Law Commission Consultation Paper
Mental Capacity and Deprivation of Liberty: Response

November 2015
Introduction

The Law Society is the professional body for the solicitors’ profession in England and Wales, representing over 160,000 registered legal practitioners. The Society represents the profession to parliament, government and regulatory bodies and has a public interest in the reform of the law. This response has been prepared by the Society’s Mental Health and Disability Committee.

At the outset we would like to commend the Law Commission’s comprehensive work on the ‘Protective Care’ scheme to replace the Deprivation of Liberty Safeguards (DoLS) which have been widely and justifiably criticised as ineffective and not fit for purpose.

Before setting out our detailed responses to the majority of proposals and questions in the consultation paper we wish to emphasise our headline views:

(1) We agree that DoLS should be replaced. However, the proposals for ‘Protective Care’ appear more complex than the current scheme. They involve two levels of care, different schemes for different settings, and two categories of detention under the Mental Health Act. Although we provide constructive responses to the questions and proposals posed within the paper we have doubts about how workable and effective ‘protective care’ may be in practice.

(2) Significant training for health and social care professionals is vital if care and treatment compliant with the Mental Capacity Act 2005 is to be provided to all those who lack capacity and are subject to liberty restricting measures. A significant funding commitment is therefore also vital.

(3) We express particular concerns about the new and central role of the Approved Mental Capacity Professional – the role is complex and could become overburdened. It is important that this does not lead to the AMCP’s specialist functions being delegated to staff who lack the necessary expertise. AMCPs must retain their independence and there should be a further layer of authorisation above them.

(4) Access to expert judicial oversight whenever restrictive care and treatment is challenged must be maintained. A new Tribunal system might be the most suitable option to meet the significant increase in applications following Cheshire West, but there must be no loss of the expertise which currently resides in the Court of Protection, and access to the Tribunal/Court must continue to be supported through non-restrictive legal aid.

2. Analysis of the Deprivation of Liberty Safeguards

PP 2-1: DoLS should be replaced by a new system called 'protective care'

We agree that DoLS should be replaced. As set out below we have significant reservations about the implementation of the proposed new scheme.
PP 2-2: The introduction of Protective Care should be accompanied by a code of practice and the existing Mental Capacity Act Code of Practice should be reviewed by UK and Welsh Gov.

This would be necessary.

### 3. Principles of Protective Care

Q. 3-1: Have we identified the correct principles to underpin protective care, namely that the scheme should deliver improved outcomes, and be based on 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?

These are laudable objectives but we would not share the assumption that the new scheme should be based on the MCA 2005 because the MHA 1983 is seen as “stigmatising”.

We agree that it is beyond the scope of the new DoLS scheme to seek to reconcile the conflicts between the Mental Capacity Act 2005 and UN Disability Convention, not least due to the timescales within which a new scheme needs to be implemented.

We do not agree that the current DoLS scheme imposes a ‘one-size-fits-all scheme’. In fact, we consider that one of the criticisms of the existing scheme is that it deals with deprivations of liberty in different settings in different ways. As a result, a significant amount of judicial time is being allocated to authorising DoLS within supported living and domestic settings under a different scheme to Schedule A1.

As such, we consider that the principle that the scheme should be tailored according to setting should be approached cautiously, as 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.

### 4. The Scope of the new scheme

PP 4-1: The scope of protective care should include hospital, care home, supported living, shared lives and domestic accommodation.

We agree.

Q. 4-2: Is the definition of supported living under the Care Act 2015 appropriate for our scheme?

We share the concerns described in the consultation paper regarding the narrow definition of supported living under the Care Act 2014.

In particular, we are concerned that under the Care Act 2014, a person’s right to choose a particular provider or accommodation (subject to certain conditions) is limited to care home accommodation, shared lives accommodation and supported
living accommodation. In relation to the proposed scheme, if the restrictive care regime were to apply equally to individuals deprived of their liberty in supporting living and domestic settings then the narrow definition used in the Care Act ought not to have any real practical effect or indeed detriment.

However, if the restrictive care scheme were to apply differently to individuals in ‘supported living’ as opposed to some other ‘domestic setting’, then the definition under the Care Act would not be appropriate and should be more widely drawn to include all persons who are living in the community with support.

6. Supportive Care

PP 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.

We support the principles and intention behind the creation of the supportive care layer of protection and the focus on an accommodation ‘move’ as a trigger for applying safeguards. This more clearly acknowledges that Article 8 rights will be engaged at this time and should be factored into decision making, as highlighted in paragraph 3.3.

The consultation paper correctly observes that most of the safeguards at the heart of ‘supportive care’ already exist (for example, S.39 MCA and statutory guidance accompanying the Care Act) and that they should be being applied in the vast majority of cases. We entirely agree that the existing legal framework does not always work properly (6.25) but would go further and say that it is too often completely ignored by a range of professionals. This is due to a significant lack of awareness of the MCA 2005 amongst front line professionals, a point emphasised in the findings of the House of Lords Select Committee which concluded that it had not been implemented adequately.

Although we empathise with the Commission’s wish to enforce the current legal framework by introducing the ‘supportive care’ scheme, any new scheme will be effective only if it is accompanied by a drive on training and raising awareness of how the MCA 2005 should operate in practice. This cannot be achieved without a greater allocation of resources.

There is a link here with the discussion in Chapter 7 about decisions which are so serious that an application to court should be considered. The position was succinctly summarised by Peter Jackson J in *Hillingdon v Neary* [2011] EWHC 3522 (COP) where he commented that:

‘Significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection, where decisions can be taken as a matter of urgency where necessary.’

In *C v Blackburn with Darwen BC* [2011] EWHC 3321 the same judge encouraged those exercising powers of guardianship to bring to the court those cases which involved ‘genuinely contested issues of residence of a resisting incapacitated adult.’
It is essential that any new scheme makes it clear from the outset that a genuinely contested question of residence for an adult without capacity falling within the ‘supportive care’ scheme should be referred to the court, and that this should happen at the outset before continued residential or supported accommodation becomes a fait accompli. If such cases are omitted from the list of the decisions which require an application to court this will have a chilling effect on the Article 8 rights of those the scheme is designed to protect. The definition given in C above may be a useful starting point. Please also see our response to PP 6-10 below.

PP 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.

We agree.

PP 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.

We agree. This is particularly important given that the reforms to the care and support funding system have been deferred. However, it is also important that this duty should include referral to the court in cases concerning ‘genuinely contested issues of residence of a resisting incapacitated adult.’

PP 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.

We agree, but express our concerns elsewhere about the risk of overburdening the newly formulated role of the Best Interests Assessors (BIAs) who would be known as AMCPs under the protective care regime. The creation of BIAs has been one of the few successful innovations of schedule A1. BIAs represent a strong source of MCA 2005 expertise which is not reflected in other roles that might be called upon to carry out assessments.

The proposed wording in 6-4 reflects the Care Act 2014 regulations which cover all forms of care and support. Some assessments under the Care Act will be relatively straightforward. Such assessments may be delegated pursuant to s.73 Care Act 2014 and will not be carried out by local authority employees.

By contrast, supportive care cases will be limited to those cases where the person’s needs are so great or specialised that some form of alternative accommodation will be required. Accordingly if the assessor is not to be a trained BIA, then they should always either have expertise ‘in relation to the condition or circumstances of the individual’ or be required to consult a person with such expertise. Relying on an assessor with no familiarity with an unusual condition or highly specialist needs is insufficient.
PP 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.

We agree and would support defined timescales in which reviews should take place.

PP 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.

We agree; this is a minimum requirement which should be met in all cases.

PP 6-7: under supportive care, a person’s care plan must make clear the basis on which their accommodation has been arranged.

We agree.

Q.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

Yes, we agree.

(2) to seek the agreement of any donee of a Lasting Power of Attorney or deputy, or a declaration from the Court of Protection.

Yes; however we consider there should be a clear requirement to refer ‘genuinely contested issues of residence of a resisting incapacitated adult’ to the court. The availability of advocacy alone will not always ensure that applications are made in a timely fashion: see for example AJ v A Local Authority [2015] EWCOP 5.

Q.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?

Yes, this would be a useful development and assist the monitoring of good service provision that meets the needs and wishes of individuals.

PP 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.

We agree. This duty should be accompanied by effective monitoring.
Q.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?

Yes, there must be an element of compulsion to referrals within a regulatory framework.

7. Care and Restrictive Treatment

PP 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.

We agree with the rationale given for the extension of safeguards under the wider ambit of the MCA 2005 definition. This would improve consistency and avoid practitioners having to seek orders from the High Court under its inherent jurisdiction which is cumbersome and costly.

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

We agree with the eligibility criteria but suggest that they should be extended to include those in respite care.

It would be helpful to understand whether the new regime would cover those who have capacity to decide to live in these settings but lack capacity to decide their care and treatment, which might be subject to imposed conditions. At paragraph 7.27 the Commission states that whereas the capacity criteria for supportive care is ‘consent to living arrangements for purpose of care and treatment’ the capacity for restrictive care is capacity to consent to care and treatment.’ This is a significant distinction.

The DoLs regime deals with those lacking capacity to consent to being accommodated for the purpose of care or treatment. This has led at times to poor capacity assessments, where assessors have assumed that capacity to consent to accommodation is synonymous with capacity to decide their care and treatment to be delivered in that accommodation.

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

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

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

The proposal that the safeguards would be triggered by meeting only one criterion
would significantly expand the numbers of those who will fall under the restrictive
care regime. We understand that part of the rationale for this might be to enhance
recognition of Article 8 rights, but this also represents a significant expansion of the
acid test set down by the Supreme Court in Cheshire West.

For example, a person whose only restriction is not to be allowed to leave the care
setting unaccompanied would come under the new regime, but they would not have
come under the DoLS regime applying under Cheshire West.

Clearly, staff have a duty of health and safety towards those living in their placements
and for some patients it would be negligent to allow them to leave unaccompanied.
This restriction is minor compared to those who are physically retrained or medicated
to control their behaviour.

In relation to 7.31(7) which sets out restrictions such as contact with certain relatives,
it is implied that these restrictions are only imposed in practice by the care home or
the local authority. In our members’ experience, it is often the case that relatives set
the conditions for contact. This could include contact with, for example, a sibling with
whom the relative is in conflict about the patient’s care.

The care home might believe that they have the power to stop the relative ordering
them to restrict that contact, particularly if the relative has a power of attorney. We
suggest it would be helpful to clarify here the source of the restrictive contact
decision.

Q. 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?
Yes.

Disabled people without family or friends have an additional vulnerability especially if they are self-funding. They are unlikely to have an allocated social worker and perhaps no visitors to check on how care is being delivered. Extending restrictive care safeguards to those dependent on paid carers and who have no advocate would be welcome.

Q7-5: 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?

There is a need to closely monitor the use of PRN medications to treat mental health conditions and also physical restraint, particularly where the individual is objecting. Covert medication would also need to be authorised in accordance with ethical guidelines and should also trigger the safeguards.

PP 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.

We agree.

Q. 7-9: 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?

We agree. This is essential.

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 BIAs who have MCA 2005 expertise. DoLS BIAs frequently find poor recording of best interests decision-making processes, including the recording of consultations with the service user and family.

Some local authorities use a capacity assessment form that has little space for the recording of best interests, while others do not use a template to conduct a balance sheet checklist of pros and cons with respect to the relevant decision. These matters need to be addressed by ADASS now rather than wait until the law reform process has resulted in legislation.

Q. 7-10: 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?

Where the driver for restrictions involves the prevention of harm to others we believe such restrictions should be properly imposed under the powers of the MHA 1983 which has clear criteria to test the need for such measures. Whilst we are aware that in practice the DoLS are used to prevent harm to others this is not the correct course to be taken. Case law in this area has been unhelpfully vague and has seen the use
of the concept of ‘best interests’ as vehicle to justify the imposition of restrictions to prevent harm to others’. This is not adequate and in our view is incompatible with the purposes of the MCA 2005.

PP 7-11: cases involving serious medical treatment should be decided by the Court of Protection.

Cases involving serious medical treatment merit the specific expertise of the Court of Protection which has the ability to respond urgent requests. The capacity of the county court regionally to deal with such cases at short notice would be very limited as is the necessary expertise of the court.

Q.7-12: should all significant welfare issues where there is a major disagreement be required to be decided by the Court of Protection?

In consideration of the potentially severe interference in the human rights of the individual we agree that serious disagreements should be decided by the Court of Protection. We note the proposal that a tribunal be formed to adjudicate on disagreements with a right of appeal to the CoP. There are advantages to a tribunal that is composed of multi-disciplinary members with a legal chair but where there are very significant and/or lifelong consequences these decisions should be reserved to specialist judges sitting in the CoP.

Please also see our comment at 6-1.

PP 7-13: restrictive care and treatment assessments should be referred to an ‘Approved Mental Capacity Professional’ (currently, the best interests assessor) who would be required to arrange for the assessment to be undertaken by a person already involved in the person’s care (eg the person’s social worker or nurse) and quality assure the outcome of that assessment or oversee or facilitate the assessment; or undertake the assessment themselves.

The role and responsibilities of the Approved Mental Capacity Professional (AMCP) will be crucial to the success of the proposed regime of protective care.

The proposed role description marks a significant change from the role of existing BIAs. We have already indicated our support for the expertise demonstrated by BIAs who are under significant pressure as a result of the increase in DoLS authorisations post-Cheshire West. We understand the resource implications this has and the need to relieve that pressure, but this should not be at the expense of expertise in MCA 2005 decision-making. Moreover, we would not wish to see a dilution and overburdening of the role of AMCP. We are also concerned that there should remain a layer of authorisation above BIAs, as is presently the case in practice.

This shift in emphasis to oversight monitoring and delegation under the AMCP role appears partly to be justified by resourcing issues for local authorities but allocates considerable powers to social workers at a professional level lower than what is currently the case. MCA awareness needs to be significantly improved, primarily by

\(^1\) Y County Council v ZZ [2012] EWCOP B34
focused training and development amongst all staff who may now be called upon to undertake assessments.

We note that assessments could be carried out by the social worker or other professionals already involved and then quality assessed by the AMCP. The risks with this approach are a dilution of the independence principle and also a real potential of a reduction in the quality of the assessments as compared to those undertaken by BIAs under the current regime.

We recognise that scrutiny by the AMCP may force social workers to improve their knowledge and use of the MCA as well develop skills in the analysis of more complex care scenarios where conflict may be present. Better recording of information will also be important as will a focus on improving skills in best interests decision making. Again, training and development of staff is crucial and this will need to be funded. Without this investment it must be doubtful whether acceptable assessment outcomes can be consistently achieved.

**PP 7-14:** 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.

This proposal would give the AMCP considerable power, so we would want to know who within the new framework would scrutinise AMCPs’ decisions. AMCPs should not quality assess their own assessments.

**PP 7-15:** 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.

We agree.

**Q.7-16:** what should the timescales be for the assessments under protective care and what records should be contained in the assessment?

A minimum period of two weeks is necessary to carry out all activities necessary for a thorough assessment, including: consultation with the service user, family and friends; preparation of assessment documents such as capacity; diagnoses checks with medical professionals and the holding of a best interests meeting.

There would also need to be provision for short term emergency assessment/authorisation which would be followed up by the full assessment process.

**PP 7-17:** restrictive care and treatment should enable Approved Mental Capacity Professionals (currently, Best Interests Assessors) to use equivalent assessments where this is necessary.

We agree that there should be flexibility to allow for equivalent assessments, such as a report prepared for submission to a court by another appropriately qualified professional.
PP 7-18: 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.

If this proposal were implemented then the AMCP would become primarily a decision making role, which would demand additional training as BIAs do not currently make decisions about care packages.

The authoriser role was a higher rank to the BIA and because of that, should have found themselves more ready to challenge decisions made in other areas of the local authority. In this case, the BIA at senior practitioner level and now an AMCP will have to make controversial decisions to authorise restrictive care with perhaps recommendations to the group manager which could lead to pressure to dilute or amend decisions made by the AMCP.

Under the DOLS scheme, the person whose role is to grant the authorisation is of a higher rank than the BIA. As such it may be easier for that person to challenge other decisions made within the supervisory body- perhaps concerning care provision. We would not want the AMCP to be deterred from making these challenges due to lack of seniority.

There is merit in retaining a supervisory level - perhaps through a panel of health and social care professionals to whom the AMCP would be accountable for their decisions.

PP 7-19: 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).

We agree.

PP 7-20: the ability to practice 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.

We agree – this is a specialised and expert role.

Q. 7-21: 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?

Since the local authority would be liable for the actions of the AMCP, there must be a regulatory structure both within the local authority and outside its jurisdiction. A Panel formed of a group manager or assistant director who is not involved in day to day area decisions about care packages together with an individual experienced in conflict/complaint resolution would be adequate.
We support the introduction of a right of the service user, family member or professional involved in care to request an alternative assessment. 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 AMCP to assess the situation and may avert the need for a costly application to the CoP.

**PP 7-22:** 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.

Having the power to set conditions and make recommendations is an important discretionary power. It should be exercised fairly and with clarity as to who has the funding and legal responsibility for the service user. In some cases BIAs make recommendations for social workers to action, for example best interests meetings when Schedule A1 directs that it is the managing authority that must implement conditions. So it would be helpful to indicate that the AMCP could make conditions or recommendations for health professionals and for co-funders e.g. the CCGs paying for partial continuing healthcare.

**PP 7-23:** the ‘Approved Mental Capacity Professional’ (currently, the Best Interests Assessor) should be given responsibility for monitoring compliance with conditions. This could be delegated to health and social care professionals who are allocated to the case, and advocates and the appropriate person would be required to report any concerns about non-compliance with conditions.

In our members' experience it is the RPRs who monitor compliance with conditions on each visit, usually monthly. They will take issue if conditions are not implemented and this alerts the allocated social worker and the Supervisory Body to action the conditions or seek a review of them. Not to do so would risk the RPR appealing the authorisation.

However, when it comes to renewal of the DoLS then the BIA does comment adversely against the managing authority and/or local authority social worker if conditions have not been implemented. With the removal of any role above the BIA ‘authorising’ the conditions and requiring the AMCP to now monitor the implementation of conditions could be seen as unduly onerous. We are also concerned that social workers may be required to then monitor their own performance in ensuring conditions are adhered to if the AMCP decides to delegate that aspect. Social workers should certainly not be monitoring conditions that have been imposed on the local authority itself as a provider of care.

**Q.7-24:** should the new scheme allow for conditions or recommendations to be made that are more restrictive of liberty than the application is asking for?

AMCPs in practice may well identify the need for greater restrictions but these should be subject to scrutiny at a higher level of authorisation.
Q.7-25: should there be specific sanctions for a failure to comply with a condition, and if so, what should they be?

There are currently no sanctions for non-compliance with conditions. If a sanction is to be imposed, then there should be a review or appeal mechanism to challenge it.

Sanctions would also mean that AMCPs would need to be more cautious as to the extent of the conditions they impose, especially for those with commissioning responsibility as distinct from the managing authority. This would also reduce the risk of judicial review of the AMCPs for exceeding their jurisdiction.

One possible sanction could be the suspension or termination of contracts for care provision. AMCPs 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. The CQC should also be informed of failures to comply with conditions imposed.

PP 7-26: 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.

This proposal is likely to be extremely resource intensive, such that many local authorities would find it difficult without a significant allocation of funds from the Department of Health.

This proposal also appears to be in conflict with the recommendation that the AMCP monitors the conditions until it becomes apparent that the monitor is a different AMCP to the AMCP who has had the dual assessor/authoriser role. This recommendation shows the difficulty associated with the expansion of the BIA role into that of the AMCP i.e acting as assessor, authoriser and monitor.

Some local authorities have such small BIA teams that they cannot possibly undertake a monitoring role. Again, this gives the impression that the responsible social worker cannot be trusted to follow the MCA principles or the proposed new regime unless someone with a specialist role other than their manager is monitoring their performance.

PP 7-27: 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.

Expanding the AMCP role to a general review of the care and treatment appears to subsume the role of the social worker leaving social workers with a funding role.

It is also proposed that the AMCP can discharge the person from the restrictive care regime, but we wonder what consultation they must undertake before a decision can be made: should they have to consult the service user, managing authority, family and health professionals to discharge such care and restrictions? The role of
authorising restrictive care and initiating a review of the care or conditions should be reserved for a higher ranking official within the adult care team.

**PP 7-28:** the ‘Approved Mental Capacity Professional’ (currently, the Best Interests Assessor) should be able to review and vary conditions without necessarily holding a full re-assessment of best interests

Keeping the care plan under review and then reviewing and varying conditions when necessary appears to confuse and overburden the AMCP role further. We would be in favour of a process by which the AMCP could be asked to review or amend conditions in a similar way to the current process, but more simplified in form.

**PP 7-29:** 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.

This proposed power to allow the local authority to discharge the person from restrictive care appears to be in conflict or overlap with the proposed power of the AMCP under PP 7-27 to discharge the person from restrictive care and treatment.

We would welcome more information on who within the local authority would be authorised to discharge the person? This appears to be reverting to an authoriser role which will be one of the few powers given to the Council itself. A panel would be preferable.

**PP 7-30:** 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.

We agree.

**PP 7-31:** 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.

We consider this to be essential. Everyone involved in producing the care plan should be adequately trained and supported in the application of the MCA 2005 and the identification of liberty restricting measures.

**PP 7-32:** 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.

The issue of DoL in domestic settings is still largely hidden due to resourcing issues for supervisory bodies who are focusing on the backlog caused by the Supreme Court judgment. Domestic settings are harder to monitor as they rely on the service user and paid or unpaid carers allowing the AMCP access.
PP 7-33: 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.

We support this recommendation to ensure compliance with Article 5 ECHR.

The consultation paper includes a psychologist as a clinical assessor and we support this for certain service users such as those with learning disabilities and neuro-psychological conditions such as acquired brain injury. Any legislation implementing this would need to specifically state this to offset any challenge that Article 5 only allows for medical evidence.

Ideally the capacity assessment would be recorded on a separate section of the clinical assessment template form to clearly focus the clinical assessor on the distinct issues of mental health and capacity.

PP 7-34: 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.

Again, we support this in order to ensure compliance with Article 5. We reiterate the comments made above with regard to accepting psychologists as clinical assessors.

Q7-35: should the medical assessment address other matters such as providing a second opinion on treatment already being provided or proposed?

Where the service user has not recently accessed mental health services, it might be helpful to allow the clinician to comment on whether the medication is appropriate or not, including the dosage, or the appropriateness of physical restraint and its impact on the individual’s mental health. Good mental health assessors will already have raised issues about treatment and medication with the managing authority even if there is currently no box allocated in the template form for that issue.

Q7-36: should doctors be eligible to act as Approved Mental Capacity Assessors (currently Best Interests Assessors)?

We do not have a particular view as to whether doctors should be eligible to act as BIAs but are surprised by the absence of nurses from this proposal.

Since the DoLs regime was brought into force in April 2009, many nurses working in CCGs or Continuing Healthcare teams have trained as BIAs. We see no reason why they could not act as AMCPs for local authority owned care homes as only independent BIAs are currently allowed to act as BIAs in these settings.

Knowledge of the MCA best interests processes is not embedded in general medical practice and there might be a risk that clinical AMCPs would focus unduly on medical best interests rather than more holistic view of best interests.
PP 7-37: 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.

There is always a need for caution in granting authority for restrictive practices when the service user has not been formally assessed. As such, there must be proper justification for urgency on the part of the local authority or the provider. In certain circumstances the managing authority would not identify the need for the authority so allowing the social worker or health professional to apply for the short term authority may be reasonable.

We should say that we consider 14 days to be a long time for someone to be deprived of their liberty on the decision of a sole individual.

The absence of any oversight role above that of the AMCP should be addressed.

PP 7-38: 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.

The fact that there is currently no power to convey a person from a hospital to a care home or from one care home to another, particularly when they are unhappy about the move has caused problems for social workers, health professionals and the police. Anecdotally, some members have indicated that the police have asked to be shown the section of the MCA 2005 that specifically authorises conveyance because they are reluctant to move someone or assist in conveyance.

There must be an express power to convey even with the service user’s objection and specific authority given by the authoriser/AMCP to transport the person.

8. Protective Care in Hospitals and Palliative Care

PP 8-1: a separate scheme should be established for hospitals and palliative care settings.

Please note that we have not had time to adequately to consider the impact of R (LF) v HM Senior Coroner for Inner South London [2015] EWHC 2990 (Admin) in commenting on this section. This case provides judicial guidance on the application of the Cheshire West acid test in the context of intensive care units.

We support a separate scheme for hospitals and palliative care settings and agree that the nature and degree of supervision and control in a hospital setting means that the ‘acid test’ is more readily met. In practice therefore, the focus is more likely to be on the ‘not free to leave’ limb of the test.

We also agree with the proposed definition of deprivation of liberty in a hospital setting as set out in paragraph 8.22, but are concerned that this may not adequately cover the situation when restraint tips over to deprivation of liberty.

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. In these cases supportive care and restrictive care and treatment arrangements may well be appropriate.

PP 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).

It would be extremely useful for a chart or flow chart to be produced for each of the proposed schemes, so that it would be possible to readily see the similarities and differences of each scheme.

There appears to be a watering down of the protection afforded by the DoLs scheme to those deprived of their liberty under the proposed scheme, in particular that there is no requirement for the person to be assessed by an AMCP during the first 28 days. This is of concern because medical professionals may not consider and apply the appropriate test of capacity, and may consider medical best interests rather than best interests in the round (see reply to Q7-36 above). Additionally, an advocate or an appropriate person, particularly if a family member may find it difficult to challenge the decisions of a medical professional.

The proposals for reviewing or challenging the deprivation of liberty, or who may do so (anyone else on the persons behalf) are somewhat sketchy. It may be that it is more appropriate for challenges relating to deprivations of liberty in hospital settings to be made in the Court of Protection, since the question of deprivation of liberty is often ancillary to the question of whether the treatment proposed, or arrangements for care and accommodation are in the person’s best interests. For example, a person may object violently to being restrained and deprived of his liberty for the purpose of providing dialysis, or being force-fed, or being given a cesarean section or termination. This may then require a determination of whether the medical treatment is in that person’s best interests.

Q.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)?

We support the requirement of a second medical opinion in certain situations, for example in ICU. 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.

Most patients in ICU will fulfill the acid test the proposals may prove costly.
We question whether it is necessary for the scheme to cover all those in ICU who are technically deprived of their liberty, but are not resisting treatment, or actively attempting to leave the unit.

9. Advocacy and the Relevant Person's Representative

PP 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.

We support the allocation of an advocate or appropriate person when a resident lacks capacity and is or may be subject to protective care. It is noted that the proposal suggests appointing advocates or appropriate persons to all residents with or without capacity.

This would require a process to identify a particular friend or relative who would have a specialist role as appropriate person over and above playing a supportive role to their relative who is in care. This could lead to difficulties where for example the resident wishes to choose a person who is not their attorney or deputy as their appropriate person or the family members are in conflict and some siblings wish to object to the appointment of such a relative as an appropriate person. There is little detail on the process for such an appointment. Is it envisaged that the local authority chooses that appropriate person, or the placement manager does so if the person lacks capacity?

PP 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.

We have concerns about the proposal to replace IMCAs with Care Act advocacy. IMCAs have played an important role since the MCA 2005 came into force and are necessarily a specialised role. In some areas, the organisation allocated the contract for Care Act advocacy may be different to the organisation allocated the IMCA contract so there would be a great loss of skills if IMCAs did not continue in their role. Care Act advocacy does not necessarily include specialist knowledge and experience of using the MCA though it ought to do so. There is a need to examine where there are boundary issues between the roles but we would not support the abolition of IMCAs.

Q. 9-3: should the appropriate person have similar rights to advocates under the Care Act to access a person's medical records?

The resident should be consulted first about the appropriate person accessing medical and social care records as they may have reservations about this access in case some matters that had been kept secret from adult children were revealed. We are puzzled as to why there is no mention of access to social care records as the same reservations would apply. Perhaps, for those adults who lack capacity, there
would be a need to conduct a best interests’ assessment about accessing such records after obtaining the resident’s views.

Q.9-4: should Independent Mental Health Advocacy be replaced by a system of Care Act advocacy and appropriate persons?

We do not support the replacement of IMHAs with Care Act advocacy and appropriate persons.

Those services supplying Care Act advocates and the advocates themselves may have no training in acting as an IMHA which provides for specialist knowledge of the MHA 1983 and expertise in liaising with patients, hospital professionals and family.

PP 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.

PP 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.

Since the judgment in AJ we understand (anecdotally) that some supervisory bodies are reluctant to appoint family members as RPRs as they are concerned that the family member may have supported the resident being sent into care against their wishes. Even though the Commission appears to have taken on board the criticisms of RPRs made by some organisations, it has to be borne in mind that there are resource issues if RPRs wish to appeal a DOLs authorisation. We believe that the RPR role and, in particular, those paid RPRs have performed a valuable role to advocate for those under DOLs authorisations. Most paid representatives supply monthly reports on residents and the supervisory body then arranges for that report to be sent to the responsible social worker to action. It is true that managing authorities do not appear to monitor RPRs and report back to the supervisory bodies on their performance. It is left to the supervisory bodies to monitor whether they are receiving regular reports which illustrate that the RPR is being proactive on behalf of relevant persons.

We are surprised at the suggestion in 9.57 that the Commission does not propose to maintain the role of the paid RPR. This appears to be on the assumption that the person already has an advocate or appropriate person. If the person only has an appropriate person, i.e. a relative, then when restrictive care becomes a DoL, this will require the appropriate person or advocate to be more proactive to try to reduce the restrictions that amount to a DoL or to initiate a review or a challenge to a tribunal or court about the terms of the DoL.

It would be a pity if the expertise of paid RPRs were lost and we would prefer for that role to be maintained for those residents who are subject to a DoL. In those circumstances a paid RPR could take over from an advocate or appropriate person to recognise that those under a DoL require specialist advocacy and support.
PP 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.

We are concerned that the Commission proposes that the AMCP would be given the discretion to appoint a RPR where the person is only supported by an appropriate person (9.58).

This would allocate authority to the AMCP which the Supervisory Body currently has. Taking account of the fact that the AMCP is supposed to review the care and monitor it, there could be situations where the AMCP is satisfied with themselves as to how they are carrying out their role and therefore would not welcome a paid RPR intervening who may scrutinise or criticise the AMCP’s actions on behalf of the local authority. This is why it is essential to have a more senior person who is not involved in the delivery or monitoring of a resident’s care who would have the authority to appoint a paid RPR or advocate rather than allowing the AMCP to have that discretion.

PP 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.

The AMCP role would again be overburdened by this proposal that they monitor the RPR.

The AMCP has been allocated too many roles which bring them closer to a key operational role for the resident rather than keeping them in a more strategic and detached protection role towards that resident. There should be a secretariat that supports the role of the AMCPs and offers them support and supervision in the execution of their statutory duties rather than have each AMCP operating autonomously without accountability within the local authority. The secretariat should be headed up by a senior member of staff, preferably at group manager level.

Q.9-9: does the role of relevant person’s representative need any additional powers?

We do not envisage that the RPR requires any additional powers.

We are disappointed that it appears the Commission is ambivalent about retaining the role of RPR which we believe to be an important one that enhances the voice and protection of service users.

Q.9-10: should people always where possible be provided with an advocate and a relevant person’s representative, and could these roles be streamlined?

It is early days after the implementation of the Care Act in April 2014 and local authorities are still getting used to Care Act advocacy and its overlap with the IMCA role in particular. However, we value the expertise of IMCAs and the role they have played in ensuring that social workers followed the MCA 2005 in, for example, ensuring that capacity assessments were conducted and also that best interests processes were followed. The cohort of those who lack capacity are particularly
vulnerable and special arrangements should be made to enforce the MCA 2005 for their benefit.

The Department of Health has acknowledged that the MCA is not yet embedded in frontline practice. Therefore, converging MCA advocacy with Care Act advocacy risks diluting compliance with MCA principles and best interests processes.

10. The Mental Health Act Interface

PP 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.

paragraph 10.21 of the consultation paper says:

'There would be a new mechanism under the Mental Health Act to enable the admission to hospital of compliant incapacitated patients in circumstances that amount to deprivation of liberty, while those who are objecting could be detained under the existing provisions of the Mental Health Act. This would remove the issues of objection and treatment, and the purpose of the admission, and hopefully establish a clear-cut interface' (para.10.21).

From this it appears that the Commission’s assumption is that a compliant mentally incapacitated patient can be cared for in a situation that constitutes a deprivation of liberty. This is highly questionable. If a patient is compliant to both being in hospital and to being treated for his mental disorder, why do they need to be subject to continuous control which is one of the components of the acid test set down in Cheshire West? The fact that such control is required at all would suggest that the patient is non-compliant.

The new mechanism would provide compliant detained patients with a lower level of protection compared with those who are detained under the existing provisions of the Mental Health Act upon which we would make the following observations:

1. We do not agree with the contention that compliant patients require a lower level of legal protection and we are unaware of any justification for this in the consultation paper. 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.

2. The proposal does not address the question of what happens in the situation of a patient who after initially objecting to his admission becomes compliant. This would presumably require a re-designation of the patient’s legal status, as would be the case in the reverse situation.
3. We do not necessarily agree that implementation of the Commission’s proposals would create a ‘clear-cut’ interface. Identifying when a patient is either objecting or would object if he was in a position to do so can sometimes be difficult.

4. Having two categories of detained patient would be confusing for patients, relatives, carers and staff.

11. Right to appeal

We would like to point out a minor error in paragraph 11.9 in this chapter. The description of the role of the Tribunal states that the Tribunal cannot ‘assess or pass judgment on whether the patient is receiving appropriate treatment or care’. In fact the appropriate medical treatment test forms part of the statutory criteria in all cases other than those which concern patients detained under s2: see s.72 (b) (ii)(a) MHA 1983.

Since the consultation opened, Charles J in his role as President of the Upper Tribunal has held in *PJ v A Local Health Board* [2015] UKUT 480 that the Tribunal has a role where it discovers an unlawful deprivation of liberty:

‘97. *It follows that in my view a First-tier Tribunal (and so the MHRT) cannot ignore and so effectively sanction a continuation of, or a possible continuation of, a deprivation of liberty in breach of Article 5 created by the implementation of the conditions of a CTO and so an unlawful, or possibly unlawful, state of affairs.*

98. *If these conclusions are wrong issues of incompatibility would arise.*’

In our view this is likely to require an adjustment in the way in which the First tier Tribunal (FTT) discharges its functions. At this early stage it is impossible to foresee the likely impact of such a change but it is reasonable to speculate that the following could feature:

- The need for representatives to alert the FTT in advance if issues of incompatibility are to be raised at a hearing
- Possible amendments to the Tribunal Procedure Rules to include case management of human rights issues, perhaps similar to Part 11, Court of Protection Rules.
- The need for some hearings to be allocated more time and therefore an increased share of the FTT’s resources.

We also wish to comment on the position as far as legal aid is concerned in the FTT. The consultation correctly states that legal aid for applications and references to the FTT is not means tested. However, there is a merits test, namely that the Director of Legal Aid Casework is satisfied that it is reasonable in all the circumstances for controlled legal representation to be granted.

There is a complex fixed fee system and providers work under a contract with the legal aid agency in which the provider is allowed a limited number of case (‘matter starts’) fixed at the start of each three year contract but which can be reviewed. However, the number of matter starts allowed is often highly contentious and
negotiations as to new matter starts can be time consuming and is considered a significant administrative burden by providers. Given that a patient who has a Tribunal hearing will be entitled to controlled legal representation whether or not his or her chosen representative has ‘run out’ of matter starts, it is far from clear what the purpose of limiting matter starts is.

The level of funding in the fixed fee scheme is low. In the past there was concern expressed by the Tribunal judiciary as to the quality and knowledge of representatives. This led to the Legal Services Commission imposing a contractual requirement that all advocates before the FTT should be members of the Law Society’s Mental Health Accreditation Scheme.

Whilst therefore we broadly support the innovation of a Mental Capacity Tribunal (see below for details) it must be properly resourced and funded if it is to provide real safeguards for patients.

**PP 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.

We welcome this proposal.

**PP 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.

We agree.

**Q.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?

We sympathise with the difficulty in arriving at a definition here. A starting point could be:

- Cases where there is reason to believe Article 8 is engaged;
- Cases where there are interventions such as regular physical restraint; and
- Cases involving disputes over medical treatment (including but not limited to serious medical treatment) for mental or physical disorder.

**PP11-4:** 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.

**Q.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?

Periods of detention under the MHA, unless discharged earlier, run for fixed periods. The number of authorisations could be used to calculate when the first referral should be made. For example, any person detained under the restrictive care provisions
where an authorisation expires should be referred to the Tribunal if it is proposed to ask for a further authorisation and the person did not challenge the first authorisation. Thereafter there should be a referral every 12 months.

Q.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?

Paper reviews are only used in the FTT in mental health cases where the patient is referred rather than appeals to the Tribunal in a CTO case; and where the patient has capacity to consent and does consent; or if the patient lacks capacity and their representative- appointed under Rule 11(7) (b) consents. This approach could be adopted in mental capacity cases.

Q.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?

It is difficult to comment without knowing more about what potential proposals are under consideration. The question appears to envisage that there will continue to be a divide between existing public law and the MCA. If this is correct, then public law remedies should be accessible and there should be flexibility as to when the public law jurisdiction can be exercised alongside the MCA.

Q.11-8: should protective care provide for greater use of mediation and, if so, at what stage?

Whilst mediation and other forms of ADR 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 ALR.

Q.11-9: what are the key issues for legal aid as a result of our reforms?

Please see above.

12. Supported Decision Making and Best Interests

PP 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).

We are generally supportive of this proposal.

The aim of the proposal is to bolster the existing provisions of the Mental Capacity Act – in particular to ensure that all practical steps have been taken to help the person
make a decision and to permit and encourage the person to participate as fully as possible. The two are not the same, one is a capacitous decision that falls outside the remit of the MCA (and therefore a best interests decision cannot be made) and the other enables the person to participate as fully as possible so that his wishes and feelings are known to the decision makers who will then make a decision in the person’s best interests. There does appear to be some confusion over the two.

The role appears to overlap with the role of Care Act advocate. It is unclear how supporters would be recruited and who would pay for and monitor their performance.

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. In these situations, professionals such as accountants and lawyers would be best placed to advise the person and ascertain whether the person has the capacity to make the decision in question. In the event that the person lacks capacity to make the decision and he has not made an LPA, then an application should be made to the court for the appointment of a Deputy.

Supported decision making is in our view best suited to healthcare and welfare decisions, such as care plans or accommodation arrangements. We would not support the inclusion of supported decisions being made about refusal or withdrawal of life sustaining treatment and, in any event, the medical professionals would have to be satisfied that the decision was either capacitous or in the person’s best interests.

**PP 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.

The Law Society is content with the current wording of section 4 of the Act, as applied by the courts *(Re M [2009])* and more recently in *Aintree University Hospitals NHS Foundation Trust v James [2013]* by Lady Hale at paragraphs 24 and 45.

We consider that the best way to ensure that the wishes and feelings are prioritised is by educating decision makers to place the person and their views at the centre of the decision making process, by way of professional guidance and highlighting the requirements of case law.

**13. Advance Decision Making**

**PP 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.

In terms of extending the scope of advance decision making to include consent to a deprivation of liberty we see no logical reason to exclude these types
of decisions in totality. This is especially so when considered against other decisions that can be made, including those which affect life and limb, such as not to receive life sustaining treatment or receive cardio pulmonary resuscitation.

This development would have a useful application in circumstances where the treatment and care options can be clearly defined in a way that is specific and time limited, and articulates a clear view of what the individual expects the care or treatment to achieve. This will in turn help to inform any subsequent decisions reached on their behalf. In particular, with short term or fluctuating loss of capacity, for example in accident and emergency settings, or making specific decisions relating to medication, the use of restraint or other controls in place in a setting.

The ability to consent to a future deprivation of liberty would be of particular value for people who have capacity to agree to their care and treatment plan before entering a hospice; or for those about to have a serious operation which will mean a spell in intensive care. The scope of the advance statements will have to be clearly defined as will the formalities needed for them to be valid and kept safe. Usefully, the BMA has published a detailed guidance note on aspects of drafting, storage and implementation of advance statements.

**PP 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.

We agree.

**Q.13-3:** how (if at all) should the law promote greater use of advance decision-making?

We would support legislative changes which reflect and raise awareness of the importance of self-determination and the role advance decision-making in its various forms can play: As highlighted by the House of Lords in its post-legislative scrutiny of the Mental Capacity Act, there remains a lack of understanding and awareness of the Act, and a paternalism in health care professionals. This has the effect of reducing the opportunity for empowerment inherent in the framework of advance decision-making.

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. Any forms or decisions reached would need to be clearly signposted within health and social care records to ensure that they are well understood and taken into account.

We see no distinction in this respect in relation to the use of LPAs, or between Supportive and Restrictive Care.

However, we would be concerned at any suggestion that decisions could be taken which permit ongoing restrictions, or circumstances which pervade over a period of many months or years without review of the appropriateness of continuing
restrictions. Article 5 compliant safeguards must be available. We agree that donees should also not be able to ‘authorise’ DoLS in these circumstances.

14. Regulation and Monitoring

PP 14-1: the Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales should be required to monitor and report on compliance with the restrictive care and treatment scheme and the hospital scheme.

We support the proposal that all persons who are deprived of their liberty under the restrictive care and treatment scheme and the hospital scheme should have the benefit of specific monitoring duties on the CQC, including those in domestic settings and supported living.

Presently those duties² (only extend to persons who are deprived of their liberty in hospitals and care home settings under Schedule A1. We therefore do not believe that the current monitoring scheme complies with the state’s obligations imposed by OPCAT in relation to deprivations of liberty in supported living and domestic settings.

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.

Whilst we acknowledge that an extension of inspection and monitoring by the CQC into an individual’s own home will necessarily engage the individual’s rights under Article 8 EHCR, this must be balanced against the importance of ensuring that individuals who are deprived of their liberty are not left without important safeguards simply because of the setting in which their deprivation of liberty takes place.

Q 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?

Q14-3: is greater regulatory oversight needed of individual decision makers and local authorities and the NHS for the purposes of protective care?

We agree with the principles of ‘right touch’ regulation (the use of the minimum regulatory force to achieve an aim). In its follow up paper Rethinking Regulation (August 2015) the Professional Standards Authority identifies raises the problems with overlapping jurisdictional boundaries.

We see the merit in placing all regulatory and monitoring functions in relation to DoLS with one organisation. The CQC currently meets the necessary requirements in

² as set out in the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments - Amendment) Regulations 2009)
relation to hospital and care settings, but its remit would need to be extended to include supported living and shared lives settings.

Any regulatory measures must be targeted and proportionate. For example, the purpose of notification of all approvals is unclear, as is what the CQC does with this information. We note from the CQC’s fifth report on the Mental Capacity Act and DoLS that compliance with this requirement is poor.

The CQC already uses an online survey for IMCAs and we would encourage expanding this, or introducing questionnaires to make best use of methods which would allow the CQC to hear directly from patients and carers. We agree with Rethinking Regulation about the importance of reflection and collective responsibility for standards, and suggest the greater use of peer review is considered.

Rethinking Regulation questions the default suggestion of adding layers of statutory regulation for individual professionals, and we would caution against adding new registration requirements for AMCPs, particularly in situations where they are already registered professionals and this may result in dual regulation. One alternative model might be for those who are commissioning best interest assessments to be required to appoint a trained and accredited AMCP, and for the AMCP to be subject to periodic reaccreditation to ensure they are up to date.

15. Other issues (including children and young people, coroners, criminal offences, Article 2 obligations and cross-border issues) (181-199)

PP 15-1: protective care should apply to persons aged 16 and over.

Although the Children Act 1989 (‘the CA 1989’) s25 (secure accommodation) and the Mental Health Act 1983 provide for the detention of under 18s, those provisions only apply in specific circumstances.

Given this gap in legislative safeguards for 16 and 17 year olds who lack capacity, the Law Society agrees that it would be appropriate to extend the proposed legal framework of protective care to this age group. However, further detail is required. For example, consideration will need to be given as to how protective care for 16 and 17 year olds would interact with the relevant legislative framework for this age group (in particular the CA 1989 and the Children and Families Act 2014) and whether it will cover settings such as residential special schools.

Q15-2: is the concept of the zone of parental responsibility appropriate in practice when applied to 16 and 17 year olds who lack capacity?

The Law Society shares the Law Commission’s concern about the potential wider implications of the recent judgment in Trust A v X, which held that the parents of a 15 year old boy (‘D’), could consent to their son’s placement in a locked ward of a psychiatric hospital on the basis that this decision fell within the ‘zone of parental responsibility’.
General comments:

As the Law Commission notes, the ‘zone of parental control’, is poorly understood. However, chapter 19 of the latest version of the Mental Health Act Code of Practice 2015 (the MHA Code 2015) includes revised guidance on this concept, which has been renamed as the ‘scope of parental responsibility’.3

The zone of parental control/scope of parental responsibility is not a legal term. In essence, this concept highlights the need to ensure that the particular intervention (e.g. admission to hospital or the provision of medical treatment) can be given on the basis of parental consent, setting out the various factors that need to be considered when deciding whether or not parental consent can be relied upon. Crucially, it is also underpinned by the well established principle that there are limits to the powers of parents to make decisions on behalf of their child.4

Parental responsibility ends when individuals reach 18 years of age. Accordingly, unless legislation is introduced to lower the age at which parental responsibility terminates to 16 years, those with parental responsibility may still have a role in making decisions for young people who are unable to make decisions for themselves. Indeed, the Mental Capacity Act 2005 Code of Practice (2007) states:

‘Under common law, a person with parental responsibility for a young person is generally able to consent to the young person receiving care or medical treatment where they lack capacity under section 2(1) of the Act. They should act in the young person’s best interests.’5

Parents (and others with parental responsibility) are not able to agree to any intervention that exceeds reasonable parenting restrictions (described in the MHA Code 2015 as ‘the degree of parenting control and supervision that would be expected for a child or young person of that age’).6 This has similarities to the ‘nuanced acid test’ described in the Law Society’s publication earlier in 2015, Deprivation of liberty: a practical guide. This guide suggests that when considering whether restrictions placed on young people who lack capacity to make decisions about their care and treatment amount to a deprivation of liberty, consideration should be given to ‘the extent to which the care arrangements differ from those typically made for someone of the same age and relative maturity who is free from disability’.7

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3 See paras 19.38 – 19.43 and in relation to deprivation of liberty 19. 44-19.48
4 See for example Gillick v West Norfolk and Wisbech Area Health Authority 1986 AC 112, Hewer v Bryant [1970] 1 QB 357 at 369. Phil Fennell Mental Health Law and Practice (2nd edn Jordans 2011), para 11.42 suggests that the zone of parental control is ‘an attempt to encapsulate the idea enunciated by Lord Denning in Hewer v Bryant [ref] where he referred to the parent’s right to the legal right custody of the child as ‘...a dwindling right...It starts with a right of control and ends with little more than advice.’
5 Para 12.16. It should also be noted that the MCA Code (at para 12.13) envisages situations where the young person is unable to make a particular decision but does not lack capacity as defined by the MCA 2005. See also the MHA Code 2015 19.31-19.33
6 MHA Code 2015 para 19.47
7 Chapter 9, para 9.10. See also discussion 9.11-9.17
Comments on Trust A v X

While there are a number of significant grounds for questioning this decision, in relation to the zone of parental control/scope of parental responsibility, we would suggest that the decision is based on a misunderstanding or misapplication of this concept.

Although in Trust A v X Keehan J purported to rely on the ‘zone of parental responsibility’, he did not refer to the relevant guidance in either the 2008 or 2015 MHA Codes, or the guidance in the MHA Code 2015 on deprivation of liberty.

Keehan J seemed to assume that D’s parents were able to agree to their son’s placement in a psychiatric hospital because this was in his best interests (the parents were acting on medical advice), even though such restrictions ‘would probably amount to ill treatment’ if placed on a non-disabled boy of that age. This approach is at odds with the view expressed by Baroness Hale in P v Cheshire West and Chester Council; P and Q v Surrey County Council (‘Cheshire West’) that ‘…what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities’.

The fact that D’s parents were acting in their child’s best interests is not the deciding factor when assessing if the care regime imposes restrictions that exceed the limits of parental authority.

The restrictions that Keehan J considered the parents could authorise went far beyond the type of restrictions that parents place on their child as part of their parenting responsibilities and therefore, by definition, did not fall within the scope of parental responsibility. Indeed, the range and intensity of restrictions far exceeded the restrictions placed on the 12 year old boy in Nielsen v Denmark (1988), which as noted by the Law Commission has been criticised by the judiciary, including Keehan J, who regarded it as ‘controversial’.

PP 15-6: the Criminal Justice Act 2009 should be amended to provide that inquests are only necessary into deaths of people subject to the restrictive care and treatment scheme where the coroner is satisfied that they were deprived of their liberty at the time of their death and that there is a duty under article 2 to investigate the circumstances of that individual’s death.

We do not agree. Where the death of an individual occurs whilst they are under ‘state detention’ (as would be the case if the death occurred under the proposed restrictive care and treatment scheme), the death should be investigated so as to comply with the law as it currently stands. To do otherwise would relegate the rights of those detained under the MCA to a lesser level than is the case for those detained under the MHA 1983. Whilst we appreciate that post-Cheshire West this has resource

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9 [57].

implications for coroners, they must be adequately resourced in order to meet an increase in the number of inquests.