# BRIEFING NOTE

# LAW COMMISSIONS PROPOSALS FOR MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

## INTRODUCTION

On 7th July 2015 the Law commission published its consultation document on proposals to change the existing scheme of authorisation and regulation in respect of those incapacitated individuals who are, or who may be, deprived of their liberty. The consultation proposals arise out of heavy criticism that they are not fit for purpose, are unduly complex and, in the light of Cheshire West, unsustainable. Appendix A attached provides a snapshot of the current DoLS regime.

The new scheme proposed which will replace the Deprivation of Liberty Safeguards will be entitled "protective care" which will establish different approaches dependent on the different care settings to which it has application. One size has been found not to fit all. The new scheme however will be much wider than its predecessor and will encompass much more than just deprivations of liberty.

The proposal is that "Protective Care" will apply to hospitals (for physical disorders) and care homes although the nature of the actual safeguards will differ according to the setting. The scheme will also apply to those in supported living, extra care and shared lives accommodation and will extend to family and other domestic settings. In these latter cases the proposal will mean that the need for court authorisation in these areas will, (unless there are additional complications which do require court intervention), fall away.

The new scheme will comprise two elements known as "**supportive care**" and "**restrictive care and treatment**". Supportive care will focus on those vulnerable individuals who lack capacity to be able to decide on their accommodation but who are not yet subject to more restrictive forms of care or deprivations of liberty. The intention is to create a preventative set of safeguards for these individuals that reduce the need for intrusive interventions in the longer term. If their care needs do however increase it may mean that they will then fall into the safeguards provided by the restrictive care and treatment component. Restrictive care and treatment will provide the direct replacement for the Deprivation of Liberty Safeguards. Its application however will be wider than its predecessor in that it will include cases where the individual's care is becoming more restrictive even though the care delivered may actually fall short of being classed as a deprivation.

The nature of both components to protective care will be further explored below.

## TIMESCALES

The consultation runs until 2 November 2015. During the course of 2016 the Law Commission will consider the responses it receives to its proposals. The next stage will then be for the Commission to produce and submit a response to the Lord Chancellor by the end of 2016. It is anticipated that this report will contain their final recommendations with their reasons and a draft bill.

**HEALTH WARNING –** this paper contains proposals upon which the Commission are inviting significant stakeholder consultation and input. The proposals contain widescale revision of the current system and it is highly likely that this proposed scheme will undergo change (which could be significant) before the final version is produced. So, as with any consultation, these proposals should not be seen, nor relied on, as being the definitive version. The Law Commission advised at a consultation meeting on

11 August 2015 that they would not anticipate anything coming on to the statute books before 2018 **at the earliest**. An added complication to the timescales is the need to rewrite a new Code of Practice to support the new scheme and an update to the existing Mental Capacity code. Pending a change to the law the existing system

as set out in the Schedule A1 to the MCA 2005 will remain in force supported by the evolving case law in this field.

**SUPPORTIVE CARE**

This element of the scheme will apply to those individuals who are living, or are about to move into, a care home, supported living or shared lives accommodation where they lack the capacity to make the decision about their accommodation for the purpose of being given care or treatment. The lack of capacity must result from an impairment of, or a disturbance of the mind or brain, closely aligning it to, and creating consistency with, the diagnostic test of Mental Capacity Act rather than the definition of mental disorder contained within the Mental Health Act. This represents a change as currently the DOLS applies to those individuals who suffer from a mental disorder within the meaning of the Mental Health Act.

It will have **no** application to those living in family settings or in other domestic settings. It is also important to understand that supportive care will **not** provide legal authority **to move** someone into that accommodation where there is objection from the individual themselves or where there is a dispute as to what is in the best interests of the individual concerned. In those cases legal advice will need to be sought about the need to make an application to the Court of Protection under s.16 MCA 2005.

Where it appears that an individual may fall within the ambit of supportive care it will be the responsibility of the local authority to ensure that an assessment is carried out. It is not however the intention of these proposals that work is duplicated or that fresh legislation is required. In most cases an assessment of an adult's needs for care and support under s.9 Care Act 2014 may already have been carried out. In most cases it would also be expected that local authorities will have already assessed their capacity to make decisions as to their accommodation. Only where an appropriate capacity assessment is lacking would it be expected that a capacity assessment will need to be initiated.

**SUPPORTIVE CARE - THE SAFEGUARDS**

Where an individual falls within the supportive care component the individual will be entitled to a number of safeguards.

The safeguards under this component will comprise the following:

(1) The local authority would be required to keep under review the person's health and care arrangements and whether a referral to the restrictive care and treatment part of protective care is needed;

(2) Care plans must include a record of capacity and best interests assessments and any restrictions imposed (including confirmation that the restrictions are in the person's best interests);

(3) The local authority would have discretion to appoint an "Approved Mental Capacity Professional" to oversee the case. This new role is to replace the role of the Best Interests Assessor (see below);

(4) An advocate or appropriate person must be appointed (if not already appointed); and

(5) The advocate and appropriate person would be responsible for ensuring that the person has access to the relevant review or appeals process.

The Law Commission see that the key to these proposals is the requirement on the local authority to keep the individual's situation under review. Again it would normally be expected that reviewing would in any event be in place under the Care Act or other existing legislation. It may simply be the case that the local authority needs to ensure that review of their supportive care component should be automatically linked to the existing review process.

The Law Commission also sees as an additional safeguard the need to protect an individual's article 8 rights when proposing a move into accommodation and sees the role of greater access to advocacy as being essential. Within

the consultation document they are also inviting comments on the draft Disabled People (Community Inclusion) Bill 2015 which has a number of proposals of relevance to individuals and moving to other care environments.

Finally the proposals recommend that all registered care providers should be required to refer individuals for assessments under the relevant components of the protective care scheme. The paper also asks for comments as to whether this requirement should find its way into the regulatory requirements enforced by CQC.

**RESTRICTIVE CARE AND TREATMENT**

This is the direct replacement for the DoLS. However its application is wider in that as well as catering for those individuals who are without doubt deprived of their liberty - it will also cover cases where the care plan includes restrictive care which may fall short of a deprivation of liberty. The idea is that it will provide safeguards for individuals whose arrangements for their care and treatment are becoming sufficiently intrusive and restrictive to warrant having some safeguards and oversight in place.

In order qualify the individual would need to:

a) Lack capacity to consent to the relevant care and treatment. [it should be noted that this differs from the relevant supportive care criterion which is based on a lack of capacity to consent to their accommodation]
b) Lack capacity as a result of an impairment of, or a disturbance in the functioning of the mind or brain. [Consistent with the LCC's proposals for supportive care but NOT consistent with the current DoLS scheme which is based on mental disorder]
c) Receive care which would fall within the ambit of restrictive care and treatment. This is going to be determined in accordance with the law commission's non exhaustive list.

Proposals that restrictive care and treatment should include but should not be limited to, any one of the following:

- continuous or complete supervision and control;
- the person is not free to leave;
- 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;
- barriers are used to limit the person to particular areas of the premises;
- 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;
- any care and treatment that the person objects to (verbally or physically);
- 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).

**RESTRICTIVE CARE AND TREATMENT - THE SAFEGUARDS**

1. The use of an Approved Mental Capacity Professional (AMCP) – this will replace the Best Interests Assessor (BIA) and they will be in the same position legally as an AMHP. They will be acting as independent decision makers on behalf of the local authority. The local authority will have a role in ensuring that applications for

protective care are "duly made" and founded on the necessary assessments. The AMCPs will have an enhanced role from their predecessor the BIA. All restrictive care and treatment assessments would be referred to an AMCP. As the RCT component is much wider the workload of the AMCP will be increased. The AMCP whilst having the responsibility to ensure an assessment is actually done - how that is achieved will be down to their discretion. Dependent on the circumstances of the case it may mean the AMCP will do it themselves or they may decide that a professional already known to the individual may be best placed to undertake the assessment. It is proposed that the standards for education, training and experience of AMCP's will be set by the Health and Care Professions Council.

2. AMCP's will be able to set conditions directly and monitor performance against those conditions although the AMCP could choose to delegate this to an appropriate health and social care professional.

3. AMCP's will be able to make recommendations to the local authority as to the suitability of the care plan.

4. The AMCP allocated to the case will be required to ensure that the arrangements are in accordance with the law.

5. The AMCP will also be required to review any restrictive care and treatment that had been authorised.

6. The AMCP will have the discretion to discharge the person from restrictive care and treatment as would the local authority.

7. Reviews would need to be timely and could occur at the request of the person or a family member, representative, care provider, advocate or appropriate person.

8. Where the restrictive care and treatment amounts to a deprivation of liberty – it must be expressly authorised in the care plan and the AMCP would be responsible for ensuring and certifying that the DoL is in the best interests of the person concerned and that objective medical expertise had been provided.

**OTHER SETTINGS – DOMESTIC SETTINGS**

Where care or treatment is proposed in a domestic setting and such care amounts to a deprivation an AMCP will be required to authorise the deprivation or discuss with the local authority or NHS trust how, and if, alternative care packages could be put in place which would end any deprivation. In some instances the case may need to be put before the court.

**DOMESTIC SETTINGS SAFEGUARDS**

The safeguards of the restrictive care and treatment component will apply.

**URGENT AUTHORISATIONS**

Self authorisation by care providers in cases of emergency is absent from the Law Commission's proposals. In cases of emergency the AMCP would be able to provide temporary authorisation for a period of seven days. If need be this could be extended for a further seven days pending full assessment.

**OTHER SETTINGS – MENTAL HEALTH PATIENTS (INCAPACITATED)**

The above scheme of protective care would have no application to incapacitated mental health patients who require treatment for their mental disorder and whose care and treatment would amount to a deprivation of liberty. The proposal is that the Mental Health Act 1983 will be amended to cater for this cohort of individuals.

**MENTAL HEALTH PATIENTS SAFEGUARDS**

1. the right to a Mental Health Act Advocate;

2. a power to provide treatment if a donee of a lasting power of attorney, a deputy, or the Court of Protection consents to the treatment on the person's behalf;

3. a requirement that treatment cannot be given under this power if it is contrary to a valid advance decision or if force is needed to administer it;

4. a requirement that a second medical opinion is needed for certain treatments including medication;

5. rights for the patient and the nearest relative to seek a review of the treatment plan; and

6. rights to apply to the mental health tribunal for an order to discharge the patient.

**OTHER SETTINGS – HOSPITAL SETTINGS (for physical disorders) AND PALLIATIVE CARE (hospices)**

The Law Commission has proposed a bespoke system for these settings.

Qualifying conditions

(a) Lack of capacity to consent to the care and treatment
(b) Real risk that at some point within the next 28 days that the care required in best interests will amount to a deprivation of liberty or
(c) The patient requires care in best interests that amounts to a deprivation
(d) Deprivation of liberty is a proportionate response to likelihood and seriousness of harm

**HOSPITAL SETTING AND HOSPICES SAFEGUARDS**

1) Up to 28 days provided registered medical practitioner has examined patient and certified to hospital managers that the criteria are met.

2) Hospital managers required to appoint responsible clinician.

3) Responsible clinician required to prepare written care plan after having consulted specified individuals and provided copies of the plan following authorisation to named individuals.

4) Appointment of advocate or appropriate person.

5) Extension of authorisation beyond 28 days only if AMCP has also carried out an assessment and confirms that the conditions are met. Deprivation can then be authorised for up to 12 months.

**SUPPORTED DECISION MAKING**

The Commission feels that there is a good case for creating a new legal process in which a person (known as a "supporter" ) is appointed to assist with decision making where a person lacks capacity. The supporter must be willing and able suitable to perform this role. The AMCP would have the power to displace the supporter if deemed necessary although there will be a right of appeal.

**OTHER MISCELLANEOUS PROPOSALS**

**Best interests –** it is proposed that s.4 Mental Health Act is amended to ensure 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.

**Advance Decision Making –** it is provisionally proposed that the ability to consent to a future deprivation of liberty should be given statutory recognition. This would only apply as long as the person has made an informed decision and the circumstances do not change materially.

**Regulation and Monitoring –** the proposal is for CQC to monitor and report on compliance with the restrictive care and treatment scheme and the hospital scheme.

**Age –**Protective care would apply to 16 and 17 year olds whereas currently the DoLS only has application to those aged 18 and over.

**Criminal Offence –** The Law Commission are inviting thoughts on whether a criminal offence of unlawful deprivation should be introduced.

**Coroner's inquests –** it is proposed that the 2009 Criminal Justice Act should be amended to reflect that inquests are only necessary into deaths that are subject to the restrictive care and treatment where the coroner is satisfied that the individual was deprived at the time of their death and that there is a duty under Article 2 to investigate the circumstances of that individual death. They are also considering whether the coroner should have the power to release the body prior to the conclusion of an inquest or investigation.

**Charging for accommodation –** The Law Commission invites responses on whether or not an individual should be charged for their accommodation when they are being deprived of their liberty in their best interests. They also wonder whether there is any "realistic way of dealing with the resource consequences if they are not charged".

**RIGHT TO APPEAL**

Individuals who are subject to the proposed restrictive care and treatment regime would have the right to appeal. The issue for the Law Commission is whether that remains with the Court of Protection or whether a First Tier Tribunal should be set up along similar lines to the successful tribunals in mental health cases. On balance the Law Commission favour setting up a Tribunal to deal with these cases. Thereafter a further appeal will lie either to the Upper Chamber or to the Court of Protection. It is noted that the Commission proposes that local authorities would be required to refer individuals to the First Tier Tribunal if there has been no application made to the Tribunal within a specified period of time.

Helen Glover
Local Authority Solicitor
12.8.2015