at the centre of the decision" and "fulfils the essence of the Mental Capacity Act and the United Nations Convention on the Rights of Persons with Disabilities" and would "support the outcome to be as close as possible to what the person themselves would have wanted". The Royal College of Psychiatrists also supported the proposal and felt it may be particularly valuable in end of life care.

11.23 Many family members and informal carers provided evidence that best interests decisions were often made without reference to their loved ones and felt that professionals would "pick and choose" randomly which factors on the check-list to prioritise. Pohwer (advocacy provider) argued:

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[113] 182 consultees expressed a view on this proposal: 119 agreed, 35 disagreed and 28 held equivocal positions.

> Whilst the best interest checklist was well crafted in the Mental Capacity Act, inherent risk aversion within the health, social care and other sectors too frequently results in insufficient weight being given to the wishes and feeling of people subject to the Act.

11.24 Compassion in Dying felt that currently there is a risk that, in practice "the best interests process becomes overly paternalistic", which means that the decision is seen as "overly clinical with relatives unclear of the motivations behind a particular decision". It was agreed that introducing a presumption that the person's wishes are determinative would be "a key step towards addressing this".

11.25 Many consultees who supported the proposal accepted that wishes and feelings could never be wholly determinative, and guidance would be needed as to how much weight to apply to wishes and feelings in individual cases. Several called for greater clarity on how much latitude decision-makers should have to depart from a person's wishes and feelings, where these are known.

11.26 Dr Emma Cave (medical law academic) argued that the proposal would ensure closer alignment with the United Nations Convention on the Rights of Persons with Disabilities, and went on to state that:

> Careful monitoring will be needed in case there are unintended effects on the section 1(2) Mental Capacity Act presumption of capacity. Elevating will and preferences within the best interests test has potential to blur the line between a person whose view is respected because they lack capacity and a person whose view is respected because it is in their best interests to do so.

11.27 Some consultees qualified their support for this proposal. For example, Bury Council and Bury CCG felt that the preferences of a person should be adhered to as long as they were "reasonably ascertainable". Nikki Mardell (MCA and DoLS lead) argued that a person's past and present wishes and feelings should be given as much weight as possible, but this must be "within the law" and for example "if the person had expressed a wish to die if in a particular state it would not be lawful to assist them with this".

11.28 The Essex Autonomy Project of the University of Essex welcomed the proposal as a "step in the right direction", but remained "legally, conceptually and practically insufficient" in its present form. It set out an alternative approach based on four principles:

(1) the best-interests decision-maker should begin with the assumption that the person's past and present wishes and feelings should be determinative;

(2) the decision must comply with P's past and present wishes and feelings unless there are compelling reasons to consider that doing so would have serious adverse consequences for P.

(3) the greater the departure from P's reasonably ascertainable wishes and feelings in respect of a decision to be made on their behalf, the more compelling must be the reasons for such a departure.

(4) where it is not possible to reasonably ascertain P's wishes and feelings in respect of the decision, the person making the decision shall minimise any restrictions on

P's rights and freedoms consistent with making the decision that accords with P's best interests.

11.29 Dr Lucy Series (mental capacity academic) also suggested that the proposal was insufficient:

> My view is that this proposal does not go far enough to satisfy the requirements of the United Nations Convention on the Rights of Persons with Disabilities nor to change entrenched practices on the ground. The retention of the language of best interests will mean that the Mental Capacity Act remains facially at odds with the requirements of the general comment, even if it can be argued that the ethos of best interests is more in line with the underlying spirit of Article 12 of the United Nations Convention on the Rights of Persons with Disabilities. Meanwhile on the ground, whilst those who closely follow the developments in Mental Capacity Act law and policy will be attuned to the growing emphasis on the person's wishes and feelings in the best interests test, the reality is that for many people applying the Act on the ground, "best interests" will still be closely linked to their own professional values – "clinical" best interests, "financial" best interests, etc. Without a radical rebranding the paternalistic values tied up in other ways of constructing best interests are unlikely to be dislodged.

11.30 Those who disagreed with the proposal often argued that statutory reform was unnecessary. For example, Dr Jonathan Waite (psychiatrist) felt that all that was needed was a change to the code of practice. St Helens and Knowsley Teaching Hospitals NHS Trust considered that the person's past and present wishes and feelings was "already prioritised within current decision making structures".

11.31 Some argued that a person's wishes and feelings should be significant, but not necessarily always determinative. NHS Sheffield CCG stated that "a person's wishes and wants may not actually be in their best interests" and "may well be an unwise decision if they had capacity to make the decision for themselves". West Midlands Regional DoLS Leads Group argued that "often a person's wishes do not accord in any way with present reality and this cannot be determinative of decision-making".

11.32 Similarly, Suffolk County Council told us that:

> Scope is required where circumstances exist to over-ride the person's past wishes – for example in the situation where the person with capacity had made a series or eccentric and unwise decisions which could not be supported with regard to their duty of care, once the person had lost the capacity to consent.

11.33 The Old Age Faculty of the Royal College of Psychiatrists, disagreeing with the proposal, was concerned that "best interests decisions do not contain any evaluation of good clinical care" and argued that "good quality health care must be the starting point for any best interests discussion".

11.34 There was also some opposition from members of the judiciary. Mr Justice Charles (Vice President of the Court of Protection and President of the Upper Tribunal (Administrative Appeals Chamber)) stated that the proposal was "unnecessary and would cause considerable complications when [P's wishes and feelings] have varied over time or cannot be met in practice".

11.35 Similarly, the judges of the family division of the High Court suggested that the proposal would “simply lead to debate about whether there is ‘good reason’ to depart from the assumption and would not produce better outcomes in these difficult cases”. It was suggested that instead the Mental Capacity Act should be amended to provide that:

> In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of –
>
> (a) the person's age or appearance; or
>
> (b) a condition of his, or an aspect of his, behaviour which might lead others to make unjustified assumptions about what might be in his best interests; or
>
> (c) an unjustified assumption that less weight should be given to the person’s wishes and feelings, beliefs and values because he lacks capacity.

11.36 Whilst Mr Justice Jackson did not submit a formal response to the consultation, he did pass comment on this proposal in Wye Valley NHS Trust v B:

> My respectful view is that the Law Commission proposal would not lead to greater certainty, but to a debate about whether there was or was not "good reason" for a departure from the assumption. To elevate one important factor at the expense of others would certainly not have helped the parties, nor the court, in the present case. All that is needed to protect the rights of the individual is to properly apply the [Mental Capacity Act] as it stands.[114]

11.37 These comments provoked responses amongst consultees. Dr Lucy Series argued that he had failed to take into account how the best interests principle “may be applied by a person diligently following the best interests checklist yet who holds a very different value base to somebody like Mr Justice Jackson”. Others argued that the Court of Protection (and others) frequently failed to consider carefully or to explain its reasons for departing from the person’s wishes and feelings, and gave examples of decisions by the Court that first identify a person’s wishes and feelings, and then go on to arrive at a decision that sits in tension with them.

11.38 On the other hand, the Bar Council agreed with the remarks made by Mr Justice Jackson J, and suggested that the code of practice could be expanded “so as to convey the importance of P’s wishes and feelings in the overall balancing exercise being undertaken” “an amendment to the legislation requiring a court or tribunal to authorise an act which goes against P’s wishes, or to which P is objecting”.

11.39 The Welsh Government in principle supported the proposal. The view of the Department of Health and Ministry of Justice was that the core principles of the Mental Capacity Act are sound and are in line with the principles of the United Nations Convention on the Rights of Persons with Disabilities, but would nevertheless “be interested to understand stakeholder’s views in this regard and will consider further whether change is necessary to strengthen the legislation further”.

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[114] Wye Valley NHS Trust v B [2015] EWCOP 60 at [17]. Emphasis in the original.

Chapter 12: 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.

12.1 A majority of consultees agreed with the proposal.[115]

12.2 King's College Hospital NHS Foundation Trust argued that the proposal would have the "significant benefit of giving the patient greater control over his / her own circumstances as well as providing clinicians greater clarity over treatment options". Barts Health NHS Trust commented that the proposal must "generally prohibitive and overwhelming" barriers which currently mean that Lasting Powers of Attorney are virtually unused (for instance, expense, legal complexity, complicated forms and double registration with the Court of Protection).

12.3 The Royal College of Nursing agreed that "there is evidence that advance decision making can be used to good effect" and "extending this under the new scheme in the proposed conditions could be advantageous".

12.4 Many consultees focused on end-of-life situations and palliative care. For example, Birmingham St Mary's Hospice argued that the process for patients who are dying should be easier, and that currently:

> For those who have expressed that the hospice is a preferred place of care and have subsequently lost capacity, we have not applied for a DoLS authorisation as we feel they have consented to this arrangement. We would appreciate clarification that this is adequate in any future law. We have had experience of DoLS and other legal issues involving multiple professionals at end of life being uncomfortable and viewed as unnecessary by families.

12.5 For example, Vincent Duffy (DoLS team leader) referred to the need to avoid:

> The need for further intrusive assessments when someone is approaching end-of life, which is usually a heightened emotional time for those concerned, can have more negative implications than positive. Ultimately, the involvement of an assessor at such a time is not going to improve the overall outcome.

12.6 Tees, Esk and Wear Vally NHS Trust agreed with the proposal insofar that "it already applies in terms of consent to a surgical procedure that carries forward even when the person is rendered incapable" for instance by the administration of an anaesthetic.

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[115] 166 consultees expressed a view on this proposal: 110 agreed, 21 disagreed and 35 held equivocal positions

South West Yorkshire Partnership NHS Foundation Trust pointed out elective medical and surgical interventions should be taken into account as “part of the risks and benefits of the intervention contained within the consent process”.

12.7 The Law Society’s Mental Health and Disability Committee argued that the ability to consent to a future deprivation of liberty would also be of particular value for those in end of life care and people about to have a serious operation which will mean a spell in intensive care. Newcastle City Council’s Legal Services suggested that arguably, advance consent is already possible under common law, “but explicit statutory provisions would be advantageous”.

12.8 Some consultees made suggestions for the implementation of an advance consent scheme. For example, Barts Health NHS Trust called for a standard consent form, confirming that the issues have been discussed and that “[an agreed list of] restrictions may be put in place in the event of [an agreed list of] contingencies occurring”.

12.9 Many consultees agreed with our proposal whilst also making clear that safeguards must be built into the process. For example, Hertfordshire County Council suggested that the relevant care plan should be monitored and reviewed regularly to ensure no changes have occurred. Several responses also stated that consent must be fully informed.

12.10 Some consultees disagreed with our proposal. Professor Rob Heywood (medical law academic) provided a detailed response which argued that:

> The patient is being asked to consent to something in the future and the only reason for seeking that advance consent is so that the patient falls outside the reach of article 5. This gives the impression that the advance consent is being obtained only for the sake of administrative convenience in the sense that the article 5 protections will no longer be in play and the burdens of complying with them can therefore be dispensed with.

12.11 He suggested that advance consent would:

> Give healthcare professionals carte-blanche to do what they want to patients without patients enjoying any concrete protection from unnecessary and inappropriate infringements on their autonomy and liberty.

12.12 Professor Heywood further doubted whether sufficient safeguards could be introduced:

> Confining advance consent to a “defined event of relatively limited duration” is problematic straightaway as a deprivation of liberty, by its very nature, is difficult to place a precise time limit on. Elective operations may result in unforeseen consequences and palliative care may need to be provided on different terms and for longer periods than was initially contemplated. The above scenarios could occur quite easily, and not infrequently, and so therefore the impact upon the patient’s liberty could end up being more substantial than was initially anticipated by the patient when they provided the advance consent.

12.13 The National Centre for Post Qualifying Social Work doubted whether it would be possible for any advance consent to be “sufficiently detailed to cover the multitude of situations which may arise". It was also concerned that limited understanding of the Mental Capacity Act generally would mean that the advance consent would not be fully informed. The Alzheimer's Society noted that "not many people would want to think that they would be deprived of their liberty, and it would be seen as an odd thing to agree to".

12.14 Your Voice Counts (advocacy provider) expressed the following concerns:

> No person could possibly give capacitated consent to being deprived of their liberty without knowing in what setting and what the exact content of their care plan would be … We think that without very detailed, skilled advance decision making, this could have the opposite effect to that intended and act as a means to disregard future wishes on the basis that 'they agreed to it when they had capacity'.

12.15 Paul Bowen QC (Brick Court Chambers) did not agree with our proposal, in particular stating that he was unaware of any case-law that suggests that advance consent to a deprivation of liberty can be given. The Bar Council was concerned that there would be "no realistic safeguards in place" and proposed that a better approach would be to:

> Ask whether, for example, a short stay in a hospice in fact engages article 5 at all. We note, for example, that the care and treatment to be provided in a hospice will generally not be for the purposes of treating a mental disability or disorder, and that there will be no prohibition on people leaving the hospice should they or their relatives wish care to be provided elsewhere.

12.16 The Court of Protection Practitioners Association did not support advance consent to a deprivation of liberty becoming part of the general consent to treatment discussion between surgeon / doctor and patient in advance of surgery because "the risks of consenting here are not medical ones, but legal, and the patient has the right to give full and informed consent".

12.17 Some consultees argued that giving statutory recognition to the ability to consent to a future deprivation of liberty was unnecessary. For example, Hywel Dda University Health Board argued that advance consent to an elective operation, post-operative sedation, and a potential admission to the intensive care unit is already dealt with through the "normal written consent process". Furthermore:

> It is common practice to avoid putting people receiving palliative care, and their families, through the DoLS process. This ensures that they are treated with dignity and respect, and are not unnecessarily distressed during what is a very difficult time. We see no reason not to simply continue with this state of affairs rather than putting someone through the difficult decision of whether or not they are willing to be deprived of their liberty once they lose capacity towards the end of their life. This seems like an unnecessary conversation to have with someone who is already having to cope with the reality of their approaching death.

12.18 A number of consultees commented on our proposal without taking a firm view. For example, London Borough of Barking and Dagenham Council argued that our proposal would be:

> Very difficult to implement in practice as it would need to be so specific and in any eventuality, new developments may be in place when the time comes and the deprivation of liberty may not be in a person's best interests. If this proposal is to go ahead, it would need to be strictly time limited vis-à-vis the date of the advance decision and the deprivation of liberty. There would also need to be a detailed review process as a safeguard.

12.19 Belinda Schwehr (consultant and legal trainer) felt that the proposal would be "a very good idea" particularly in a domestic setting, where the person is "being locked in at night on the footing that the risk is minimal and it enables a person to remain in their own home for longer". But she also had some reservations:

> The difficulty with advance consent is that a person will never be able to envisage the flavour and context of the regime or the proportionality of it in advance. No one would consent to a disproportionately savage regime on account of shortage of money, for instance: so the principle must be expanded to a future deprivation of liberty in the context of a lawful care package, in my view.

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.

12.20 A majority of consultees agreed that the restrictive care and treatment scheme and the hospital scheme should not apply in cases where they would conflict with a valid decision of a donee or advance decision.[116]

12.21 Many consultees agreed on the basis that the proposal reflected the current legal position. For example, Hertfordshire County Council noted that it replicated to a large degree the no-refusals requirement of the DoLS and argued that it would require "a mechanism to enable the decisions to be contested in the Court of Protection". The National Centre for Post Qualifying Social Work argued with our proposal, and suggested extending it to include welfare deputies.

12.22 Belinda Schwehr (consultant and legal trainer) agreed with our proposal, arguing that:

> The holder of a welfare power of attorney or deputyship stands in the shoes of the individual, and hence would constitute a refusal to consent to deprivation of liberty, which could not be overridden.

12.23 Whilst many consultees agreed that the proposal reflected the current legal position, some felt that the no-refusals requirement was misunderstood or not applied in practice. Some of those supporting the proposal were also concerned that the proposal might give attorneys "too great a power" and questioned how local authorities would deal with

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[116] 104 consultees expressed a view on this proposal: 72 agreed, 11 disagreed and 21 held equivocal positions.

an advance decision that will not agree to a care home placement when this may clearly be the only appropriate option to meet needs.

12.24 Some consultees disagreed with our proposal. For example, West Berkshire District Council stated that:

> This does not seem reasonable in relation to the restrictive care and treatment scheme particularly and takes away from external scrutiny of any restrictions in place. That scrutiny is critical as many donees are unaware of least restrictive options that may improve the life of a person subject to restrictions.

12.25 Devon County Council argued that the restrictive care and treatment scheme and the hospital scheme:

> Should still apply in order to avoid the risk of an irresponsible attorney making a decision that is demonstrably not in the best interests of the relevant person and which ultimately puts them at risk. Should the schemes be inapplicable in such circumstances an urgent hearing before the Court of Protection would be required seeking an order revoking the Lasting Power of Attorney pursuant to section 22(3)(b) and 22(4) of the Mental Capacity Act. This may take some time to obtain and the person may be put at unnecessary risk during this period.

12.26 It argued that in order to protect the rights of the relevant person and the done (while ensuring that the detaining authority was able to protect a vulnerable adult where it appears the donee is not acting in the person’s best interests), the following alternative system should be put in place:

> To allow the schemes to apply but to make it a condition imposed upon the detaining authority that in circumstances where an authorisation conflicts with a valid decision of a donee under a Lasting Power of Attorney or an advance decision, this must trigger an immediate referral to the tribunal for consideration as to whether the authorisation is in the person’s best interests and to ensure that it is compliant with the person’s article 5(1) rights. If the tribunal is satisfied that the authorisation is appropriate, then this could overrule the advance decision or the donee.

12.27 A number of consultees did not take a firm view of the merits of our proposal, but made comments on certain aspects. For example, Stockton-on-Tees Borough Council argued that there should be a discretion for the Court of Protection to consider cases where there has been inappropriate decision-making by a donee.

12.28 Professor Peter Bartlett (mental health law academic) stated that:

> It is worth remembering that a significant number of donees of Lasting Powers of Attorneys, intentionally or not, do not do a very good job fulfilling their roles. While I would certainly not start with a presumption of scepticism in this regard, I would equally want at least a light touch approach to ensure that things are proceeding as they ought.

Question 13-3

How (if at all) should the law promote greater use of advance decision-making?

12.29 This question elicited 119 responses and included many suggestions as to how advance decision-making could be promoted by the law.

12.30 Professor Rob Heywood (medical law academic) argued that patients needed to have greater faith in the legal effectiveness of advance decision-making. In particular, "the important assessment of capacity at the time the decision is made perhaps needs to be revisited". He also made a number of further suggestions. First, he suggested that awareness needs to be raised through education and advertising campaigns, in particular targeting younger people. Second, he suggested that GPs could take a greater role in promoting them. Third, he suggested that solicitors could be encouraged to raise the issue with clients when constructing a will.

12.31 Professor Jenny Kitzinger (co-director of the Coma and Disorders of Consciousness Research Centre) submitted a detailed response to this question. She argued that practitioners should be required to discuss the options with patients and service users, and highlighted research which showed that "a 'window of opportunity' to discuss options with patients, and protect their wishes" is being missed by practitioners, "which has a huge subsequent emotional cost to families and financial cost to the NHS".

12.32 Professor Kitzinger also argued that Court of Protection Practice Direction 9E (which provides that cases involving serious medical treatment should be brought before the Court of Protection)[117] should be reformed. :

> Practice Direction 9E is silent on the question of advance decisions to refuse treatment (and also on lasting power of attorney for health and welfare). This leaves it open to a reading that court hearings are required even concerning those permanent vegetative state patients who have explicitly refused artificial nutrition and hydration in a valid and applicable advance decision in accordance with the Mental Capacity Act. This is the interpretation given to it by some lawyers who say that they would advise CCGs / Health Boards to apply to the courts before withholding/withdrawing artificial nutrition and hydration in such cases. However, another reading of Practice Direction 9e is that it is irrelevant where there is a valid and applicable advance decisions to refuse treatment since Practice Directions apply only to decisions the Court of Protection has jurisdiction to take and there is nothing in any relevant provision to suggest that the validity or applicability of all advance decisions to refuse treatments has to be determined by the Court of Protection.

12.33 Professor Kitzinger summarised her own research which indicated that Practice Direction 9E was "causing confusion and delays" and that those writing advance decisions would not want to have their advance decisions to come before the court, but want their prior decision to have effect, "in a timely manner and in accordance with the

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[117] 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.

Mental Capacity Act". She therefore recommended that Practice Direction 9E be amended provide that decisions about the withholding or withdrawal of artificial nutrition and hydration from a person in a permanent vegetative state or a minimally conscious state, should be regarded as serious medical treatment and brought to the court "unless there is a valid and applicable advance decision refusing treatment or unless an attorney with the relevant decision-making powers authorises withdrawal".

12.34 Compassion in Dying also responded in detail to our question, and drew our attention to a report which they produced on the subject of advance decision making: *Plan Well, Die Well*.[118] Compassion in Dying identified lack of awareness among health care professionals as a barrier to use of advance decision-making, and argued that:

> There should be a positive duty on health care professionals to inform patients about their options for advance decision-making. There should also be training for health care professionals of all levels on advance decision-making and also on initiating conversations with patients about their treatment preferences.

12.35 It further identified a lack of support available to people making advance planning documents as a barrier to use of advance decision-making. Whilst recognising the work that the Office of the Public Guardian has done to simplify the process of applying for a Lasting Power of Attorney, it argued that the process is still seen as "daunting and complicated". Finally, Compassion in Dying pointed towards the lack of a formal system for advance decision-making. It suggested three remedies for this. First, the right to refuse treatment in advance should be included within the NHS constitution. Second, there should be a centralised register for advance decision, similar to the Organ Donor Register. Third, there needs to be guidance regarding how advance decisions should be treated in emergency situations, and more robust systems for coordinating care and information between settings.

12.36 The Bar Council suggested a statutory duty to inform people of the options for advance decision-making should be placed on those carrying out needs assessments under the Care Act 2014, advocates appointed under the Care Act or the proposed scheme, solicitors instructed to settle a will, and GPs.

12.37 The Law Society's Mental Health and Disability Committee stated that:

> The use of mechanisms such as standard statutory forms would have the benefit of prompting a discussion between health and social care professionals and individuals. It would also provide an opportunity for greater clarity for the individual about different treatment and care options, and for their relatives, carers as well as inform healthcare professionals about their views.

12.38 Many consultees highlighted the need for more information to be made available. Hywel Dda University Health Board argued that the use of advance decisions can be encouraged through awareness raising and education, and argued that:

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[118] Compassion in Dying, *Plan Well, Die Well* (2015).

> We do not see how greater use could be encouraged through the law. Governments need to do more to promote their use among the general public, and health boards need to do the same among their patients.

12.39 The National Family Carer Network stated that:

> We have heard a lot from families (through consultation meetings and events we have run) about what they see as lack of information about advance decision-making and confusion about the different instruments available. Information needs to be given to people at the right time for them to make use of it and in ways that they can accept and understand.

12.40 Many consultees suggested that health and social care professionals should do more to highlight the benefits of advance decision-making. Hertfordshire County Council argued that:

> Social and health care professionals should receive additional training in order to be better equipped to identify situations where an advance decision may be appropriate. It would be difficult to standardise their use, as each situation should be dealt with based on the needs of the individual. Better understanding and improved knowledge on advance decision making would be welcomed. We would also suggest clear guidelines with regards to advance decision making, which is universal and becomes an integral part of a social or health professional's on-going development and training.

12.41 Hospice UK and the National Council for Palliative Care highlighted the difference between advance decision-making and advance care planning. Advance decision-making was described as a statement of a person's preferences with regard to refusal of treatment, whereas advance care planning was seen as "a structured conversation with individuals and their family / carers about their preferences". They argued that the role of legislation is not to require advance decisions to be made, but rather to affirm the primacy of the tools of advance decisions, assigning power of attorney and participation in advance care planning.

GENERAL COMMENTS

12.42 We also received some general comments and suggestions on the issue of advance decision-making.

12.43 For example, Michael H Stone argued that advance decisions should be used as much as possible, stating that people should:

> Really, really, try to get the decision in advance of incapacity from the patient. Then, tell everyone supporting the patient, what the patient had decided, and simply "follow the patient's own decision".

12.44 The Centre for Law and Social Justice and Centre for Disability Studies, University of Leeds and CHANGE, Leeds were concerned about the use of advance decision-making:

> We understand the importance of advance refusals of treatment or particular care arrangements, and the salience of this in the DoLS framework as it stands. Yet, there

> is a danger that this forces us to see the person through the incapacity / capacity dichotomy, whereas the UN Convention of the Rights of Person with Disabilities instead prioritises support for the exercise of legal capacity. This calls into question the reliance on advance refusals where it is still possible to support that person to make a relevant decision, or to elicit their current will and preferences.

12.45 Elizabeth Byrne McCullough took the opportunity to inform us of developments in Northern Ireland on advance decision-making. She noted that the new Mental Capacity Act (Northern Ireland) 2016 does not include any provision for advance decisions, which she argued sent out the wrong message:

> We want people to see advance decisions and advance care planning in a positive light, that it can be part of exercising ones right to decide what is best for yourself - nobody knows you better - when you have capacity and for a time when you don't.

Chapter 13: Regulation and Monitoring

Provisional Proposal 14-1

The CQC, 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.

13.1 This proposal was supported by the majority of consultees.[119]

13.2 For example, the Equality and Human Rights Commission agreed that the remit of the DoLS regulators should be extended, and noted in relation to monitoring in supported living, shared lives accommodation and in domestic settings that:

> Whilst it is acknowledged that there are proper concerns about privacy and to ensure respect for family life in this context, the Equality and Human Rights Commission agrees with this approach. It will clearly be very important, however, that the details of implementation of any inspection regime in the domestic setting are sensitive to privacy and family life issues and no more intrusive than necessary.

13.3 The Law Society's Mental Health and Disability Committee stated that:

> Our members have experience of many individuals living in their own homes / supported living with 24 hour care and who are subject to significantly restrictive regimes, including seclusion, restraint and restrictions on access to the community. The care arrangements are likely to be very similar to those which would be in place if the individual were living in residential care or a hospital yet they do not have the benefit of CQC monitoring and inspection. We do not believe that there is any obvious justification for such an omission.

13.4 A number of consultees (particularly from the housing and supported living sector) agreed with our proposal, whilst highlighting the need to distinguish between personal care and housing provision. For example, the Methodist Homes Association argued that:

> The proposals about monitoring and oversight of the new system really do have the potential to blur the boundaries between what is within the regulated activity of "personal care" and what is actually part of a wider housing function. Our view is that the CQC are not best placed to monitor arrangements that go beyond the delivery of personal care.

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[119] 126 consultees expressed a view on this proposal: 95 agreed, four disagreed and 27 held equivocal positions.

13.5 Similarly, ARCO argued that the CQC should not monitor compliance with the scheme where the activities which constitute the deprivation of liberty go beyond "personal care" and into "activity by housing staff".

13.6 Other comments from care and housing providers pointed to the demands of regulation placed on them. The National Care Forum stated that:

> Our members report 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. This in part is due to the sheer volume of applications that have had to be made, and in some areas the slow response of local authorities, but also it is due to an inconsistent approach by different inspectors.

13.7 The issue of how deprivation of liberty would be monitored in domestic settings attracted several comments. For example, many queried whether the regulators would be given new powers to enter domestic settings or how they would monitor ongoing compliance with a new DoLS replacement scheme.

13.8 The Human Rights Implementation Centre at Bristol University argued that the current methodology adopted by regulators is problematic for domestic settings:

> This may require a new power of entry for inspectors. Regulators such as the CQC cannot rely solely on intelligence from others e.g. advocates / visitors / relatives / carers to discharge their role in such settings, as OPCAT compliance requires interviews with patients and visits by National Preventive Mechanism inspectors. A more pragmatic approach may therefore be needed to ensure coverage of the range of places of deprivation of liberty included in the proposals. In any event, it is crucial that if the [DoLS regulators] are to be given this broad mandate under OPCAT, they must be provided with the necessary additional financial and other resources and capacity to do so.

13.9 It suggested that the problems of monitoring the DoLS in domestic settings could be addressed in a number of ways, such as greater training of staff, clarity over the standards (domestic and international) that apply, appropriate financial resources, and coordination among the monitoring bodies.

13.10 Housing LIN argued that where the person lacks mental capacity to invite the inspector into their home, it could be appropriate for entry to be made on the basis of a best interests decision.

13.11 Some consultees disagreed with our proposal. For example, Hertfordshire County Council argued that extending the role of the DoLS regulators would create a further burden on them and over-complicate the exiting process. Instead it suggested that the regulators should be able to request data about the scheme from local authorities.

13.12 A number of consultees took the opportunity to comment on the proposal without taking a firm view, or to comment more generally on the current regulatory system. For example, West Berkshire District Council argued that the regulatory process must be "simplified to make it effective and workable" because the current processes are "painfully bureaucratic". Similarly, Mencap argued that:

> The current monitoring of DoLS by the CQC is too concerned with administrative process and not enough with practice. When registered services are inspected by the CQC, the inspector will check staff understanding of the Mental Capacity Act and DoLS but there will be no direct link to practice. It is crucial there is a strong focus on practice and the outcomes for individuals.

13.13 Other consultees pointed to the varying levels of understanding of the Mental Capacity Act and DoLS amongst inspectors. For example, Wakefield Council Adults Health and Communities team stated that:

> Feedback from care homes that have had inspection visits from the CQC is that the CQC are still learning regarding the Mental Capacity Act and have an incomplete understanding of DoLS. If the system were to change again, there would be significant training implications for the CQC.

13.14 A number of consultees felt that the CQC had generally been ineffective in monitoring the DoLS role and therefore this role should be given to Safeguarding Adult Boards. Some consultees mentioned that the way the DoLS regulators collate data and information should be changed.

13.15 Dr Lucy Series (mental capacity academic) argued that the CQC needs to be able to regulate at the local authority level, as well as at the care provider level. She argued that the main key safeguards, such as independent assessments, reviews, appointment of the relevant person's representative and Independent Mental Capacity Advocate, lie at the level of the local authority, and yet the CQC are under no duty to monitor these aspects of the DoLS. Dr Series therefore argued that the CQC should be given powers:

> To monitor the operation of local authorities in relation to the new protective care framework, and a clear statutory duty to report on the operation of the framework at the level of the local authority as well as the level of the provider. Otherwise we shall learn little about the true operation of the framework and any systemic issues that policymakers and others should have regard to addressing.

13.16 Dr Series went on to comment on the CQC's powers to interview the relevant person, and in particular that the DoLS reports to date have not described how this power has been used. She argued that:

> Inspectors should be under a duty to record any interviews with the relevant person or others about their experiences of protective care, and the CQC should have an overarching duty to report upon the findings of inspectors using these interview powers in their annual report. This would ensure that where the power is used it is appropriately documented, and the annual report is informed by the views of those the system is supposed to serve, not merely those responsible for implementing it.

13.17 A number of consultees commented on OPCAT, and how regulation is necessary to ensure compliance with it. The Human Rights Implementation Centre at Bristol University argued that regulatory oversight must include effective National Preventive Mechanism monitoring to ensure compliance with OPCAT. It argued that in a number of ways current DoLS regulation does not meet the requisite standard, and that some of the generic inspectors who carry out DoLS inspections for both the regulators (as opposed to the specialist inspectors who carry out Mental Health Act inspections) are not appropriately qualified, and their methodology to inspections differs.

RESPONSES FROM THE DOLS REGULATORS

13.18 The CQC raised a number of concerns about our proposal. First, since it has no power to enter and inspect private dwellings, currently the inspection methodology involves visits to the individual in their home, and this relies on the permission of the person. However, it stated that:

> Gaining permission does however presume that the person has capacity to give it. In instances where individuals may not have such capacity, the CQC's right to be in their private accommodation is difficult to establish in many circumstances, especially where there is no power of attorney or available relevant documentary evidence. Our presence in the property would always be conditional, and we could be required to leave at any time.

13.19 It argued that extending their powers to enter private dwellings would raise issues under article 8 of the ECHR. Secondly, the CQC pointed out that it has no oversight of care that is not provided by a care provider which is not registered. It stated that:

> Although we are aware that people being cared for by their own families / foster families / shared lives can be subject to controversial restrictions on their liberty, we have no current powers to take any action in relation to them. Our power to enter and inspect, to monitor and ultimately to effect any improvements through enforcement action, depends upon their being registered with CQC. We can prosecute registered persons, or we can restrict or cancel their registration. As there is no proposal that family members should have any registration relationship with us, it is difficult to see how we would be able to gain entry to their premises, monitor the care being delivered, or effect any changes.

13.20 Thirdly, it raised resource concerns, arguing that it does not have the resources to inspect more locations than at present "unless it were agreed that our oversight could be carried out using our current sampling methodology":

> With regard to domestic settings, if the expectation was that our remit would be restricted to monitoring these safeguards rather than monitoring a registered person's level of compliance with the Health and Social Care Act, CQC would be required to develop a new monitoring framework and methodologies (including consideration of whether a sampling approach would be adequate), and employ a new type of inspector, with further associated costs.

13.21 The DoLS regulators in Wales did not respond to the consultation. But the Welsh Assembly Government pointed to the legal and financial implications of our proposal.

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?

13.22 Ninety-five consultees responded to the question of how the legal framework might encourage greater joint working and alternative forms of regulation.

13.23 A number of consultees argued that it would be useful if the legislation could be used to enable the regulatory bodies to share information. Sitra suggested that the "partnership requirements and duty of cooperation embodied in the Care Act 2014" could be mirrored in the new legislation to encourage and enable joint working. A similar suggestion was made by DAC Beachcroft LLP.

13.24 However, PASAUK expressed concern that these Care Act duties were not being implemented properly due to resource issues. Kent County Council cited similar concerns:

> Greater co-operation and joint working is always to be encouraged and the law provides a good framework. This should reinforce joint working as stated under the Care Act but in reality we continue to experience difficulties in sharing information and working in co-operation between relevant partners that are included in the Care Act.

13.25 A number of consultees argued that boards should be established in the legislation to encourage joint working. For example, the Sanctuary Group (service provider) suggested a structure similar to Safeguarding Adults Boards. Others suggested a statutory requirement for meetings or a forum between the various actors within the DoLS framework.

13.26 Several consultees suggested non-legislative changes. For example, the Human Rights Implementation Centre at Bristol University suggested the use of joint protocols between the relevant organisations and adequate training and oversight in order to clarify "expectations, issues around confidentiality and accountability". A number of consultees argued that changing the legal framework would make little difference cannot make much of a difference. For example, it was argued that resources, local cultures, IT systems and the willingness of staff co-operate are far more important facts.

13.27 Some consultees focused their comments on ensuring joint working health and social care, rather than with the DoLS regulators. For example, Luton CCG argued that it should be a statutory requirement for CCGs to have a Mental Capacity Act lead to work with local authorities and frontline staff. Similarly, Bedford Borough Council argued health and social organisations need to have dedicated leads who can ensure Mental Capacity Act compliance.

RESPONSES FROM REGULATORY BODIES

13.28 The CQC doubted whether reforms in relation to joint working would be effective. It stated that:

> While we are continually looking to improve the way we work with other organisations, we do not anticipate that this would minimise the resource implications of the new scheme for CQC. [Organisations such as advocacy providers] … may have information which could inform our monitoring of the scheme; however they would not be able to provide us with information on a regular basis. While advocacy services would have regular contact with individuals subject to the scheme, their role does not extend to reviewing the service provider. We do not believe that they or other organisations would be able to provide assurance to CQC in a way which would significantly alleviate the resource requirement for us.

13.29 Ofsted supported a statutory duty to share information:

> From Ofsted's perspective an open channel of communication including the timely sharing of information relating to schemes operating within settings we regulate and inspect will be vital. Ofsted's ability to inspect and regulate effectively will depend on the availability (ideally before we undertake an inspection) of information relating to schemes being operated within regulated and inspected settings.
>
> An express statutory cross regulator / inspectorate duty to share information of relevance to the other inspectors' / regulators' remits will ensure that the relevant regulator / inspectorate will be aware of the existence of schemes within regulated settings and will provide a bespoke channel through which concerns relevant to each inspector / regulator's remit can be shared. This will mean that any concerns which may impact on the welfare of children can be identified and acted upon as quickly as possible.

Question 14-3

Is greater regulatory oversight needed of individual decision makers and local authorities and the NHS for the purposes of protective care?

13.30 Most consultees argued that greater regulatory oversight is needed of individual decision-makers and local authorities and the NHS.[120]

13.31 For example, PASAUK stated that it was:

> Concerned at the comparative lack of regulatory oversight of individual decision-makers and both local authorities and the NHS as commissioners and providers of protective care. We believe that it would appropriate for a specialist division to be established within CQC to scrutinise Mental Capacity Act / DoLS activity as there is for the Mental Health Act.

13.32 The British Psychological Society stated that:

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[120] 137 consultees responded to this question: 74 said "yes", 33 said "no" and 30 held equivocal positions.

> We believe that some regulation of decision makers would be helpful. The Approved Mental Capacity Professional and hospital decision makers have a lot of power, the quality of decisions should be monitored / reviewed / audited on a regular basis.

13.33 Some consultees argued that as well as regulatory oversight, there should be greater consequences for non-compliance with the new legislation. For example, the Mental Health Alliance called for "sanctions or financial penalties on those who fail to comply with the requirements set out in the new proposals".

13.34 A number of consultees argued that greater regulatory oversight was not needed. For example, the Old Age Faculty of the Royal College of Psychiatrists stated that "additional oversight may in fact complicate health care and prevent effective health care delivery to the most vulnerable". Similarly, Hertfordshire County Council argued that:

> There are already a number of bodies which oversee decision makers, local authorities and the NHS and therefore if it already works well, there is no reason why more should be created. The creation of an additional regulatory body would seem a waste of valuable resources which could be used elsewhere.

13.35 Some consultees argued that the other scrutiny / oversight arrangements proposed under protective care would be sufficient. For example, Devon County Council felt that the role of the tribunal and independent advocacy would ensure effective oversight. The London Borough of Tower Hamlets also referred to the professional regulators (such as the HCPC) and the Local Government Ombudsman.

13.36 Other consultees argued against increased regulatory oversight on the grounds that current regulatory framework is not effective. For example, Steve Broach (barrister) argued that:

> The priority is effective implementation of the existing regulatory frameworks. Inspectors need to have detailed training on the requirements of the new scheme to be able to identify non-compliance.

13.37 A number of consultees argued that rather than increased regulatory oversight, the role of the supervisory body should be retained. For example, Vincent Duffy (DoLS team leader) argued that:

> Internally within the health and local authority bodies a tier of scrutiny much improved upon the existing signatory process under DoLS should be introduced. The purpose being to ensure that decision makers base decisions on the legislation and facts obtained and can challenge where the due process has not been complied with.

13.38 Gateshead Council did not express a firm view on the question, although it commented on how governance structures could be improved, including through performance and quality assurance systems.

RESPONSES FROM THE DOLS REGULATORS

13.39 The CQC noted that it has "no general power to enter and inspect civic centres or to require the production of reports, staffing rotas, internal policies or guidance from local authorities", but also stated that the regulatory gap has been addressed:

> To a certain extent in the past by asking local authorities to provide us with information voluntarily. This cannot be relied upon, and without any legal power, we are reliant on local authorities providing us with accurate information. If the current position is maintained, we will continue to face this gap in our ability to monitor any new scheme.

13.40 The CQC stated that any additional oversight role would require significant additional resources, and that:

> The CQC's purpose as quality regulator is to assess the quality of care provided by services for the people who use them. Any extension of this remit to include the wider role of local authorities and commissioners comes with the risk of diluting the CQC's purpose, and of duplication with existing oversight mechanisms for local authorities and commissioners. Any such recommendation therefore should not be given without considering the context of the CQC's wider role in health and social care.

13.41 The DoLS regulators in Wales did not respond. But the Welsh Government argued that greater regulatory oversight is not needed, as the Welsh regulators believe that is already suitable oversight of individual decision-makers, local authorities and the NHS in place in Wales.

GENERAL

13.42 Several consultees took the opportunity to comment more generally on regulatory issues. For example, the Human Rights Implementation Centre at Bristol University emphasised the different forms of regulation that can be implemented:

> Whilst we support the introduction of alternative "informal" forms of intelligence gathering / regulation, they must supplement but not supplant the system of regular visits by regulators / monitors. The latter is crucial to ensure compliance with OPCAT and effective oversight.

13.43 We received a response from the UK National Preventive Mechanism coordination, which is designated under OPCAT to focus on preventing torture and ill treatment in all places of detention. It stated that it:

> Very much welcomes the Law Commission's attention to OPCAT compliance in proposing new regulatory and oversight arrangements for situations in which people who lack capacity to consent to care and treatment are deprived of liberty.

13.44 It also commented on the potential application of OPCAT to supported living and shared lives accommodation, as well as domestic settings. Whilst it did not state definitively whether the UN Subcommittee on the Prevention of Torture believes that such settings should fall within the scope of OPCAT, it set out the following statement from the Subcommittee:

> The preventive approach which underpins the OPCAT means that as expansive an interpretation as possible should be taken in order to maximise the preventive impact of the work of the National Preventive Mechanism.
>
> The Subcommittee on Prevention of Torture therefore takes the view that any place in which a person is deprived of liberty (in the sense of not being free to leave), or where it considers that a person might be being deprived of their liberty, should fall within the scope of the OPCAT if it relates to a situation in which the State either exercises, or might be expected to exercise a regulatory function. In any situations, the National Preventive Mechanism ought also to be mindful of the principle of proportionality when determining its priorities and the focus of its work.

13.45 Finally a number of consultees were critical of the performance of the DoLS regulators, including the CQC. For example, Dr Jonathan Waite (psychiatrist) felt that the CQC was "unfit for purpose in achieving regulatory oversight, their inspections continue to ignore practice and remain obsessed with documentation". West Berkshire District Council described the current regulatory system as "overly complicated and bureaucratically unwieldy". Several consultees suggested that the DoLS regulators should train their staff to be more knowledgeable about the DoLS and Mental Capacity Act, or recruit more.

Chapter 14: Other Issues

Provisional Proposal 15-1

Protective care should apply to persons aged 16 and over.

14.1 It was agreed by a majority of consultees that protective care should apply to persons aged 16 and over.[121]

14.2 For example, Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs argued that:

> The revised legislation should include all persons over the age of 16 years. As well as bringing age ranges in line with the Mental Capacity Act it will also offer seamless and transparent guidance regarding protective and restrictive care for young persons between the ages of 16 - 18. This is coterminous with provisions in the Mental Health Act, which can apply to persons of all ages. It also falls neatly into the transitions arrangements for children and young persons when preparing adult services to meet their needs. Any protective and restrictive care schemes applied to young persons 16 - 18 would dovetail into a similar service provision for adults.

14.3 Natspec (the Association of National Specialist Colleges) felt that the extension of safeguards to 16 and 17 year olds who lack mental capacity was appropriate given that it aligns with mental capacity legislation age requirements. It also emphasised the need for both appropriate checks and ensuring that parents are fully informed and involved in decisions.

14.4 Vincent Duffy (DoLS team leader) stated that:

> A person in need, whether it be a young person (16 and over) or adult, should be entitled to the protection that the safeguards afford … They should be afforded the same service as adults, with less demands being placed upon the courts in making this decision.

14.5 Kent County Council agreed and noted that:

> Despite the new transition provisions in the Care Act, the care planning for young people passing from children's services to adult services still requires improvement. The inclusion of young people 16+ in the protective care scheme may hopefully increase focus on proper planning for this age group.

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[121] 167 consultees expressed a view on this proposal: 126 agreed, 13 disagreed and 28 held equivocal positions.

14.6 A number of consultees agreed with our proposal, while noting concerns about interfaces with current legislation and statutory processes, such as Gillick competence, Caldicott guardians, the Children and Families Act 2014 and the Children Act 1989.

14.7 The regulatory landscape was another issue mentioned by several consultees, specifically the potential overlap between the roles of Ofsted and CQC. Ofsted noted that:

> Currently the regulatory framework and associated legislation are not sufficiently aligned. This has the potential to create confusion for providers of services, parents / carers and for the regulator. Ofsted's remit is to report on the standard of care provided and the continuing fitness of registered persons with reference to the appropriate regulations. Ofsted's role is not to scrutinise the method by which a deprivation of liberty has been authorised / initiated.
>
> Should the proposed scheme be implemented the legislation which governs how Ofsted inspects and regulates settings where schemes are in place for children would need to dove tail with how the schemes are regulated by the CQC. A scheme which draws clear legislative boundaries between the roles of all inspectorates and regulators involved would enable Ofsted to regulate effectively whilst ensuring that individual children whose liberty is being deprived are afforded adequate protection.

14.8 Some consultees argued that the age limit should be lowered further. For example, the Huntercombe Group (mental health care provider) described this as "a missed opportunity to provide much needed clarity in this area and to level the field for all needing such measures, regardless of age". RadcliffesLeBrasseur argued that our review should extend to considering the position of all children under the age of 18, stating that:

> This is an area that cries out for clarification and codification, perhaps via a Children's Capacity Act, which could codify and clarify the whole issue of capacity in relation to those under 18.

14.9 Some consultees disagreed with our proposal. For example, the Court of Protection Practitioners Association argued that deprivations of liberty of those aged 16 and 17 should continue to be authorised in the Family Division or the Court of Protection. It considered that incapacitated persons aged 16 and 17 already have sufficient safeguards under the current law (for example looked after children have an independent reviewing officer) and stated:

> To bring those young people under the protective care and restrictive care scheme appears to amount to a considerable duplication of services and professionals. This is not to the good of the young person unless the needs are not otherwise met under the Children Act and transition / pathway planning schemes in place. Instead local authorities ought to be required to address whether they are being unlawfully deprived of their liberty and seek to apply to court for that to be authorised (wither the family court or Court of Protection).

14.10 A number of consultees commented generally on our proposal, without taking a firm view on its merits. Some pointed to the resource implications of providing safeguards to disabled children who attend special residential schools and college facilities.

Hampshire County Council pointed out that young people are already subject to protection through the Children Act 1989, including the use of detention in secure accommodation under section 25, and stated:

> Extremely careful consideration should be given to ensure that any potential benefits accrued by making the DoLS framework additionally applicable to this age group are not outweighed by the potential burdens across the whole of the children's care system before any such step is further countenanced. If evidence is clear that change is needed then amending existing processes and guidance which already apply to this age group would be significantly preferable to the imposition of a whole new set of statutory expectations.

14.11 In separate responses, the National SEND Forum and the National Association of Independent Schools and Non-Maintained Special Schools pointed to a number of existing difficulties in this area. They reported that schools make regular requests to the placing local authorities to apply to the Court of Protection for orders authorizing deprivations of liberty, but "the majority have had no response from local authorities and find themselves in a precarious legal position". They pointed to the high volume of cases caught by the acid test particularly since "for young people with complex needs, placed in schools, continuous supervision is a routine practice", stating that:

> One unanticipated consequence of this has been that vulnerable children and young people have been placed at risk of harm when it was suggested to providers that they were no longer allowed to prevent them from leaving residential schools and children's homes, even when the risk to them was clear. We have been contacted by a number of providers who have changed their admissions procedures as a consequence resulting in a loss of provision for these children, who are deemed too "high risk" for schools to admit.

14.12 Some consultees were concerned generally about planning for transition from children's to adults' services. The National Family Carer Network suggested that the Mental Capacity Act must be "incorporated firmly into transition pathways for young people moving into adult life" and families should be informed about the changes that come into effect as their child becomes 16". It also pointed to confusion over how the Children and Families Act and the Mental Capacity Act interact:

> Some people are interpreting the Children and Families Act as meaning that parents can continue to make a wide range of decisions for their sons / daughters up to age 25; others think this relates only to educational provision. It would be very helpful if the Law Commission could comment on this.

14.13 Together for Short Lives (charity) expressed similar concerns about the transition to adults' services, stating that:

> Whatever the age from which the new legislation will apply, there will always be a period of transition for the young person and their families. Under the current DoLS legislation, our members have told us that nearly six in ten of the parents whose children use their services "do not understand DoLS at all" – the remaining four in ten "only understand a few aspects" … Planning for transition from children's to adults' services should begin far advance of the transition itself – usually by the age of 14.

We propose that discussions around DoLS and the role of parents should begin at the same time, so that the young person and their family are ready for the legal change.

14.14 Peter Edwards (lawyer and director of Peter Edwards Law) raised concerns about the discrimination faced by children and young people who are deprived of their liberty – many without authority. For example:

(1) in respect of adults who are deprived of their liberty in a psychiatric hospital, a decision-maker has a choice of least restrictive alternatives between the Mental Health Act and the Mental Capacity Act, if the person lacks capacity and is not objecting. No such choice exists if a person is under 18;

(2) Approved Mental Health Professionals rarely have experience of children's issues (such as parental responsibility) and in many cases are not able to access children and adolescent mental health services before the decision to detain is taken; and

(3) there is no equivalent for children and young people of the adult acute admission ward. Most of the specialist units only cater for those with longstanding needs and not for those who have a short term acute episode.

14.15 Several care providers pointed to the difficulties caused by the *Cheshire West* decision and the difficulties caused by the confusion over where the boundaries lie between restrictions and deprivations of liberty. Many asked whether deprivations of liberty would now extend to practices designed to avert an imminent risk and routine practices such as locking doors to some areas or using high handles on doors.

14.16 The National SEND Forum and the National Association of Independent Schools and Non-Maintained Special Schools commented that the terms "children" and "young person" are used inconsistently in law. For example, the *Mental Health Act Code of Practice* describes a child as someone aged up to 13 and a young person as someone between 14 and 17, whereas the Mental Capacity Act describes a child as someone aged up to the age of 15 and the Children Act describes a child as someone up to 17. It suggested a common definition of a child is someone aged up to 15 and that a young person includes 16 and 17 year olds.

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?

14.17 No overall majority view was reached in answer to this question, but the largest number of consultees believed that the zone of parental responsibility is appropriate when applied to 16 and 17 year olds who lack capacity.[122]

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[122] 117 consultees expressed a view on this question: 41 said "yes", 39 said "no" and 37 held equivocal positions.

14.18 The National SEND Forum and the National Association of Independent Schools and Non-Maintained Special Schools considered:

> On balance we think we need to retain the concept of zone of parental responsibility, imperfect though it may be, as it offers a potential bridge in practice and policy between those aged under 16 and those aged over 16.

14.19 The Court of Protection Practitioners Association also considered that the zone of parental responsibility should continue to apply to 16 and 17 year olds, arguing that:

> The Government and the courts recognise that 16 and 17 year olds are not fully autonomous adults; they are still maturing and require the safety net of parental rights to catch them should they fall. In our experience the majority of parents caring for mentally incapacitated young adolescents are very respectful of their age and resist any categorisation of them as younger children. That said they are realistic about the management of their care and utilise their parental responsibility to ensure a smooth operation of services for them in advance of their majority.

14.20 St Andrews Healthcare argued in a similar vein, stating that:

> We are still dealing with children here (according to most definitions). Parents should be able to consent to decisions that are in the best interests of their child if that child does not have capacity in relation to the matter at hand.

14.21 A number of consultees argued that the zone of parental responsibility is not appropriate in practice when applied to 16 and 17 year olds to authorise a deprivation of liberty. For example, Steve Chamberlain (best interests assessor and trainer) stated that:

> 16 and 17 year olds should be treated as adults within the remit of the Mental Capacity Act. The zone of parental authority is a contentious area when dealing with individuals who are approaching adulthood. For young people of that age, the best interests process should be fully enforced, perhaps with an explicit priority to consult those with parental responsibility regarding the best interests decision, and a duty to provide clear reasons if and when a decision is made against the parent's wishes. For more complex cases, the decision may need to be made by the court.

14.22 Paul Bowen QC (Brick Court Chambers) set out his analysis of the legal position:

> A right of parental authority does exist and is protected by article 8, but it is a qualified right that may be lawfully restricted in the interests of protecting the article 5 and 8 rights of children. The introduction of the safeguards of the restrictive care regime in place of parental consent for incapacitated children of 16 or 17 strikes a fair balance between these competing rights. However, for younger children and children over 16 who are cared for in their own home, the article 8 right of parental authority should prevail: parental consent, coupled with the positive obligations of the State, constitute adequate safeguards for the protection of these children's article 5 rights.

14.23 He further argued that if the parent of a 16-17 year old objects to a placement, then they must have the right to oppose the placement in a Court. Also, the parents' article 8 rights in relation to other important decisions concerning their child's care, such as consent to treatment, access to medical records, and access to their child without restriction should not be ousted at the age of 16.

14.24 Cafcass argued that 16 and 17 year olds should be afforded the same safeguards as adults when they are deprived of their liberty. This was because:

> On reaching the age of 16, most children are able to make the majority of decisions about their lives independently of their parents if they so wish. It may be more difficult for parents to make decisions about restrictive care or treatment in these cases. It would therefore be beneficial for both older children and their parents for such decisions not to rest entirely with the child's parents and for additional safeguards to be imposed as outlined in the proposed protective care scheme.

14.25 Some consultees focused on the uncertain nature of the concept as a reason for doubting its appropriateness. Garden Court Chambers' Court of Protection Team described the concept as "poorly defined and not delimited", and doubted whether it complies with the article 5 requirements that the law governing deprivation of liberty be sufficiently clear and certain. Peter Edwards (lawyer and Director of Peter Edwards Law) stated that "there is confusion about whether the scope of parental responsibility … and what chance does that give to staff working at the coal face?"

14.26 Ofsted argued that:

> As a sole method of "approving" a deprivation of liberty, the concept of the zone of parental responsibility may not be sufficient to ensure that a decision to deprive a young person of their liberty is within their best interests. There are many factors which should be considered in addition to the application of the zone of parental responsibility when such a decision is being made. Young people who may be subject to a deprivation of liberty based solely on a parental decision may be denied vital safeguards to ensure that the decision is in the young person's best interest and continues to remain the case.

14.27 It also reported that the decision in *Trust A v X*[123] has:

> Led some residential special schools to undertake a standardised regime of seeking parental consent to deprive children of their liberty as a way of neutralising the framework and associated authorisations required to deprive a child of their liberty. This is of serious concern to Ofsted. Such blanket approaches may breach the children's home regulations and / or national minimum standards for residential special schools. Where we believe this to be the case, we will report on and / or take action upon under the relevant legislation (by way of setting a requirement for a children's home or setting a recommendation under the national minimal standards for a residential special school). However, it is unclear to Ofsted, how the rights of the child, the requirements of the regulations and the views of the parents should be balanced. We are concerned that this places Ofsted in the role of the arbiter of such situations, which is both challenging and inappropriate.

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[123] [2015] EWHC 922 (Fam), [2016] 1 FLR 142.

14.28 A number of consultees commented on the question without taking a firm view. For example, the Independent Children's Homes Association reported that:

> There have been circumstances where a home has had their inspection outcome affected adversely because of decisions taken either to restrict / prevent movement or not. As a result providers now have lowered the risk threshold that can be managed and this has significantly reduced the numbers of placements available to the degree that local authorities inform us that on many occasions they cannot find suitable placements.

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?

14.29 We received 100 responses from consultees in relation to this question.

CURRENT DIFFICULTIES IN IDENTIFYING THE SUPERVISORY BODY

14.30 Several consultees told us that key difficulties arise when individuals are in situations whereby the funding authority is different to the residing authority. Kingwood (learning disability service provider) commented that problems arise for individuals who have lived in residential care and moved to supported living "where the funding authority was different to residing authority". According to Rochdale Borough Council Adult Care, it is common to find that once the supervisory body has authorised an assessment, it may be discovered later that funding is by another body.

14.31 According to the Disabilities Trust:

> At present it is extremely difficult logistically, particularly given that the majority of our services take service users from a wide range of Local Authority areas. For people in a community setting it is the funding authority (local authority or CCG) who is responsible and not the local DoLS Team. Trying to get funders to accept responsibility can be difficult. A simple one-point referral / registration system might help, and we would welcome a more streamlined system.

14.32 Flintshire County Council and Denbighshire County Council noted the complications for people moving between England and Wales, and from England or Wales to Scotland or Northern Ireland.

14.33 Barts Health NHS Trust pointed out that that the requirement for hospital patients to be supervised by their local authority of residence can result in situations whereby the deprivation of liberty has to be assessed by an authority many miles away. Similarly, problems were said to arise for patients who live near the hospital but who are formally the responsibility of a "distant borough".

14.34 Bury Council and Bury CCG told us that in the North West confusion over identifying where the placement commissioner is located can occasionally cause delays in processing applications. But they also felt that the alternative – giving the "host" authority responsibility for the applications – would have a number of disadvantages in that:

(1) P's history and case details are owned and monitored by the placing authority and the patient is often well known to them;

(2) there is a real possibility of mudding the water with regard to responsibility of care; and

(3) some local authority areas would be disadvantaged as they have a high proportion of care homes / specialist facilities in their area.

AREAS WHICH COULD BE CLARIFIED UNDER THE NEW SCHEME

14.35 The British Association of Social Workers argued that:

> The concept of ordinary residence is not well understood. Managers in care settings are more familiar with safeguarding practice, which means that the local authority where the care setting is situated, pick up the issues. This can create unfair situations, especially where care settings are concentrated and / or take people from all over the country.

14.36 Priory Group (healthcare provider) suggested that clarity is needed about which supervisory body is responsible when someone is placed in long term care away from their original area, "as there continues to be disagreements between local authorities across the country about this".

14.37 A number of local authorities called for clarification in relation to self-funders and those eligible for NHS continuing health care funding. Several reported that it is difficult to determine who is responsible for self-funders whose care has been arranged or commissioned by other local authorities and who were lacking capacity at the time. Some also informed us that it can be difficult to identify the appropriate supervisory body when a person is receiving NHS continuing healthcare as the NHS funding areas do not reflect those of local authorities.

14.38 North West ADASS suggested that the relationship between Welsh commissioners and hospital placements in England must be revisited because the unintended consequence of the way it was framed in the DoLS means that border authorities end up picking up Wales residents for the DoLS, when admitted to an English hospital in an emergency.

14.39 A number of consultees also reported that in practice very few difficulties arise in practice and no further clarification is required.

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?

14.40 A majority of consultees thought that a fast track determination scheme is needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence.[124]

14.41 For example, Kingwood (learning disability service provider) thought the option of a fast track determination would help to resolve current issues around ordinary residence. The Mental Capacity Act Project recommended that in fast tract cases where the commissioning bodies cannot decide who will assess, they should both send a practitioner so as to encourage a collaborative approach and increase oversight.

14.42 Devon County Council, who were in favour of a scheme, told us:

> A fast-track scheme would certainly assist to reduce the chances of complex reimbursement determinations being required to compensate a successful lead authority following a determination process in which an authorisation has been in place for perhaps six or more months. However, in terms of maintaining a system that is protective of P's rights, this would not be insurmountable in the absence of a fast-track system as long as obligations are clearly defined and authorities are fully aware of the reimbursement repercussions when pursuing a determination.

14.43 The National Care Forum stated that:

> Delays that arise when identifying the supervisory body for the purposes of the DoLS are completely unacceptable and as with common-place ordinary residence fee disputes they are usually about local authorities seeking to avoid costs, with too little regard for the person at the centre of the dispute.
>
> This is why regulatory oversight of local authorities is required. Anything that helps to clarify responsibility under the new scheme would be extremely helpful to providers who, along with the individuals concerned, often get caught in the middle of these disputes. At the very least we would welcome a fast track determination scheme for cases where there is a dispute over the person's ordinary residence.

14.44 Some consultees qualified their support for a fast track determination scheme. For example, East Sussex County Council had concerns that having a different mechanism for determining ordinary residence "may create an incentive to 'use' deprivation of liberty inappropriately in order to fast track a case". A number of consultees requested further clarification on how the scheme would work in practice. For example, Lancashire County Council, agreeing with the scheme in principle, asked "who should ultimately fund the assessment process".

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[124] 102 consultees expressed a view: 63 said "yes", 26 said "no" and 13 held an equivocal position.

14.45 The Court of Protection Practitioners Association suggested that the fast track process should consist of a mediation procedure between the competing public bodies and an arbitration process in the event that agreement is not reached. Maxwell Gillott Solicitors thought that if there is a dispute, “whoever is approached should act first and resolve the dispute later”, as would be in the patient’s best interests and in line with the Care Act.

14.46 Consultees who disagreed with a fast track determination process often pointed to the resource implications. A number of local authorities felt that a fast track scheme could complicate a system which appears to be well understood and works reasonably well. Northumberland County Council considered that it would not be achievable or desirable to have a fast-track system for determining ordinary residence on the kind of timescale required, since the issues involved are often complicated and would add further confusion.

14.47 According to the Bar Council:

> We do not see the need for a fast track system in this subset of cases. Provided there is clarity about which body should hold the fort pending resolution, and about the recovery of costs following a decision being taken, we do not consider that cases involving deprivation of liberty require special treatment on this issue.

Question 15-5

Should a new criminal offence of unlawful deprivation of liberty be introduced?

14.48 It was considered by the majority of consultees that there should not be a new criminal offence of unlawful deprivation of liberty.[125]

14.49 Several consultees were concerned that the introduction of a new criminal offence could potentially leave many health and social care workers vulnerable to prosecution post *Cheshire West.* For example, Hywel Dda University Health Board pointed out that the huge increase in numbers has meant many people are being unlawfully deprived of their liberty as there are insufficient best interests assessors to assess all applications.

14.50 Dr Clementine Maddock (psychiatrist and academic) argued that:

> Such an offence would place families in fear of being prosecuted for locking a door to prevent a confused mother, father, wife or husband wandering at night and potentially becoming lost and dying of exposure. Staff in care homes would also be placed in an invidious position of allowing patients to put themselves at risk of wandering for fear of being prosecuted.

14.51 Some consultees felt there was insufficient clarity as to what a deprivation of liberty actually is to warrant there being a criminal offence.

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[125] 163 consultees expressed a view: 31 said “yes”, 95 said “no” and 37 held an equivocal position.

14.52 South Essex Partnership Trust and Southend CCG favoured “a link to the regulatory framework and enforcement pathways via the CQC or appropriate body”, rather than introducing a criminal offence. It continued:

> Most of the time when a deprivation is found and has not been applied for it has not been a deliberate act but a lack of understanding which would be better served by education not a criminal prosecution or even a fine.

14.53 A number of consultees suggested that existing law provided adequate protections. For example, Cambridge County Council and Essex County Council, noted the offence of ill-treatment and wilful neglect contained in section 44 of the Mental Capacity Act 2005. Other consultees felt that any such individuals would have a civil remedy available to them under the Human Rights Act against public authorities which have failed to protect their human rights.

14.54 MDDUS commented on the effect that any new offence would have on medical practitioners:

> In relation to the potential introduction of a new criminal offence of unlawful deprivation of liberty, MDDUS perceives that doctors are already heavily regulated by the General Medical Council. Such measures may simply be counter-productive by simply serving to enhance the anxiety of practitioners and most importantly for the small category of patients that are not already protected by criminal sanctions there is an existing civil remedy under the Human Rights Act against public authorities which have failed to protect their human rights.

14.55 Consultees who were in favour of a new criminal offence frequently noted the importance of safeguarding and protecting those who lack capacity. For example, the Alzheimer’s Society argued:

> This would be a positive step in ensuring that the basic rights of people with dementia are protected and guaranteed. Currently, we see people who are illegally being deprived of their liberty, but little is done to stop it from happening. Making it a criminal offence will offer some much needed protection and an enforcement mechanism.

14.56 According to Paul Greening (MCA manager):

> While I am not generally in favour of using the criminal law to enforce social care responsibilities, I do think that there needs to be a sanction that makes clear the seriousness of any care plan that involves depriving a person of their liberty. While I would expect charges under this offence to be rare, the potential criminal sanction against the managing authority would serve to emphasise the importance of getting the appropriate authority for any deprivation of liberty – preferably in advance of any placement.

14.57 Dr Hugh Series (psychiatrist and academic) posed a number of questions, rhetorically, on the operation of a new offence:

> How would you decide who was responsible for the unlawful deprivation? Would it be the family or the state? So who would go to prison, if that were the penalty? What is the burden and standard of proof? There are many reasons why deprivation of liberty

> might be considered unlawful. At present, deprivation of liberty without meeting all of the six criteria is unlawful, so that would mean that just about every managing authority in the land would be committing a criminal offence. That is an untenable position.

14.58 A number of consultees were qualified in their support for a new criminal offence. For example, Denbighshire County Council supported a new offence in principle but was concerned that it could be problematic in practice given the large numbers of applications and the considerable delays in the necessary assessments being completed. The Mental Capacity Act Project responded with a "cautious yes" to this question, whilst also commenting that "perhaps the focus should be on enforcing current laws rather than creating a new offence".

14.59 The response from legal practitioners was mixed. Simon Thomason (lawyer) did not think that a criminal offence was appropriate given the increase in numbers of people who require authorisations since the Supreme Court decision in *Cheshire West* and are on waiting lists due to the shortage of best interests assessors. Steve Broach (barrister) agreed cautiously with the introduction of a new offence due to the "genuine lacuna in the criminal law which ought to be filled". Bindmans LLP supported the introduction of the offence, arguing that criminal sanctions "signal the importance of the matter, act as a deterrent, send out a clear message and drive up quality". Paul Bowen QC (Brick Court Chambers) felt that an effective civil remedy should be a sufficient safeguard. He argued that "at present it is very difficult to obtain damages for unlawful deprivation of liberty" and advocated "a statutory right to bring civil proceedings to recover damages for unlawful deprivation of liberty", with "appropriate quantum fixed at regular intervals by statutory instrument".

14.60 Several consultees commented on this question without taking a frim view. Vincent Duffy (DoLS team leader) noted that a new offence would hopefully help motivate some managing authorities who have a poor understanding of the deprivation of liberty safeguards to "proactively consider the way they deliver their services, with a view to always considering the least restrictive". However, he also considered that an offence may create tensions between the supervisory bodies and managing authorities if care homes and hospitals feel "under additional threat of being found criminally unlawful having made a referral but not receiving the required assessments to authorise and make lawful".

14.61 Your Voice Counts (advocacy provider) also held mixed views on this issue:

> We are not confident that making unlawful deprivation of liberty a criminal offence would be helpful, though equally given our experience of managing authorities almost universally failing to understand the DoLS and frequently, even when they do understand, choosing to ignore their responsibilities, it seems clear that some considerably greater sanction or consequence is needed. It is very difficult to square this, however, with the many urgent hospital discharges that we see every day into homes that have no DoLS in place. We know that the lengthy DoLS application process in non-residential settings, meanwhile, has prevented or significantly delayed people moving into supported tenancies that were clearly very appropriate and that they themselves had been eager to move into.

14.62 In a detailed response, Professor Peter Bartlett (mental health law academic) focused on whether generally a specific disability-related defence is appropriate:

> This in turn raises the same issues as is always the case when criminalisation is proposed in the disability context of something which is already covered by criminal law. Would this involve a smaller penalty than for other wrongful detention? If so, are we saying that detention of this group is somehow 'less criminal' than for other citizens? That, obviously, does not look good. If the problem is that the existing law does not cover this group, is not the sensible approach to amend the existing general law rather than to pass a disability-specific one?

Provisional Proposal 15-6

The Coroners and 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.

14.63 This proposal was supported by a majority of consultees.[126] We received six responses from coroners on this issue – four of whom agreed with this proposal and two disagreed.

14.64 Many consultees felt this proposal would help to reduce caseloads. East Anglia's Children's Hospices argued that the proposal "will significantly reduce the numbers of people dying who will need to have an inquest". A response from an coroner (who wished to remain anonymous) suggested:

> If I apply this proposal to the DoLS inquests that we have held this year, only one of the 90 cases would have resulted in an inquest. All of the other cases would have been discontinued after preliminary inquiries.

14.65 Others noted the positive impact on families. Compassion in Dying felt that the proposal would "contribute to a more positive bereavement process for the family". Age UK described the current system as "distressing and undignified", and stated:

> While guidance from the Chief Coroner has clearly set out that in cases where the death is uncontroversial the inquest may be a "paper" one without witnesses having to attend or requiring a post-mortem, adherence to this guidance appears to vary widely across the country.

14.66 Agreeing with the proposal, DAC Beachcroft LLP also queried the effectiveness of the Chief Coroner's current guidance:

> We are aware that efforts are being made by coroners to reduce the impact of current law, including holding inquests on the papers within 24 / 48 hours of death. We question the benefits of such a system adding any value, apart from costs. The rigour

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[126] 152 consultees expressed a view on this proposal: 104 agreed, 20 disagreed and 28 held equivocal positions.

> around current death certification, the reporting of deaths in a care setting to CQC and the recently introduced duty of candour in hospitals should provide sufficient legal safeguards where death is due to natural causes, without needing further oversight by the coroner.

14.67 South West Yorkshire Partnership NHS Foundation Trust supported the proposal, but also suggested a role for CQC:

> Where the person was subject to the restrictive care scheme and the hospital care scheme at the time of their death, there should be a statutory notification to CQC as there is for deaths under the Mental Health Act and which CQC are able to determine if they require further investigation. This would provide an additional layer of safeguard and enable CQC to determine if any trends are emerging with particular providers or indeed of a national nature which requires attention.

14.68 The National Panel for Registration recommended:

> The salary scale of coroners needs to be addressed to support efficient use of their time without an unintended consequence through the opportunity to increase salary payments with caseloads.

14.69 Regarding article 2 of the ECHR compliance, Andrew Haigh (coroner) suggested "if article 2 cases are effectively sieved by the system then the UK will not be in breach". In addition he stated:

> I do not agree with the system being that coroners should discontinue a lot of these investigations because this will still necessitate an administrative burden which should not be there at all. The answer … is that only appropriate cases should be reported to the coroner in the first place. Appropriate article 2 criteria should be laid down … to cover the need to report at all.

14.70 Of those consultees that disagreed, some felt the proposal would be impractical. Andrew Tweddle (coroner) argued:

> We have a slick system in place, which causes little or no delay to the ultimate funeral and minimises the distress to the family… The consultation document considers adding in various layers of huge complexity to decide matters of article 2 … which will only give rise to further uncertainty and delay and potential inconsistency and expense.

14.71 Maxwell Gillott Solicitors expressed concerns that the proposal would merely result in disputes about whether or not article 2 is engaged, resulting in "uncertainty" and "some cases not being subject to inquest where they should". Surrey CCG Mental Health and Learning Disability Collaborative argued that "the inquest into the death of Connor Sparrowhawk[127], also known as Laughing Boy, highlighted that state agencies will often dispute that article 2 is engaged".

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[127] Connor Sparrowhawk died in an assessment and treatment unit for people with learning disabilities in 2013. In 2015 a jury inquest ruled that neglect contributed to his death.

14.72 Others highlighted the importance of enforcing the current legal duty placed on coroners. The Law Society's Mental Health and Disability Committee stressed the law should be complied with as it currently stands, and that "to do otherwise would relegate the rights of those detained under the Mental Capacity Act to a lesser level than is the case for those detained under the Mental Health Act".

14.73 INQUEST and INQUEST Lawyers' Group argued that the proposal would create "a hierarchy of rights" and, by putting a burden on coroners to determine if article 2 is engaged at a very early stage, which was "likely to result in incorrect decisions being taken" and "the risk that deaths which should be investigated will not be, falling foul of the state's obligations under article 2". They felt the current problems could be remedied "by the allocation of additional resources and more efficient administrative procedures" as opposed to any legal change. Similarly the Court of Protection Practitioner's Association suggested that the current problems were the result of an increase in DoLS applications, rather than a fault in the law.

14.74 Several consultees felt our proposal did not go far enough. For example, the Chief Coroner of England and Wales argued that the new scheme should not be considered state detention for the purposes of the Coroners and Justice Act 2009, and also as an interim measure proposed an amendment to section 1 of the Coroners and Justice Act 2009 "to declare that, for the purposes of coroner jurisdiction, a person who dies while subject to a DoLS authorisation does not die 'in state detention'". The response from Anne Coffey MP made a similar suggestion.

14.75 Hospice UK and National Council for Palliative Care also called for a narrower interpretation of state detention:

> Currently, anyone who dies whilst subject to DoLS is considered to have passed away in state detention. However, a person subject to DoLS, or the new system of restrictive care is not being detained by the state for the purpose of receiving treatment which they might refuse, it is a lack of capacity to consent to care. The difference is significant and not merely semantic.

14.76 A joint response from Michael Tapley, Dr David Jolley and Ann Regan[128] suggested that the definition of a death in state detention should be revised "to exclude those people whose death is expected or there is no reason to question the circumstances (particularly in hospices)". Barts Health NHS Trust argued that the coroners' duty to investigate should not apply to hospital patients "unless there is reason for a coroner's referral independently of the person being under the hospital scheme".

14.77 A number of consultees made alternative proposals. NUTHFT MCA and DoLS Steering Group suggested the establishment of "an automatic internal review mechanism by a designated independent Mental Capacity Act / DoLS senior clinician in each hospital". This person would then decide whether or not to refer a particular case to the coroners' office. Paul Matthews (coroner and author of 'Jervis on Coroners') suggested the use of section 19 of the Coroners and Justice Act 2009 to appoint medical examiners to examine all deaths under the new scheme, who could redirect any case they had

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[128] In the form of an article written for European Journal of Palliative Care.

concerns with to a coroner, and thereby reducing the coroner's caseload to only those cases where an inquest is necessary.

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?

14.78 A majority of consultees felt coroners should have the power to release the deceased's body for burial or cremation before the conclusion of an investigation or inquest.[129]

14.79 Consultees frequently referred to the difficulties currently faced by families. For example, Devon and Torbay Independent Mental Capacity Advocate Service described "families being extremely distressed at the delay in having their loved ones' body released and understandably failing to understand the reasons for such a delay". Maxwell Gillott Solicitors described this situation as "incredibly upsetting for family members, so anything that can be done should be done, subject to not impacting negatively on the inquest itself".

14.80 Barchester Healthcare added:

> Most deaths of people subject to DoLS are "natural deaths" recognised as such by relatives, care staff and GPs, and occur in the person's own home. Delays in release of the body can be deeply distressing.

14.81 MDDUS argued that without a power to release the deceased's body:

> There is considerable scope for additional and avoidable distress to the bereaved family, with the consequent risk of criticism of medical practitioners by grieving relatives for circumstances out with the control of the practitioner.

14.82 Kent County Council argued that the introduction of this power would reduce "the administrative burden for providers and other relevant professionals". Camden and Islington NHS Foundation Trust emphasised that "coroners should have this power especially on the grounds of an individual's religious beliefs or prior wishes".

14.83 The Alzheimer's Society highlighted issues surrounding brain donation, where:

> There is a rigorous consent process when a person registers as a brain donor, and they may participate in a significant amount of research before death which the donor expects to culminate in the donation of their brain for use in research. Ideally, the brain must be received within 24 hours to be of use (72 hours at the very most). The DoLS requirement for a coroner's inquest can result in delays in brain donation which significantly limit the value of the tissue for research.

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[129] 121 consultees expressed a view: 96 said "yes", 10 said "no" and 15 held equivocal positions.

14.84 The Alzheimer's Society also provided a series of case studies. In one case, a son was prevented from seeing his recently deceased mother as "the room was sealed and they were waiting for the police to arrive". In another, the donation of brain tissue from a prospective donor was delayed by 86 hours, meaning the tissue was unsuitable for medical purposes.

14.85 The Tri-Borough Councils agreed that there should be a power to release the deceased's body in straightforward" cases but also noted that this is not a problem in practice:

> Locally we have not been informed of a person's body not being released other than an enquiry that was sent to us from a person whose mother's body was not released who was under DoLS, although his was more about obtaining the death certificate and who from.

14.86 Some consultees qualified their response, noting such a power should be at the coroner's discretion, subject to their inquiries into the circumstances of the death. For example, Anchor (housing and care provider) agreed with the question "only if it is absolutely certain that there would be no further evidence required in order to determine the cause of death".

14.87 The British Association of Social Workers suggested that the power should only be exercised "in restricted cases", but also stressed:

> Whilst the current situation is unacceptable to families, where it has been established an inquest is necessary under the new legislative proposals, then the proceedings should not be just a rubber stamp.

14.88 A small number of consultees did not agree that coroners should have this power. The Mental Capacity Act Project argued that it would be sufficient to restrict the need for a coroner's inquest in most cases. Others were concerned that by releasing the body early, additional evidence may be missed and therefore hinder justice. Surrey CCG's Mental Health and Learning Disability Collaborative argued this power would also "possibly prevent exhumation and the associated distress for relatives should foul play be suspected".

14.89 Nottinghamshire County Council argued:

> It would be beneficial to ensure continuity across different settings. When a crime is committed a body is not released until the investigation and inquest is resolved. It would therefore make sense that when a DoLS death occurs, that the case is resolved prior to the body being released. When someone dies while under DoLS, the regulations confirmed this is equivalent to a death in custody. Therefore this proposal would result in differential levels of scrutiny. Funeral directors and medical professionals also need to be better informed about the coroner's processes in relation to deprivation of liberty.

14.90 Some consultees argued that coroners already have this power (or a similar power) and should exercise it. The Chief Coroner of England and Wales commented that this was "a redundant question" as coroners already had this power.

14.91 Hertfordshire County Council's Coroner Service stated:

> The Coroners and Justice Act states the coroner is required to release the body for burial or cremation "as soon as reasonably practicable". We cannot see where this would present an issue. The power to release the body before the conclusion of investigation or inquest currently exists and is certainly the practice in Hertfordshire.

14.92 INQUEST and INQUEST Lawyer's Group added:

> A coroner must release the body for burial or cremation as soon as it is reasonably practicable and where this cannot be completed within 28 days, the coroner must notify the next of kin or personal representative. However, a coroner can only authorise the release of the body if the coroner is satisfied that it is no longer needed for the purposes of the investigation.

14.93 The response suggested that any evidence of delays occurring should lead to the Chief Coroner of England and Wales issuing further guidance to coroners.

14.94 Andrew Harris (coroner) stated "bodies are virtually always released long before the conclusion of any investigation". Another coroner (who wished to remain anonymous) stressed:

> I do not delay releasing bodies to the family. Once I am satisfied by preliminary inquiries, as to the cause of death and I am satisfied that no further investigations concerning the body are required, I will sign the disposal and release form. I certainly do not wait for the outcome of the Inquest to release the body.

Question 15-8

Is the current law on the reporting of deaths to the coroners satisfactory?

14.95 It was felt that the current law on the reporting of deaths to the coroners was satisfactory by the majority of consultees.[130]

14.96 Several consultees linked this question to the definition of "state detention" for the purposes of the duty on a coroner to carry out an investigation. In effect it was argued that this definition, which includes the DoLS, leads to over-reporting. Rachel Griffiths (consultant) said:

> The unintended consequences of recognising so many people as technically in "state detention" causes great distress. This cannot be satisfactory.

14.97 The Chief Coroner of England and Wales added:

> The current law is not satisfactory. The unintended consequences of the law have brought extra work to the coroner, with extra expense to the public purse, and extra distress to bereaved families -and all for no public benefit. Nothing has been achieved

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[130] 112 consultees expressed a view: 27 said "yes", 68 said "no" and 17 held equivocal positions.

> by it. It is all unnecessary … Where a person who is subject to a DoLS authorisation dies from natural causes and the family have no concern about the death and there is no other reason to investigate, the coroner should not have to open a formal investigation into the death. Nothing is to be gained by it. On the contrary much is to be lost: time, money and public confidence in the coroner service.

14.98 Central Locality (Southport and Formby CCG) stressed:

> The requirement for all deaths (including, expected deaths) of patients who are subject to a DoLS authorisation, to be reported to the police and the corners office is seen as unnecessarily extreme … The locality feels very strongly that this legislation is not sustainable and does not safeguard those who need to be protected.

14.99 These consultees felt there should be no automatic requirement to report deaths to the coroner in all DoLS cases. Andrew Haigh (coroner) argued that "the answer therefore is for the deaths not to be reported at all to the coroner wherever possible".

14.100 A joint response from Hospice UK and the National Council for Palliative Care called for a simpler process if a person dies when under the DoLS replacement scheme consisting of paper-based reviews in cases when a death is "expected and based on an identified cause" and referrals to a coroner only where the death was unexpected, suspicious or not related to the person's diagnosis.

14.101 Chris Lucas (a best interests assessor from Hampshire) felt:

> It would be helpful for deaths to be referred to the coroner when the person is deprived of their liberty and where the person feels the death was linked to / influenced by the deprivation of liberty / restrictions. Where a person is deprived of their liberty and they die of expected natural causes, routine referral to the coroner just causes stress to families.

14.102 Several consultees highlighted a lack of consistency in the reporting of deaths. Oxfordshire County Council stated that "current practice is led by non-statutory guidance only" and "is subject to very wide local variation and interpretation". Tees, Esk and Wear Valley NHS Trust was concerned that "although national guidance has been issued, it is left to individual coroners to decide how it should be interpreted in practice".

14.103 The National Panel for Registration stated:

> Although it is clear as to whose duty it is to refer (and registrars, police and prison officers are aware of the circumstances in which they must report a death), there is no consistency / clarity / instruction for other personnel involved in the process i.e. care home and hospital staff.

14.104 A number of consultees raised specific concerns about the practice of asking "non-statutory questions". Lancashire County Council highlighted explained:

> The system that we have ended up with in terms of death registration is almost unworkable and is sub optimal. As the registrar has no statutory provision to ask whether a DoLS is in place there is no consistent approach across the country and

> having to ask a non-statutory question as part of a statutory process creates difficulties.

14.105 As an example Suffolk County Council Registrars and Coroners Service explained that in its area the coroner has requested that registrars include a non-statutory question as part of their pre-registration questioning. But this has caused problems:

> The registration appointment is probably the worst place to advise a family that a coroner's investigation will be required. Registration is seen by many families as a formality to obtain the paperwork they need to continue with funeral arrangements and administration of the estate. There is little expectation at this stage that they will leave the appointment empty handed.
>
> Registration appointments being started but not being utilised is not a good use of staff resources which are already stretched as a result of public sector spending cuts. It also impacts on appointment availability and ultimately KPI (key performance indicators) achievement.

14.106 Many reported that not all registration services are asking family members non-statutory questions and are relying other services or professionals to identify and report that the person was subject to the DoLS when they died. The National Care Forum stated:

> The current law on the reporting of deaths is not satisfactory as it is not clear who has responsibility for referring cases of deaths, under the DoLS, to the coroner. It seems highly likely that a considerable number of these cases are currently going unreported. Easy to understand information should be readily available for families in these circumstances to help people understand the process.

14.107 The National Panel for Registration argued that when registration services presume a DoLS authorisation would have been reported to the coroner:

> This creates further difficulties in that the death registration could be completed in good faith, the body disposal papers issued, and then if it comes to light after the disposal of the body, then the coroner has a reduced opportunity to investigate this with supporting post mortem and toxicology information, including a potential additional delay of having to apply to the Chief Coroner for permission to open an inquest without a body. Alternatively if an exhumation is required this is at a significant cost and in the region of £5,000-£10,000.

14.108 It proposed a duty on doctors "to report unexplained or unnatural or violent deaths to the coroner", changes to reporting mechanisms "to ensure that families do not make an appointment to register the death before the coroner's inquest has been completed" and the creation of a prescribed form to ensure the referral completed "in a timely and consistent way nationwide".

14.109 INQUEST and INQUEST Lawyers' Group added:

> The law on reporting deaths to coroners should be tightened. Section 18 of the Coroners and Justice Act 2009 grants the Lord Chancellor the power to issue regulations requiring medical practitioners to notify a senior coroner of deaths

> occurring in prescribed circumstances. No regulations have been issued. Our findings show real concerns regarding the quality of information provided about a death, which impacts on the type of investigation / inquest held.

14.110 A number of consultees argued that the current law was satisfactory did not need to be reformed. For example, the Tri-Borough Councils stated:

> The current system seems to work quite well, as long as the managing authorities make sure they have reported the death as soon as it happens or as quickly as they can afterwards. Both of our local coroners also feel that the systems they have in place are working well although they said their workload has gone up.

14.111 PASAUK argued that while the law is satisfactory:

> Health and social care professionals require a better understanding of their duties to report. There should be a national initiative to promote a better understanding of the role of the coroner across health and social care and for coroners and their officers to be more aware of local safeguarding policies, procedures and structures, including Safeguarding Adults Boards, to promote information sharing and partnership working. Furthermore the coroners' service should develop an information sharing service across its jurisdiction; this would enable any patterns of deaths across county borders, from different establishments which are owned or managed by the same company or NHS Trust, to be closely monitored for trends or concerns which occur due to organisational or cultural factors.

14.112 Hertfordshire County Council's Coroner Service commented:

> We are content with the current processes for reporting deaths to coroners, as per the Coroners and Justice Act 2009. However, with regards cases where the deceased is subject to DoLS, the processes appear to require refining. A clear and effective notification process, with defined responsibilities is required which ensures that coroners are aware of the presence of DoLS in a timely manner. This practice does not appear to be embedded as yet.

14.113 Andrew Tweddle (coroner) commented:

> Whilst there is undoubtedly an impact on families, I can see the benefit of referrals to coroners in the way that is happening now in cases where families may well have concerns and which, but for the involvement of the coroner, might pass unnoticed. It seems to me that those cases are such that the current legislation should remain unaltered and the status quo be preserved so that the very useful safety net that the coroner can provide, as in other situations of death, may be maintained.

14.114 He added that he was opposed any idea that an investigation into deaths might be transferred to another agency because:

> If any person or organisation is to investigate a death then it should be the coroner, as it is the coroner who has the experience and training to be able to investigate such matters appropriately.

14.115 Some consultees argued that the current law should be expanded to include compulsory reporting of others. For example, Nottinghamshire County Council felt the reporting of deaths:

> Should include reports of people who have died whilst a DoLS assessment is outstanding. Nationally there are long waiting lists for assessments and the coroner only wants to hold inquests on people who are detained - i.e. have been assessed. Those who have not yet been assessed are arguably more vulnerable and at greater risk than those who have been assessed and have the recognised safeguards in place to protect them.

GENERAL COMMENTS ON OUR CORONERS REFORMS

14.116 We received several general comments from consultees on the issue of coroners. Many provided personal experiences of coroner's investigations and highlighted the impact of the Supreme Court's decision in *Cheshire West.*

PERSONAL EXPERIENCES

14.117 André Rebello (coroner) referred us to a letter from a member of the public, describing the "upset and intrusion into family life caused by DoLS being treated as state detention". In this case an expected death at a care home resulted in several police officers arriving at the scene of the death, interviewing family members and examining the body. The member of the public described the examination as "undignified" and felt police offers at the scene had "the attitude that [they] were attending a crime scene". This ultimately made the grieving process for the particular family even more distressing.

14.118 Another consultee described his experience of a relative committing suicide in state detention, which was deemed to be a death by natural causes following a coroner's investigation and refused a jury and article 2 inquest. They questioned the independence of coroners "when their employer and fellow judges are involved in the case" and described the process as "a simple tick-box exercise [with] no supervision that assessments are carried out … and reported correctly". They argued:

> HM coroners are not appropriate persons to hold inquests in respect of DoLS deaths where either a local authority or the Court of Protection (or both) has been involved.

14.119 A further consultee described how, in order to arrange for their mother's preferred funeral director to take her body to the funeral parlour, they had to go through "extensive negotiation via phone calls and emails to the coroner and the funeral direction, involving repeated assertion of my mother's stated wishes". They felt "very few families would have the knowledge, stamina and emotional resilience to manage in such circumstances".

14.120 Keith Newbegin (a consultee whose wife died of dementia in a care home) explained how his family were initially told by the undertaker "he could not keep the body looking reasonable after a post mortem for more than 48 hours", meaning a relative thought she would not be able to see his wife to say goodbye. He added: "we had thought some time ago of donating [his wife's] brain but the DoLS means you delaying release of the body within 24 / 48 hours so it is of no use".

14.121 K. E. Newman commented that the:

> Coronial system should be considerably easier of access to family and independent advocates of deceased, who should be entitled to legal aid in order to make representations on behalf of the deceased in favour of an article 2 inquest and at any subsequent inquest proceedings. Currently the coronial system is heavily weighted in favour of public bodies, who can invariably draw on significant public funds for representation and against the family and independent advocates who in almost all cases can have no recourse to public funds.

14.122 In a joint response from Hospice UK and the National Council for Palliative Care the problems caused in an individual case were described:

> When a patient who is subject to a DoLS authorisation dies, we have to gain the approval of the coroner's office before moving the patient to an undertaker. The local coroner plans to approve moving patients to the family's choice of undertakers, providing there are no suspicious circumstances surrounding the death. However, my hospice has limited cooling facilities for patients' bodies after death, and we cannot keep the deceased at the hospice for more than 24 hours. Therefore, when a patient died on a Friday night, and the local coroner was not available, the covering coroner insisted that police attended and that the body was moved to the mortuary used by our local coroner's office. This mortuary is in a neighbouring town. This was despite a lack of suspicious circumstances.

14.123 They quoted a medical director and consultant in palliative medicine who suggested coronial referral:

> May need to form part of the best interests discussion about admitting people to hospices or in commencing services to people's homes. The threat of coronial referral after death may be a deterrent to patients and families who might otherwise receive hospice care.

THE IMPACT OF *CHESHIRE WEST*

14.124 Many consultees commented on the impact of the *Cheshire West* decision on coroners' caseloads. Stockport Council Registration Services noted there is now "a guaranteed additional 120 -150 inquests this year, an approximate 25% increase".

14.125 The UK Brain Bank Network had "serious concerns around the increasing scale of the problem" post-*Cheshire west.* It described that "brain banks" in the network were experiencing increasing delays, thus reducing the quality of tissue and the number of samples of an adequate quality for research.

14.126 Andrew Tweddle (coroner) noted:

> The extra work that DoLS cases have produced should not be underestimated. In 2014, I dealt with 34 DoLS cases. This year (2015) I have dealt with 117 cases to date. This places increased pressure on an already pressurised service … At the moment neither myself, nor my support staff, nor my Coroners Officers have been given any further support in any way to deal with this substantial increase in work. This needs to be addressed.

14.127 Equally, John Ellery (coroner) said:

> I … like all other coroner areas in England and Wales, can report a significant increase in deaths being reported to my office which would not otherwise be the case. I In 2014 we had few such deaths reported to us, but this year (2015) we had many more deaths reported to us resulting in 57 inquests.

14.128 Another coroner (who wished to remain anonymous) added:

> We started to hold inquests into the death of DoLS patients when the Chief Coroner's Guidance was published in December 2014. Since that time was have held around 90 DoLS inquests (around eight per month). To put this into context, prior to DoLS cases, my jurisdiction had around 300 inquests per year. The additional DoLS inquests will result in a 30% rise in the total number of inquests … I note that my local authority boroughs have received over £550,000 to assist them with the DoLS burden. I have sought a small sum (no greater than £20,000) to provide for a Court usher, but the Lead Authority has stated that they are not able to allocate any of this money to the Coroners service …The time from receiving the report of the death, to inquest, on a DoLS case within our jurisdiction is around two to seven days.

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?

14.129 No overall majority view was reached in response to this question, but the largest number of consultees thought that people should be charged for their accommodation when they are being deprived of liberty.[131]

14.130 For example, St Andrew Healthcare argued that people should be charged because otherwise there would be a "perverse incentive" for a person to be deprived of their liberty and for to challenge less restrictive care plans. It also felt there would be an "adverse cost implication on public authorities which could not be mitigated without funding from central government".

14.131 Medway Community Healthcare, commented that:

> If individuals were not charged in these circumstances then we could see situations in which families ask for their relatives to not be admitted / placed or to be discharged to their care as a means of access state funding for care.

14.132 ARCO suggested that not charging for accommodation would mean that "people (or their relatives) might seek to be declared as lacking capacity in order to have their care paid for by the state".

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[131] 138 consultees expressed a view: 57 said "yes", 33 said "no" and 48 held equivocal positions.

14.133 Peterborough City Council stated:

> The Council cannot see that it is practicable to remove charges from those being deprived of their liberty in their best interests. To do so would go against the principles of advanced decision making and might also provide a perverse incentive for representatives to challenge mental capacity. In addition where individuals have placed themselves as self-funders whilst capacious, the removal of charging might lead to a requirement for alternative care settings to be sought for financial rather than best interest reasons.

14.134 PASAUK agreed with charging for accommodation, but felt that some other services should be provided free of charge to those deprived of liberty:

> It is appropriate to charge people for their accommodation and general care and support needs being met, whether they are being deprived of their liberty or not. However, people should not be charged for any specific care approach or intervention that is required as part of the restrictive practice. Thus if one to one care, a specific chair or monitoring device is prescribed in the care plan, this should be publicly funded, regardless of the person's means. General good practice in relation to continuous supervision, such as ensuring care staff are present in areas such as lounges, and general control measures should be funded through the core funding stream (whether private or public).

14.135 Northumberland County Council commented:

> We see no case for further extending the existing range of circumstances in which recipients of social care support are exempted from charging. In our view, existing exemptions from charging under section 117 of the Mental Health Act – and arguably also free long term continuing health care – have the effect of making the system less comprehensible, less fair and more administratively burdensome, and we think that the right approach would be to develop a simpler overall system, in which any protection against charging applies globally to all those receiving state funded long-term care, rather than adding further exemptions to an already over-complicated system.
>
> On the basis of experience of the operation of the other exemptions, we would expect the outcome of removing charges for people deprived of their liberty to be increasing numbers of disputes about whether care home residents and others should be classified as being deprived, driven by the desire of family members to protect their inheritance.

14.136 West Midlands Regional DoLS Leads Group argued that providing accommodation free of charge would not be affordable and "would seriously disadvantage those people who receive the same care but have capacity to consent to the arrangements". These concerns were also expressed by a number of local authorities, such as the Association of North East Councils which stated:

> If all those who were subject to deprivation of liberty automatically became eligible for free residential care, the impact on local authority finances would be simply unsustainable. There would be other, non-financial, adverse consequences as well … including inequity in the treatment of those care home residents who are subject to

> deprivation of liberty and those who are not, and the perverse incentive for people to be deprived of liberty.

14.137 A number of consultees argued that people should not be charged for their accommodation when they are deprived of their liberty. It was frequently argued that when a person is deprived of their liberty, the state is responsible for this state of affairs and the principle of reciprocity means that the person should not be forced to pay.

14.138 Turning Point argued that those subject to deprivation of liberty should have the same rights and safeguards as those detained under the Mental Health Act and who receive free section 117 after-care. Surrey CCG Mental Health and Learning Disability Collaborative also drew an analogy with former detained patients receiving section 117 after-care.

14.139 Nottingham County Council commented:

> In a hospital, custody or prison setting people are not charged rent for the period of detention. So why would it be appropriate in this instance. It is suggested that a basic bed and board charge would be reasonable, price pointed at the average price for the geographical area that they live in and for someone with similar needs who does have capacity. It is not thought reasonable to charge additionally for the cost of the care provided as they are not there of their own volition.

14.140 Age UK argued that the current situation whereby DoLS residents are charged, gives rise to inequalities between different groups of people deprived of their liberty and engages article 14 of the ECHR and told us that the most important thing to focus on is ensuring that deprivation of liberty under the Mental Capacity Act is only authorised as a matter of last resort.

14.141 Other consultees drew similarities with those eligible for continuing health care funding. According to Maxwell Gillott Solicitors:

> We do not think it is at all appropriate to charge someone for their accommodation when deprived of their liberty. It is tempting to think that, if they are not objecting, it is fine and they can be charged, but first, they lack capacity so a lack of objection is not determinative (as per *Cheshire West)*, and it cannot be right to charge one group of people subject of a deprivation of liberty, and not the other, when they face the same restrictions. Those eligible for continuing health care funding do not have to pay for their accommodation and care, we query whether that system can be expanded on, albeit we are fully aware of the resource implications and … an agreement by the current government to effect a change making it responsible for funding in the same way as with Mental Health Act patients, is unlikely.

14.142 A number of consultees held equivocal positions on this issue. For example, South Gloucestershire Council thought that charging does not seem right ethically, particularly if they are objecting, but was not sure how the resource implications would be met it not. Sanctuary Group (service provider) thought that long term funding of social care requires significant reform, to be led by government.

14.143 The Alzheimer’s Society thought that care planning and advanced decision-making involving the person, members of the family / carers and advocates should be used to avoid a situation where accommodation is used without certainty around who will pay for it. It argued “it is incumbent on all those involved in a person’s care to ensure plans are in place for such eventualities”.

Question 15-10

Does the law concerning foreign detention orders cause difficulties in practice?

14.144 A majority of consultees thought the law concerning foreign detention orders does not cause difficulties in practice.[132]

14.145 Most consultees who did not think that foreign detention orders cause difficulties did not expand further on their reasons. However, the Court of Protection Practitioners Association noted that matters have not been drawn to its attention as presenting practical difficulties in the management of cases and that “the case law in this area is developing and providing clarity”.

14.146 Lancashire County Council reported:

> We have only had one case of a Scottish resident being placed in a Lancashire care home and deprived of liberty. The case was referred to the Court of Protection who said they could not deal with it and referred it to the High Court. No significant problems in this area.

14.147 A number of consultees commented that the law does cause difficulties in practice. Garden Court Chambers’ Court of Protection Team noted that patients who remain subject to a foreign order have no recourse to safeguards under the Mental Health Act where they have capacity nor to the Mental Capacity Act where they lack capacity. It pointed out that in such cases there is no provision for oversight by the Court of Protection or any other body in England and Wales as to whether regular reviews of the person’s detention are in fact conducted by the foreign jurisdiction. It continued:

> Currently the operation of Schedule 3 of the Mental Capacity Act does not permit the Court of Protection to do more than provide a limited review when considering whether to recognise and enforce compulsory psychiatric placements, upon applications seeking such recognition and enforcement. The Court held in Re PA, PB and PC that the limited review should encompass the Court being satisfied that (1) the Winterwerp criteria are met and (2) that the individual’s right to challenge the detention under Article 5(4) is effective (i.e. that they have a right to take proceedings to challenge the detention and the right to regular reviews thereafter).

14.148 The most detailed response on this issue came from the Official Solicitor which considered that there are difficulties with the current law. They noted that there is no requirement on the foreign jurisdiction, before making a placement decision, to consult any competent authority in this country, or to transmit a report on the adult together with the reasons for the proposed placement. The Official Solicitor therefore noted that in

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[132] 37 consultees expressed a view: five said “yes”, 24 said “no” and eight held equivocal positions.

cross-border placement cases there is no opportunity for the competent authorities to raise concerns about the proposed placement (for example because the local commissioners have concerns about the standard of care afforded by the proposed placement to detained patients) or for the authorities to refuse consent to the placement. It was argued this was of particular concern where the foreign order provides for deprivation of liberty (and may contain other coercive measures) and is to be given effect in this jurisdiction. The response continued in the following terms:

> Once the Court of Protection has recognised the order it has no further role as the substantive challenge to the merits of the underlying measure can only be made to the foreign court. The Court of Protection is not therefore responsible for ensuring that the reviews provided for in the foreign jurisdiction are in fact carried out and there is no obligation on the placement to raise the lack of review with any public authority in England and Wales. The detained person will not have the benefit of an Independent Mental Health Advocate and there is no role for a relevant person's representative (or for any professional substituted for those roles consequential on this consultation). It is unclear how and with whom in this jurisdiction, the detained person can raise any issue regarding their continued deprivation of liberty (having regard to the fact that the person is detained here and on a practical basis their ability to raise the issue before the foreign court may be limited).

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?

14.149 We received responses to this question from 52 consultees.

14.150 Nikki Mardell (MCA and DoLS lead) noted that when a person has been placed into a different UK jurisdiction there is confusion as to who will assess the person, and whether authorisation is lawful according to the country of ordinary residence. Hertfordshire County Council stated that "there is a difficulty in relation to being aware of the standards of detention and the subsequent difficulties in monitoring it".

14.151 Jill Lewis (social worker) commented that:

> Language preferences could be an issue. For example, if a Welsh speaking person was placed in England and required [an authorisation], the Welsh language legislation would require the individual to be assessed by a best interests assessor with Welsh language skills, or the services of a skilled interpreter.

14.152 Leicestershire County Council reported that – because Scotland and Northern Ireland do not have DoLS type schemes – that cross border placement often requires Court of Protection intervention in order to ensure appropriate safeguards are in place. It stated that when people from Scotland are placed in England and Wales, the supervisory body has to authorise the deprivation of liberty where appropriate but with no ability to influence the care plan.

14.153 Bracknell Forest Council, Royal Borough of Windsor and Maidenhead and Slough Borough Council highlighted the financial issues that arise, noting that they have had to fund a DoLS authorisation in England for a case from the Channel Islands.

14.154 Hywel Dda University Health Board commented that there can be difficulties in that there is not always a means to authorise a continued deprivation of liberty when someone is transferred to a different UK jurisdiction. Warrington Borough Council believed that levels of knowledge and expectations varied between staff in the different UK jurisdictions.

14.155 According to Central Bedfordshire Council considered that :

> Issues relating to information sharing need to be resolved to ensure that when an individual is placed out of area (including in a different UK jurisdiction) there is good information sharing between the relevant authorities.

14.156 Some consultees took the opportunity to make general comments about general differences between England and Wales. The British Association of Social Workers commented that the DoLS in England and Wales allowed for different levels of training for best interests assessors, but felt that in hindsight this was a mistake since assessors "need to be able to operate with equal skill and knowledge in both countries". Similar comments were made by the ADSS Cymru and WLGA.

14.157 According to Denbighshire County Council:

> The main difficulty has been the fact that the training requirements and therefore approval of best interests assessors in England is different to those in Wales – leading to some confusion. There has also been a resource issue with authorities asking the host authority (i.e. where the relevant person is placed) to carry out the assessments on their behalf – often this is not practical due to lack of resources i.e. not enough best interests assessors within local authorities and a shortage of independent best interests assessors.

Chapter 15: Other Comments

15.1 Alongside receiving responses to the provisional proposals and questions in our Consultation Paper, we also received a number of comments on wider topics.

IMPLEMENTATION OF THE MENTAL CAPACITY ACT AND DOLS

15.2 A number of consultees took the opportunity to comment on the poor implementation of the Mental Capacity Act. For example, the Mental Health Foundation and Foundation for People with Learning Disabilities referred to the "lack of understanding and high levels of confusion amongst staff about DoLS and its interface with the Mental Health Act". The Mental Health Lawyers Association stated that the Act "is too often completely ignored" due to "a lack of awareness of the relevant legal framework". Bedford Borough Council noted that "the Mental Capacity Act was implemented in 2007, yet there is still limited awareness and practical application in practice"

15.3 It was suggested by several consultees that the capacity test in the Mental Capacity Act is not properly understood. The Tri-borough Councils suggested that the first principle of the Act should be amended to make clear that "someone cannot be labelled and written-off as 'lacking capacity', in relation to all issues in life or a whole domain". Garden Court Chambers' Court of Protection Team argued that care providers should be required to take steps to comply with the statutory principles.

15.4 Stuart Turner (social worker) commented that:

> This is one of the greatest failings in how the Mental Capacity Act and DoLS have been implemented – the majority of health and social care staff just did not understand them. Part of my role is to deliver Mental Capacity Act and DoLS training and guidance to staff at Thurrock Council. I am fortunate that we are a relatively small unitary authority, so that is made slightly easier for me. It does appears to have paid dividends – we have stayed out of court since the enactment of DoLS, so either we are very lucky, or our staff have a better than average understanding on Mental Capacity Act. Either way, in my view, training, awareness, and understanding are key to a new scheme's success.

15.5 Many consultees pointed to resources constraints post-*Cheshire west.* For example, Mike Henshaw (head of legal services at Alternative Futures Group) stated that:

> The Courts cannot cope with the demand and the Official Solicitor does not have sufficient staff to act as litigation friend. Local Authority legal staff and Adult Services teams do not have sufficient staff to submit DoLS applications resulting in them not being submitted. The process in itself is expensive and bureaucratic and not the best use of resources. An unfortunate side effect due to the cuts in legal aid is that the savings of vulnerable people have been used to pay for legal fees to firms appointed to act for them by the Official Solicitor.

15.6 West Sussex County Council reported that in 2013-14 it received 249 DoLS applications, in 2014-5 there were 2,614 applications, and in the first half of 2015-6 it received 2,200 DoLS applications. It added that these figures do not include community cases. Consequently it is currently prioritising cases based on those who will “most benefit) from the safeguards.

15.7 Some consultees highlighted the problems faced in hospital settings. Dr Jennifer Reid (elderly care) argued that post-*Cheshire West* :

> The goal-post changed and suddenly all patients lacking capacity to choose to stay in hospital required DoLS (even if they were quite happy staying in hospital). At that point the entire scheme became unworkable. Following this left me applying for around three DoLS a day – and never getting any response back as the whole system was overwhelmed. This meant that the more significant cases – those where the patient was being restrained against their wishes – became lost – and if anything their safeguarding became worse than pre-DoLS – the form was done and then nobody would challenge the status quo as we were waiting for a DoLS response – and waiting – and waiting – and waiting (one of my DoLS gained an assessor eight months after the patient had died).

IMPLENTATION OF THE PROPOSED PROTECTIVE CARE SCHEME

15.8 Some consultees commented on how any new scheme should be implemented. Liquid Personnel (social work recruitment consultancy) supported the use of standardised forms:

> Love or hate the DoLS Forms, they do provide a template for the minimum expected of an assessment to determine if a person is indeed being deprived of their liberty. Any new scheme must provide a suitable template such as the CoP 10 or else local authorities will simply develop their own and they could be a huge potential problem of a wide variation in the quality of the assessment.

15.9 Torbay and South Devon NHS Foundation Trust suggested the introduction of a national payment scale for Approved Mental Capacity Professionals who work independently in order to “stop the spiralling costs for assessors, which vary enormously, are often very high and are funded from the public purse”.

FLUCTUATING CAPACITY

15.10 A number of consultees commented on the issue of fluctuating capacity and the implications for any future scheme. For example, Berkshire Joint Legal Team noted that persons with fluctuating capacity sometimes does not welcome support, and suggested there should be “more emphasis on GPs referring to the local authority in such circumstances”. Millennium Care Services suggested that advanced decision-making should be used for people with fluctuating capacity.

15.11 Dr Jonathan Waite (psychiatrist) described “sun-downing” – whereby a patient typically has greater capacity in the morning. He noted:

> In the mornings they are aware of their need for care and supervision, but in the afternoon they become restless and are driven by a desire to leave their place of residence – sometimes because they regress in time and want to be home to meet

> their children from school or their spouse from work. I would contend that restraining a person in these circumstances is a restriction rather than a deprivation of liberty.

PERSONAL EXPERIENCES

15.12 We received numerous accounts of personal experiences of the DoLS. Some of these are summarised below (and have also been anonymised).

15.13 Several family carers and relatives described situations whereby a DoLS authorisation had been put in place but they had not been informed, or the DoLS had not been explained to them. For example, a family carer told us about having to take a phone call from a social worker about her mother:

> I was astounded - I did not know who this person was and why she had been in to see my mother and why she thought she had the right to make these assumptions. I asked who she was and she told me that she was to assess deprivation of liberty. I had never heard of such a thing and thought she was a fraudster … I was very angry at this invasion of my mother's privacy from an unknown source plus the assumption that I would be willing to conduct a conversation about it over the telephone.

15.14 Another family carer described the difficult DoLS assessment process:

> We were subjected to annual assessments as required under the law which were traumatic for both of us, entailing interviews by both psychiatrists and social workers which my wife could not understand and upset her and myself who had to go through all the awful effects of her illness. Dementia is progressive and nobody gets better so why after the first assessment do we need annual repeats, surely in dementia cases one assessment will suffice. The considerable expense would be better spent on care.

15.15 Many described the DoLS as a waste of time and resources. A consultee described how their brother, with severe autism, was put through two DoLS assessments in the space of several months as a result of a move, with no change in outcome. They described the scheme as “overly protective” and “appears to ignore that [their brother’s] situation will not change during his lifetime given the nature of his disabilities”.

15.16 Some consultees referred to poor communication skills amongst health and social care professionals, and a failure to explain what the DoLS are and what is their purpose. Others cited cases of poor understanding by professionals. A brain injury case manager referred to a case whereby a man [M] with a brain injury who lacked capacity to decide where to live, needed to be moved from his home to a unit which better met his needs, but was refusing to be moved:

> I asked M’s finance deputy and the hospital social worker, what is the best way to go forwards from here? I was given contradictory information: informed that the DoLS was the best way to go; also that the DoLS was not appropriate and I would need to apply to the Court of Protection; also that even if M consented to move then it should involve the Court of Protection due to his lack of capacity. No-one agreed. The best interests’ assessor was consulted and was ambivalent about whether the DoLS could be used for a transfer, given that this involved a journey of an hour and a half and a change of authority responsible. In the meantime, the hospital social worker stated that he had made an emergency DoLS application, and utilised it to effect a

> compulsory transfer which involved physical force. However, once M arrived at the rehabilitation unit no DoLS was in evidence. I have been informed that either way, this was an illegal transfer … it was clear that obtaining information about DoLS is difficult, and even the social workers who profess to know about the DoLS are misinformed. I would have hoped to come out of such a situation as this better informed, however I am more confused.

15.17 Another consultee noted her experiences as an attorney appointed under a Lasting Power of Attorney, of trying to work with health and social care professionals who she felt did not understand the legal frameworks:

> Neither supervisory authority, nor … managing authority, seem to be aware of the fact that they act against legislation ... and when this was raised with them, they are extremely slow to respond, apologise and set right. Employing people who do not know what they are doing, is hardly helpful to the hard-pressed registered attorney for health and welfare.

15.18 A number of consultees suggested that unlawful / unauthorised deprivation of liberty were commonplace. Several examples of people being required by local authorities and CCGs to move into care homes were given, with one service user arguing this is because that care home accommodation is "considerably cheaper than implementing care packages for independent living in the community". Similarly some consultees felt that the DoLS were being used to force people into care arrangements they do not want.

15.19 A number of consultees described more positive experiences of the DoLS. A parent carer has said that "I understood the process and am happy with my daughter's placement", whilst also noting that she found "the language of the words used such as deprivation and detaining, actually very upsetting". Another carer described a phone call from a best interests assessor after her visit:

> She was excellent; she was very in tune with the challenges a family may face when choosing residential care over home based support, spent plenty of time giving a very clear and personalised description of my son's assessment, and her reasons for the decision to grant the authorisation all of which made perfect sense.

15.20 A family carer described the case of her mother, who was subject to a DoLS authorisation:

> I found both the care home management and the DoLS team extremely helpful and knowledgeable and appreciated the additional criteria the DoLS team specified for Mum's care. I felt her case was treated with compassion and understanding and my views were heard and taken into account. I fully supported the DoLS team in adding Mum to the register and implementing the safeguards … I wanted to commend the team on how they had acted in Mum's best interests. I guess you usually get to hear when things go wrong. In this case the system worked well.

Appendix 1: List of Consultees

Number	Name of consultee
1	Glenn O'Halloran (advocate)
2	Stuart Turner (social worker)
3	Mohammed Rashid
4	Natalie Turner
5	Michael H Stone
6	Andrew Tweddle (coroner)
7	André Rebello (coroner)
8	Andrew Haigh (coroner)
9	Clayton Lister
10	John O'Donnell
11	Hospiscare Exeter and Mid and East Devon
12	Tracy Moses
13	Anonymous
14	Anonymous
15	Aaron Lohan (advocate)
16	Robert Wheeler (surgeon)
17	Jane Moore
18	Steve Benson (mental health workforce development officer)
19	Bill Bailey
20	Anonymous
21	Ben Troke
22	Julie Stanway (deputy director of care at a children’s hospice)

23	Paul Barker
24	Lorraine Currie
25	Louise Morgan
26	NUTHFT MCA and DoLS Steering Group
27	Jose Lawrence
28	Kingwood (LD service provider)
29	Jemma Swallow
30	Stephen Down (best interests assessor)
31	Juliet Parkin
32	Nigel Readings
33	Trish O'Hara
34	Jackie Howard
35	Peter Estall
36	Elizabeth Byrne McCullough
37	Christine May (hospice transition coordinator)
38	Stephen Ward (MHA and MCA lead)
39	Brian Gathercole (social worker)
40	Val Halton
41	Joan Gauld (family carer)
42	London Borough of Hounslow - Social Services Management Team
43	Rodalyn Emperado
44	Peter Scanlon
45	Eva Sisa (social worker)
46	Integritas Support Ltd (training provider)
47	Helen Turton (best interests assessor and Approved Mental Health Professional)

48	Julie Ryder (adult safeguarding nurse)
49	Polly Traxler (social worker and manager)
50	Dr Caroline Barry (palliative medicine)
51	Dr Stephen Brett (President of the Intensive Care Society)
52	Marie Rose P. E. A.
53	First-tier Tribunal (Health, Education and Social Care Chamber)
54	Kirby Mukwenda
55	Sue Garwood (housing consultant)
56	David Flood (adult safeguarding nurse)
57	Royal Borough of Greenwich BIAs forum
58	The Walton Centre NHS Trust
59	Dr Shaun Meehan (GP)
60	Yatheesh Sivanandan
61	Bill McMellon (best interests assessor)
62	Emma Kemp
63	John Ellery (coroner)
64	Janet Rogers
65	Hertfordshire BIAs
66	Mike Henshaw (head of legal services at Alternative Futures Group)
67	Advocacy Focus
68	Steven Whiteman
69	Emma Fowler (psychology student)
70	Gaynor Appleby
71	Anonymous
72	Pamela Charlwood
73	Professor Rob Heywood (medical law academic)

74	Bury Council and Bury CCG
75	Paul Gantley (mental health tribunal member)
76	Michelle Moore
77	Cindy Freeman
78	Anon
79	EKHUFT
80	High Hurlands Homes
81	Life Path Trust (learning disability charity)
82	Care Council for Wales
83	Phil Spencer (GP)
84	Association for Palliative Medicine
85	DoLS Leads for Bracknell Forest Council, the Royal Borough of Windsor and Maidenhead and Slough Borough Council
86	Eleanor Murphy (best interests assessor)
87	Chris Lucas (best interests assessor)
88	Christian Wilcox
89	Dr Kezia Lange (psychiatrist)
90	Caroline Pomeroy (best interests assessor)
91	Paul Bedford (social worker and best interests assessor)
92	Tim Gould and Jules Brown
93	Dr Tania Gergel (visiting research fellow in psychiatry)
94	Tom Hore (director of Bristol Mind)
95	A group of BIAs from East Sussex
96	UHL Adult Safeguarding Team and BIAs
97	Anonymous
98	Dr Jennifer Reid (elderly care)

99	Nancy Plowes
100	Kath Anderson
101	London Borough of Barking and Dagenham Council
102	National Centre for Post-Qualifying Social Work
103	Health and Care Professions Council
104	Hertfordshire County Council’s Coroner Service
105	Tristan Wood (former housing association manager)
106	Anneliese Hillyer-Thake (safeguarding lead)
107	Keith Dudleston
108	Claire MacIntyre
109	South Gloucestershire Independent Mental Capacity Advocate service
110	Hywel Dda University Health Board
111	Lucy Bright (best interests assessor and academic)
112	Dr Emma Cave (medical law academic)
113	Mental Health Foundation and the Foundation for People with Learning Disabilities
114	Old Age Faculty of the Royal College of Psychiatrists
115	West Berkshire District Council
116	Paul Harper (MCA and DoLS lead)
117	Aishwarya Kainth
118	Averroes (think tank)
119	Nikki Mardell (MCA and DoLS lead)
120	Pauline O'Hare
121	Jo Pope (hospice associate director)
122	Hertfordshire County Council
123	London Borough of Sutton

124	RadcliffesLeBrasseur
125	Anonymous
126	Pam Henderson (carer)
127	Kelly Kaiser (social worker)
128	Anonymous
129	Suzanne Watterson
130	Anonymous
131	Welsh Intensive Care Society
132	Jill Lewis (social worker)
133	Kerry Kilburn
134	Suffolk County Council Registrars and Coroners Service
135	Mental Capacity Act Project (include footnote stating The Mental Capacity Act Project is an initiative to support health teams within the NHS to implement the Mental Capacity Act).
136	Manchester Think Quality and Partnership Board Group
137	Rachel Goldsmith (social work student)
138	Rosemary Trustam (social worker)
139	Naomi Karslake
140	Dr John Sykes
141	Ernie Holden
142	East Sussex County Council (Adult Social Care)
143	Harrow Council's social care practitioners
144	Dr Clementine Maddock (psychiatrist and academic)
145	Dr David Jolley (psychiatrist and academic)
146	Wendy Carr (social worker)
147	Andy Hill (best interests assessor)
148	Rita Panayides (best interests assessor and trainer)

149	Vincent Duffy (DoLS team leader)
150	The London MCA / DoLS ADASS Network
151	Anonymous
152	Derek Boothby (MCA lead)
153	Durham County Council (Children and Adult Services)
154	City & Hackney SAB
155	Mr Justice Charles (Vice President of the Court of Protection and President of the Upper Tribunal (Administrative Appeals Chamber))
156	Dr Jonathan Waite (psychiatrist)
157	Kathy Liddell (family carer)
158	Cambridge House (service and advocacy provider)
159	Kate Blamires
160	Dorset Advocacy
161	Sheffield City Council - Advocacy Organisations and Sheffield Safeguarding Adults Customer Forum
162	Anonymous
163	Frances Horspath
164	ML and BS Smart
165	Elizabeth Piercy
166	Luton CCG
167	Sarah Rochira (Older People’s Commissioner for Wales)
168	Dementia Care
169	Dorothy House Hospice Care
170	Bedfordshire CCG
171	Thomas Wilbey
172	Anonymous
173	Michael Tapley, Dr David Jolley and Ann Regan

174	Mark Halford
175	London Borough of Lambeth BIAs
176	Care England
177	Anonymous
178	Dr Kate Dean (geriatric medicine)
179	Greg Slay (mental health professional and quality assurance lead)
180	Brent SAB
181	UK National Preventive Mechanism coordination
182	Healthwatch Staffordshire
183	Queen's Hospital (Burton, Staffordshire)
184	Phil Stafford
185	Thames Valley Area Safeguarding Network
186	Anonymous
187	Joint response from Shropshire Partners in Care, Telford & Wrekin Council and independent Care providers
188	Anan Rampersad
189	Adult Safeguarding, Nottingham University Hospitals NHS Trust
190	Wale Oyeleye
191	Nickollette Herron
192	Dr Jon Maskill
193	Older People's Advocacy Alliance
194	Anonymous
195	George Szmukler (emeritus Professor of psychiatry)
196	Dr Ben Spencer (psychiatrist and academic)
197	Flintshire County Council
198	Rachel Hubbard (best interests assessor)

199	National Association of Independent Schools and Non-Maintained Special Schools (NASS)
200	Nottingham City Council's Adult Social Care Department
201	National SEND Forum
202	Anonymous
203	Royal Hospital for Neuro-disability
204	British Association of Brain Injury Case Managers (BABICM)
205	National Family Carer Network
206	Dr Ceri Evans (consultant psychiatrist)
207	NHS Sheffield CCG
208	Andy Nuttall, Jo Henderson and Mary Woods
209	Independent Advocacy North East
210	British Medical Association
211	K. E. Newman
212	Torbay and South Devon NHS Foundation Trust and Torbay Council
213	Worcestershire Health and Care NHS Trust
214	John Young (best interests assessor and trainer)
215	Gloria Musekiwa (best interests assessor)
216	Kelvin Skidmore (best interests assessor)
217	Herefordshire Council
218	Kristy Atkinson, Lorraine Elliott, Fiona O'Donoghue, Paul Harper
219	Anonymous
220	Healthwatch Bucks
221	Devon County Council
222	Notting Hill Housing
223	Housing LIN

224	Susan Wilson (best interests assessor)
225	Real Life Options (learning disability charity)
226	SARCP
227	Leicestershire County Council
228	Tri Borough Councils
229	National Autistic Society
230	Waltham Forest Housing Association
231	Croydon Council and Croydon CCG conference for health and social care professionals
232	Croydon Council and Croydon CCG conference for service users and carers
233	Tim Gorvett (social care lead)
234	Northumberland County Council
235	Tameside Metropolitan Borough Council
236	Suffolk County Council
237	St Helens and Knowsley Teaching Hospitals NHS Trust
238	Royal College of Nursing
239	Anonymous
240	Tim Wilson (workforce development manager)
241	2gether NHS Foundation Trust Gloucestershire
242	Dr Jim Roper
243	Gloucestershire County Council
244	Anonymous
245	Susan Greening
246	BIAs across Rhondda Cynon Taf, Merthyr and Cwm Taf
247	Nick Hodge
248	Sefton Council

249	Independent Children's Homes Association
250	Simon Thomason (lawyer)
251	Janine Pettett
252	Faculty of Intensive Care Medicine and Intensive Care Society’s Legal and Ethical Policy Unit
253	Lancashire County Council
254	Cllr. Tony Martin
255	Empowerment Matters
256	Hampshire County Council
257	Sanctuary Group (service provider)
258	Association of North East Councils
259	South London and Maudsley NHS Foundation Trust
260	Northern Devon Healthcare Trust
261	Lincolnshire CCGs Federated Safeguarding Team
262	Teeswide SAB
263	Stockton-on-Tees Borough Council (DoLS Team)
264	South Tees Hospitals NHS Foundation Trust
265	Healthwatch – Hartlepool
266	North Tees & Hartlepool NHS Foundation Trust
267	Hartlepool Borough Council
268	Stoke-on-Trent City Council, Staffordshire County Council and North Staffordshire Combined Healthcare Trust
269	Shropshire Council Consultation Event - Care Providers
270	Norfolk County Council DoLS Team
271	West Midlands Regional DoLS Leads Group
272	Anonymous
273	Weston Area Health NHS Trust

274	Denbighshire County Council
275	Paul Greening (MCA manager)
276	Carers Trust
277	Esther Hack (mental health workforce development officer)
278	Lyn Romero (Chief Social Worker for Adults in England)
279	Kirklees Council
280	Newcastle Gateshead CCG
281	National Valuing Families Forum & Yorkshire and Humber Family Forum
282	PASAUK
283	Alan Capps (family carer)
284	South Gloucestershire Council
285	Older Adult Consultant Psychiatrists and Senior Nurses in Aneurin Bevan Health Board
286	Tees, Esk and Wear Valley NHS Foundation Trust
287	Roslynn Azzam (DoLS lead)
288	Bedford Borough Council
289	Carmarthenshire County Council
290	Shepway Adult Community Team, Kent County Council
291	Oxfordshire County Council
292	Ann Dalby
293	Mental Health Lawyers Association
294	Jackie Wilson
295	Warrington Borough Council
296	Sue Ryder (hospice)
297	Anonymous
298	The Huntercombe Group (mental health care provider)

299	Professor Richard Jones (solicitor and legal academic)
300	Solent Mind, Swan Advocacy, Dorset Advocacy, Speakeasy Advocacy, East Hants Mind, Choices Advocacy (South of England Advocacy organisations)
301	Roger Laidlaw (best interests assessor)
302	A joint response from North West Training and Development Team and Pathway Associates
303	Berkshire Joint Legal Team
304	Celia Kitzinger and Sue Wilkinson and Advance Decisions Assistance
305	Charlotte Peters Rock
306	Independent Age
307	Dr Ian Leonard (psychiatrist)
308	Dr. Eliza Kitis (family carer)
309	Age UK
310	Rachel Ward (independent mental capacity advocate)
311	Steven Richards (advocate and trainer)
312	ARCO
313	Dr Val Williams (academic)
314	Alwyn Davies (best interests assessor and Approved Mental Health Professional)
315	Living Options Devon (advocacy provider)
316	North Somerset Council
317	Matthew Graham (social work academic)
318	Ian Penfold
319	Vocal Advocacy
320	Liz Sinclair
321	Jane Sword
322	BIAs in Stockport Metropolitan Borough Council

323	DOSH
324	Paul Bowen QC (Brick Court Chambers)
325	Joanna Burton (solicitor and trainee advocate)
326	Durham Dales Patient Reference Group
327	Ashford and Canterbury and Coastal CCGs
328	Meg Lansom (social worker, best interests assessor and dementia charity trustee)
329	Anonymous
330	Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists
331	Swindon Advocacy Movement (advocacy provider)
332	Anonymous
333	Vicki Jackson (family carer)
334	Carl O’Riordan (best interests assessor)
335	Kent and Medway NHS and Social Care Partnership Trust
336	SAB National Chairs Network
337	Internal Safeguarding Board at Dudley Group NHS Foundation Trust
338	Gwent Deprivation of Liberty Safeguarding Consortium
339	Challenging Behaviour Foundations
340	Professor Julian Hughes (psychiatrist and academic) and Charlotte Emmett (law lecturer)
341	Rochdale Borough Council Adult Care
342	Peter Kirwan
343	Steve Chamberlain (best interests assessor and trainer)
344	Somerset County Council
345	Medway Council
346	East Anglia's Children's Hospices (EACH)

347	British Association of Social Workers
348	College of Occupational Therapists
349	Members of the Mental Capacity Act Practice Influencers Forum, Great Western Hospitals NHS Foundation Trust
350	John Nightingale
351	The Bar Council
352	Lancashire Care NHS Foundation Trust
353	British Geriatrics Society
354	Pohwer (advocacy provider)
355	National Care Forum
356	Gillian Carpenter
357	Birmingham St Mary's Hospice
358	South Essex Partnership Trust (SEPT) and Southend CCG (in co-ordination with Southend Borough Council)
359	NELFT NHS Foundation Trust
360	Millennium Care Services
361	Francis House Children's Hospice
362	Surrey County Council DoLS Team Manager and best interests assessors
363	Centre for Law and Social Justice and the Centre for Disability Studies, University of Leeds and CHANGE, Leeds
364	Shelley Cummings
365	Voiceability
366	Housing and Support Alliance
367	NHS Nene and NHS Corby CCGs
368	Mencap
369	Derby City Council’s Safeguarding and Professional Standards Team
370	Brighton and Hove City Council

371	Camden and Islington NHS Foundation Trust
372	Jacqueline Clarke (family carer)
373	East Cheshire NHS Trust
374	Bracknell Forest Council
375	St Helens Council
376	Barts Health NHS Trust
377	Steve Broach (barrister)
378	Care Forum Wales
379	Devon and Torbay Independent Mental Capacity Advocate Service
380	West Sussex County Council
381	Human Rights Implementation Centre at Bristol University
382	King’s College Hospital NHS Foundation Trust
383	Cafcass
384	Browne Jacobson LLP
385	Advocacy Centre North
386	Persons with learning disabilities in the County Durham area
387	Paul Stables
388	Swindon Borough Council
389	Chartered Institute of Housing
390	Compassion in Dying (charity specialising in advance decision-making)
391	Peterborough City Council
392	Blackpool Teaching Hospitals NHS Foundation Trust
393	Haringey Council
394	Amanda Colclough (best interests assessor)
395	Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs

396	Sense
397	Camden Council and Camden Safeguarding Adults Partnership Board
398	Medway Community Healthcare
399	Methodist Homes Association
400	The Disabilities Trust
401	North West ADASS
402	Law Society's Mental Health and Disability Committee
403	Liquid Personnel (social work recruitment consultancy)
404	Leeds Community Healthcare NHS Trust
405	Royal College of Anaesthetists
406	Dr Helen Burgess
407	Wakefield Council
408	Neil Allen (barrister and academic)
409	Chief Coroner of England and Wales
410	Central Locality (Southport and Formby CCG)
411	Advonet, IMCA Team (advocacy provider)
412	Sunfield
413	London Borough of Tower Hamlets
414	Tracy Keats
415	Nottinghamshire County Council
416	Lawrence Isaac
417	Gateshead Council
418	Robert Robinson (solicitor for HL)
419	Dimensions (learning disability care provider)
420	Natalie Brown (an Independent Mental Capacity Advocacy coordinator)
421	District Judges Elizabeth Batten and Margaret Glentworth

422	Alzheimer’s Society
423	South West London and St George’s Mental Health NHS Trust
424	Shared Lives Plus
425	University College London Hospital NHS Foundation Trust
426	SEAP (advocacy provider)
427	CQC
428	Rachel Griffiths (consultant)
429	Sitra
430	Bristol City Council
431	Garden Court Chambers’ Court of Protection Team
432	Royal College of Psychiatrists
433	South West Independent Mental Capacity Advocate Group
434	Betsey Lau-Robinson
435	Kent Community Health NHS Foundation Trust
436	Belinda Schwehr (consultant and trainer)
437	Chief Social Worker's Practice Reference Group for Adult and Mental Health Social Work
438	Oldham Council
439	Calderdale Council (Adults, Health and Social Care Services)
440	LGA and ADASS
441	Mills and Reeve LLP
442	n-compass Advocacy Service
443	Your Voice Counts (advocacy provider)
444	Anonymous
445	Dr Edward Lams
446	Mental Health Tribunal’s Members’ Association's Executive Committee

447	Anchor (housing and care provider)
448	ADSS Cymru and WLGA
449	Lincolnshire County Council Adult Care Directorate and Lincolnshire Partnership NHS Foundation Trust
450	Judges of the Family Division of the High Court
451	Derbyshire County Council
452	Salford City Council DoLS Team
453	Mind In Croydon Advocacy Service
454	Celia Walsh
455	National Panel for Registration
456	Lancashire Care Association and the Lancashire Registered Care Managers Network
457	Central Bedfordshire Council
458	Sheffield Citizens Advice
459	John Lish
460	Priory Group (healthcare provider)
461	Judy Weiner (independent mental capacity advocate)
462	Lincolnshire County Council
463	Barchester Healthcare
464	DAC Beachcroft LLP
465	Cambridgeshire County Council
466	Irwin Mitchell LLP
467	Royal Marsden NHS Foundation Trust
468	Luton Borough Council
469	Essex Autonomy Project
470	Royal United Hospitals Bath NHS Foundation Trust
471	Cloverleaf Advocacy

472	Sussex Partnership NHS Foundation Trust
473	North Staffordshire Combined Healthcare NHS Trust
474	Peter Edwards (lawyer and director of Peter Edwards Law)
475	Mental Health Alliance
476	Bupa UK
477	Dr Suzanne Jane Randall
478	Essex County Council
479	Minstead Training Trust
480	Swan Advocacy
481	Joanne Ward
482	South West Yorkshire Partnership NHS Foundation Trust
483	North Yorkshire County Council
484	Wayne Horner
485	Sharon Thompson (MCA and DoLS project lead)
486	British Society of Rehabilitation
487	Centre for Disability Law and Policy at the National University of Ireland, Galway
488	Professor Jenny Kitzinger (co-director of Coma and Disorders of Consciousness Research Centre)
489	INQUEST and INQUEST Lawyers' Group
490	Buckinghamshire multi-agency response
491	Rebekah Schiff
492	Hill Dickinson LLP
493	Dr Lucy Series (mental capacity academic)
494	Rae Hughes (social worker)
495	Joint response from a number of acute trusts across London
496	Ginny Smith

497	Health and Social Care Commissioners and Providers in North East Lincolnshire
498	Leeds City Council
499	Action on Elder Abuse
500	Carole Burrell
501	Karen Davies
502	Ben McCormack
503	Court of Protection Practitioners Association
504	Professor Richard Beale (chair of the London Adult Critical Care Operational Delivery Networks' Steering Group)
505	Maxwell Gillott Solicitors
506	Board of Deputies of British Jews
507	Jonathan Nash (legal academic)
508	Annette Wilby
509	Delia Gilbert
510	Michelle Pratley (barrister)
511	People First (Self Advocacy)
512	Catholic Medical Association
513	Richard Rook (former Department of Health senior policy manager)
514	Bindmans LLP
515	Leicester City Council
516	Turning Point (care provider)
517	South of England DoLS Leads Group
518	Surrey CCG's Mental Health and Learning Disability Collaborative
519	Ceredigion County Council
520	Catherine Brewin
521	Patients Association

522	Kent County Council
523	Staffordshire and Stoke on Trent Partnership NHS Trust
524	British Psychological Society
525	Hospice UK and the National Council for Palliative Care
526	Dr Rita Pal
527	Nursing and Quality Directorate for Dorset Healthcare University NHS Foundation Trust
528	West London Mental Health NHS Trust
529	Dean Blackburn
530	St Andrew's Healthcare
531	Lucy Sasse (best interests assessor)
532	Jane Marston
533	York Teaching Hospital NHS Foundation Trust
534	North Tyneside Council
535	Ann Coffey MP
536	UK Brain Bank Network
537	Bath and North East Somerset Councils
538	Registration Services, Stockport Council
539	Ofsted
540	Sunderland City Council
541	MDDUS
542	Mind
543	Law Society of Scotland's Mental Health and Disability Committee
544	Southend-on-Sea Borough Council
545	Southend-on-Sea Borough Council, South Essex Partnership Trust and Southend CCG
546	London Borough of Newham

547	Dr Sara Forman
548	Halton Borough Council
549	Cllr David Perry
550	Together for Short Lives
551	Professor Peter Bartlett (mental health law academic)
552	Conwy County Borough Council
553	Bradford BIAs
554	Weightmans LLP
555	Matthew Berry
556	Shirley Buckley
557	Dr Hugh Series (psychiatrist and academic)
558	Official Solicitor
559	Christine Hutchinson
560	Helen Whittaker
561	Equality and Human Rights Commission
562	Dr Basil Cardoza
563	Welsh Government
564	Andrew Harris (coroner)
565	David Oliver
566	Keith Newbegin
567	Department of Health and Ministry of Justice
568	Derek Twigg MP
569	Sheffield City Council’s BIAs
570	Sheffield City Council’s Care Home Providers
571	Sheffield City Council’s Health Professionals
572	Sheffield City Council’s Social Care Professionals

573	Sheffield Health and Social Care NHS Foundation Trust Learning Disabilities Service
574	Swansea City and County Council
575	Yorkshire and Humberside MCA DoLS Regional Forum
576	London Borough of Lambeth's Adults with Learning Disabilities Providers Forum
577	London Borough of Lambeth's DoLS Service
578	Newcastle City Council’s Legal Services
579	Shropshire Council Consultation Event - Health
580	Shropshire Council Consultation Event - Other
581	Mr and Mrs E, and HL
582	Cheshire and Merseyside Strategic Clinical Networks and Greater Manchester, Lancashire and South Cumbria Palliative & End of Life Care Networks
583	Martin Buckley (service user)
584	Shropshire Council Consultation Event - Shropshire Council

Appendix 2: List of Consultation Events

Number	Event	Date
1	Webinar, Community Care	7 July 2015
2	Webinar, Research in Practice	13 July 2015
3	Kensington and Chelsea, Kensington	13 July 2015
4	North Wales BIA's, Conwy	14 July 2015
5	BIA's Training, Anglia Ruskin University, Chelmsford	15 July 2015
6	Hospice UK, Sheffield	16 July 2015
7	Voluntary Organisations Disability Group, London	16 July 2015
8	Pohwer Conference, London	17 July 2015
9	Housing and Support Alliance, Birmingham	20 July 2015
10	Law and Social Work Practice National Conference, Bristol	20 July 2015
11	Nottingham Adult Safeguarding Board, Nottingham	21 July 2015
12	Local Government Association and ADASS, London	22 July 2015
13	LGA Care Act implementation group, London	22 July 2015
14	South East Disability Forum, Southampton	23 July 2015
15	Hospice UK Southern Regions, London	27 July 2015
16	South Gloucestershire Regional DoLS/BIA network, Bristol	28 July 2015
17	Mental Health Alliance and Royal College of Psychiatrists, London	29 July 2015

18	London Borough of Richmond, London	31 July 2015
19	South East BIA Forum, Horsham	4 August 2015
20	Alzheimer’s Society, London	4 August 2015
21	N Compass Advocacy Conference, Wirral	6 August 2015
22	Princess Alice Hospice, Surrey	10 August 2015
23	East Midlands MCA/DoLS Forum, Nottingham	11 August 2015
24	Hertfordshire Council Senior Managers, Hemel Hempstead	12 August 2015
25	Portsmouth Hospital NHS Trust, Portsmouth	13 August 2015
26	DoLS Regional Network, Leeds	17 August 2015
27	Yorkshire and Humber MCA/DoLS Group, Leeds	17 August 2015
28	Buckinghamshire County Council, Aylesbury	20 August 2015
29	Hft Carers Charity, Bristol	24 August 2015
30	BIA Forum Hounslow, London	25 August 2015
31	Care England, London	25 August 2015
32	Freeman Hospital, Newcastle	27 August 2015
33	Bradford MCA/DoLS Network, Bradford	1 September 2015
34	Government Department Roundtable, London	3 September 2015
35	MCA/DoLS Leads Forum, Exeter	4 September 2015
36	National Network of Safeguarding Adults Board Chairs, London	7 September 2015
37	Cheshire East Council, Chester	8 September 2015
38	DAC Beachcroft LLP, London	8 September 2015
39	Hospice UK, London	9 September 2015

40	Lancashire County Council, Chorley	10 September 2015
41	James Cook Hospital Neuropsychology Executive Committee, London	11 September 2015
42	Radcliffes LeBrasseur Solicitors, London	14 September 2015
43	British Geriatrics Society, London	14 September 2015
44	St John’s Buildings Chambers and 5 Merseyside LA’s, Liverpool	15 September 2015
45	Royal College of Anesthetists, London	15 September 2015
46	Birmingham City Council, Birmingham	17 September 2015
47	Voiceability, London	21 September 2015
48	Housing LIN Care Providers Conference, London	21 September 2015
49	Housing LIN Care Providers Conference, Manchester	22 September 2015
50	Black Country Authorities, Location TBC	24 September 2015
51	National Court of Protection Practitioner's Association Conference, Leeds	24 September 2015
52	Paul Matthews, Coroner, London	25 September 2015
53	Irwin Mitchell Solicitors, Birmingham	29 September 2015
54	39 Essex Street, London	29 September 2015
55	39 Essex Street and King’s College, London	30 September 2015
56	The Royal Marsden NHS Foundation Trust, Chelsea	1 October
57	Metropolitan, Cambridge	1 October 2015
58	HHJ Sycamore, London	01 October 2015
59	College of Occupational Therapists, London	2 October 2015
60	Brandon Trust, Bristol	5 October 2015
61	Clarke Willmott LLP, Bristol	5 October 2015

62	Judge Charles	6 October 2015
63	Hampshire Council, Location TBC	6 October 2015
64	Association for Real Change National Conference, Wolverhampton	8 October 2015
65	Mental Health Tribunal Association, London	9 October 2015
66	Alzheimer’s Society	12 October 2015
67	National Housing Foundation, London	12 October 2015
68	DAC Beachcroft LLP, London	12 October 2015
69	DoLS Discussion Forum, Lancaster	13 October 2015
70	North Yorkshire DoLS Forum, Northallerton	14 October 2015
71	Dorset MHAs, BIAs and Advocates, Dorset	15 October 2015
72	Croydon CCG and Council MCA Conference	16 October 2015
73	BIA meeting Carmarthenshire County Council, Carmarthenshire	19 October 2015
74	Trust Care Management Ltd, Peterborough	20 October 2015
75	Keele University seminar	21 October 2015
76	University of Sussex, Sussex	26 October 2015
77	Dementia Council, Birmingham and Solihull Mental Health Foundation Trust, Birmingham	28 October 2015
78	Mental Health Foundation and AAA, London	29 October 2015
79	Kingston University seminar	29 October 2015
80	Parliamentarians, Houses of Parliament, London	3 November 2015
81	National IMCA Conference, Derby	12 November 2015

82	Learning Disability Today Conference, London	26 November 2015
83	Department for Education	15 December 2015

Appendix 3: List of alternative names for the new scheme

We received suggestions for the name of the new scheme during consultation, as well as following the publication of our interim statement where we requested stakeholders contact us with suggestions. These are listed below:

List of suggested names for the new scheme
Adult Liberty and Rights scheme
Adult Protection scheme
Adult Rights Scheme
Assurance of Liberty Assessments
Assured Care and Treatment
Authorised Supervision
Best Interests Care Authorisation / Validation
Best Interests Care Framework / Safeguards
Best Interests Custody Safeguards
Best Interests Framework
Bournewood (Safeguards)
Capability and Restriction Evaluation (CARE)
Capacity and Access to Rights Enhancement Scheme (CARE Scheme)
Capacity and Liberty Safeguards
Capacity and Rights Enhancement Scheme (CARE Scheme)
Capacity Safeguards
Care and Capacity Assessment
Care and Liberty Authorisation
Care Authorisation Certificate

Care Order (Adult Care Order)
Care Safeguards
Care without consent
Continuous supervision and control safeguards
Deprivation of Liberty- Prevention and Protection
Deprivation of Liberty Safeguards (i.e. keep the original name)
Duty of Liberty Safeguards
Enabling Care
Enabling Liberty
Enhanced Care and Support, Assessment of Autonomy and Inclusion
Enhanced Mental Capacity Safeguards
Enhanced Oversight Scheme
Enhanced Support Safeguards
Ensuring Rights Plan / Scheme
Escalated Care and Support Scheme
Freedom Assessment
Freedom of Speech scheme
Freedom Protection
Human Rights Passport
Human Rights Safeguards
Inclusive Care
Interim Restriction of Rights
Involuntary Support Arrangements
Liberty and Protection Safeguards
Liberty and Rights Safeguards
Liberty and Security of Person Safeguards

Liberty Care
Liberty Care Order
Liberty Protection Scheme
Liberty Safeguards
Limitation of Boundary Rights Safeguarding (LoBRS)
Limited Liberty Procedures
Limiting freedom safeguards
Looked after Adults
Loss of Freedom Authorisation (LFA)
MCA Authorised Support Plan (for those subject to the current DoLS regime)
MCA: Protection of Liberty and Security Safeguards
MCA: Right to Liberty and Security Safeguards
Mental Capacity and the Reinstatement (or Restoration) of Liberty
Mental Capacity Care Framework / Safeguards
Mental Capacity Safeguards
My life plan' - Safeguarding
Preservation of Liberty / Autonomy, Governance / Guidance of Liberty / Autonomy, Care under Auspices, Maintenance of Freedom(s) (singular or plural)
Preservation of Liberty Safeguards (PoLS)
Promoting Liberty Safeguards
Promotion of Liberty
Promotion of Rights and Inclusion of Care Order
Protected Freedom Safeguards
Protected Independence Safeguards
Protecting Liberty
Protecting Rights

Protection of Freedom
Protection of Individual's Liberty
Protection of Liberty in Care
Protection of Liberty Safeguards (PoLS)
Protection of Liberty Scheme
Protection of the Rights of the Individual
Protection of Vulnerable Safeguards
Protection Rights for Restrictive Care (PRFRC)
Protective Care
Protective Care and Rights Scheme
Protective Care Safeguards
Protective Empowering Care
Protective Restrictions or Restrictive Protection
Protective Rights for Boundary Care (PRFBC)
Protective Safeguards
Protective Support
Qualified Liberty Procedures
Restrained Restricted Liberty
Restricted Freedom Safeguards
Restriction of Freedom Authorisation (RFA)
Restriction of Liberty
Restrictive Care and Support
Restrictive Care Protection Rights (RCPR)
Restrictive Care Safeguards
Right to Liberty and Security Assessment
Right to Liberty in Care Safeguards

Right to Liberty Safeguards
Rights and Freedom Safeguards
Rights and Independence Liberty Scheme (RILS)
Rights Assessment
Rights Respecting Care
Risk and Rights scheme
Safe Care
Safeguarded Care Scheme
Safeguarding' - My life plan
Safeguarding Boundary Rights (SBR)
Safeguarding Capacity
Safeguarding Care
Safeguarding Fundamental Freedoms
Safeguarding Liberty
Safeguarding Limitation of Boundary Rights (SLoBR)
Safeguarding of Liberty (SOL’s)
Safeguarding Rights in Care and Treatment (SRICT)
Safeguarding rights to liberty
Safeguards for Deprivation of Liberty
Safeguards for Liberty and Security of Person
Safeguards for mental incapacity
Similar to Part 4A Treatment of Community Patients not recalled to hospital under MHA
Statutory Protective Care
Structured Care
Supporting Liberty
Supportive Care

Supportive Care – Level 1 and Level 2 – or high need / low need
Supportive Care and protective (instead of restrictive care and treatment) care
Supportive Care and Restrictive Care – no need for umbrella term
Supportive Care with two levels (low and enhanced) or Protection of Freedom
The Enhancement of Liberty Safeguards
The Fundamental Freedoms Safeguards
Upholding Rights Plan / Scheme
Use of language from Part II of MHA such as compulsory or detention