



Special Report: the Law Commission's *Mental Capacity and Deprivation of Liberty* Report (Law Com No. 372)

In this special report, we provide full coverage of the recently published Law Commission Report on proposed amendments to the Mental Capacity Act. We include a detailed summary of the report by Tim Spencer-Lane, lead lawyer at the Law Commission working on the project, and responses from a range of perspectives.

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Editor

Alex Ruck Keene

The picture at the top, "Colourful," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

Mental Capacity and deprivation of Liberty: the Law Commission's review of the Deprivation of Liberty Safeguards

Tim Spencer-Lane, Lawyer, Law Commission

The Law Commission's report *Mental Capacity and Deprivation of Liberty* was published on 13 March 2017. The report (which includes a draft Bill) is the culmination of a three year review of the Deprivation of Liberty Safeguards ("DoLS") under the Mental Capacity Act. The Law Commission's report calls for the DoLS to be replaced, and sets out a new scheme called the Liberty Protection Safeguards. This article summarises the Law Commission's recommendations.

Background

The Law Commission's review of the DoLS began in 2014 following a reference from the Department of Health. The reference was a response to a report by a House of Lords Select Committee which concluded that the DoLS legislation was "not fit for purpose" (House of Lords, 2014), and to a decision of the Supreme Court (known as "Cheshire West") which gave a significantly wider interpretation of deprivation of liberty than had been previously applied. In July 2015 the Law Commission published a consultation paper setting out provisional proposals for law reform. An interim statement was published in May 2016.

The case for reform

Responses to the Law Commission's consultation paper confirmed that the current regime is in crisis and needs to be overhauled. The DoLS were described as "an administrative

and bureaucratic nightmare" and criticised for placing additional pressure on an already over-stretched system. A number of responses from families described how distressing and confusing the DoLS process had been for their loved ones. Hospital clinicians reported that the DoLS process delivered no tangible benefits to the person's treatment plan (particularly in intensive care units and end of life care) and deflected resources away from the provision of treatment. Consultees generally described the language adopted by the DoLS as, at best, unhelpful, and felt that the DoLS were out of kilter with the empowering philosophy of the Mental Capacity Act.

Many responses (particularly from NHS bodies and local authorities) pointed to the practical and financial impact of *Cheshire West*, such as the increasing backlog of cases, referrals for authorisation being left unassessed, the legal timescales for authorisations being frequently breached and shortages of people qualified to perform roles under the DoLS provisions. Many local authorities and NHS bodies reported that they are not even considering obtaining authorisation for deprivations of liberty in cases outside hospital and care home settings, or involving 16 and 17 year olds, where the DoLS do not apply.

The Law Commission's final report therefore calls for the DoLS to be replaced "as a matter of pressing urgency". In particular the Commission describes the DoLS as overly technical and legalistic, and not capable of dealing with the increased numbers of people considered to be deprived of their liberty following *Cheshire West* and requiring safeguards.

The Liberty Protection Safeguards

The Law Commission's replacement scheme is called the Liberty Protection Safeguards. This is essentially a "policy label" since it does not appear in the draft Bill. The new scheme serves the same essential purpose as the DoLS and where possible it makes use of existing mechanisms and procedures provided by health and social care and mental capacity legislation. People with experience of these areas of law will notice a number of familiar elements. But in designing the Liberty Protection Safeguards we have removed the features of the DoLS that we have identified as being both inherently inefficient and actively detrimental to the interests of people who are deprived of their liberty.

The Law Commission's intention is to, as far as possible, bring forward formal consideration of the justification for a deprivation of liberty so that it occurs before the arrangements are made, rather than only afterwards. The new scheme would remove the power of hospitals and care homes to issue themselves urgent authorisations.

The arrangements that can be authorised

Whereas the DoLS only apply to hospitals and care homes, the Liberty Protection Safeguards would also apply to other settings, for instance supported living, shared lives and private and domestic settings. In fact the new scheme is not limited to specific forms of accommodation or residence; it encompasses any situation where Article 5(1)(e) is potentially engaged.

Currently, any deprivation of liberty outside of a hospital or care home must be authorised directly by the court. The Law Commission

argues that this is costly, ineffective, and potentially distressing for the person and family concerned, and that an administrative authorisation process would be a far more effective and efficient way of dealing with deprivations of liberty.

The draft Bill enables the authorisation of "arrangements" which enable the care or treatment of a person, and which would give rise to a deprivation of that person's liberty. Deprivation of liberty is not defined, and instead has the same meaning as in Article 5(1) of the ECHR. Therefore any future case law developments could be absorbed by the new scheme.

Authorisations could be given to cover transport between places and arrangements carried out in more than one place (for example if a person living at home needs regular respite in a care home). The specific arrangements that may be authorised are:

- arrangements that a person is to reside in one or more particular places;
- arrangements that a person is to receive care or treatment at one or more particular places; and
- arrangements about the means by which and the manner in which a person can be transported to a particular place or between particular places.

Private and domestic settings

The Law Commission's report refers to ongoing debate over the reach of Article 5 when it comes to private or domestic settings. But it also points out that the courts set the parameters and have

confirmed that deprivation of liberty can occur in such settings. The Commission argues that the current system, which requires a court application in every case, is distressing for the person and family concerned, costly for the State and unrealistic (it points to evidence that in practice court applications are not being made by public authorities to protect the Article 5 rights of those in private or domestic settings). The report therefore concludes that an administrative authorisation process would be a far more effective and unobtrusive way of dealing with deprivations of liberty in such settings. Moreover, by not defining deprivation of liberty, the Commission argues that any future case law developments can be accommodated by the scheme.

16 and 17 year olds

Whereas the DoLS apply to those aged 18 and over, the Liberty Protection Safeguards would apply to people aged 16 and over. Currently, unless detention under the Mental Health Act is appropriate, a court application is required to authorise a deprivation of liberty of a 16 or 17 year old. The Law Commission argues that this situation is unnecessarily onerous and expensive for the State (especially NHS bodies and local authorities, which are often expected to bring cases to court), and potentially distressing for the young person and family concerned. The report also points to evidence that public authorities are not currently taking cases to court when they should.

The responsible body

Under the Liberty Protection Safeguards the “responsible body” is charged with considering requests for authorisations, setting up the

required assessments and giving the authorisation. This would replace the existing “supervisory body” role.

The Law Commission’s intention is that there should a stronger link (to the extent that is practical) between the commissioning of the person’s care or treatment, and authorisation of the deprivation of liberty which is required to enable that care or treatment. This has the clear advantage that the body with the power to put in place less restrictive arrangements would be accountable for the whole process and in particular for justifying that the deprivation of liberty is necessary and proportionate. This approach also removes from local authorities in England the burden that they currently undertake of authorising deprivations of liberty in hospital settings, and would help to make the NHS an active partner in protecting people’s Article 5 rights.

We also recognise the importance of legal certainty in identifying the responsible body. The Liberty Protection Safeguards provides for the following three criteria to be applied to identify the responsible body in any case:

- if the arrangements are or proposed being carried out primarily in a hospital, the responsible body is the “hospital manager” (which would in most cases be the trust that manages the hospital in England or the local health board in Wales);
- otherwise, if the arrangements or proposed arrangements are being carried out primarily through the provision of NHS continuing health care, the responsible body is the relevant clinical commissioning group

in England or local health board in Wales;
and

- otherwise the responsible body is the “responsible local authority” (in most cases this will be the authority that is meeting the person’s needs or in whose area the person is ordinarily resident).

The conditions for an authorisation

The Liberty Protection Safeguards set out the following conditions, which must be met in order for the responsible body to authorise arrangements:

- the person lacks capacity to consent to the arrangements which would give rise to a deprivation of the person’s liberty
- a medical assessment has confirmed that the person is of unsound mind within the meaning of Article 5(1)(e) of the ECHR)
- the arrangements are necessary and proportionate by having regard to the likelihood of harm to the person and/or other individuals if the arrangements were not in place and the seriousness of that harm;
- The required consultation has taken place (for instance with friends and family members)
- The authorisation would not conflict with a valid decision of a donee or a deputy as to where the person should reside or receive care or treatment.

The capacity assessment, medical assessment and necessary and proportionate assessment must be provided by at least two assessors. If the assessments are carried out by two

assessors, they must be independent of each other – or if there are more than two assessors, at least two must be independent of each other.

Independent review

Strasbourg case law has emphasised that deprivation of liberty procedures must be aimed at preventing arbitrary detention, and that a key part of this is that those involved in the care and treatment of the individual do not also have the final say on whether they should also be deprived of their liberty. The Liberty Protection Safeguards therefore require an “independent review” to be carried out in all cases in order to confirm that it is reasonable to conclude that the conditions for an authorisation are met, or (in certain cases) to refer the case to an Approved Mental Capacity Professional. No one who is involved in the day-to-day care or treatment of the person can act as the reviewer or the Approved Mental Capacity Professional.

In cases which are not referred to an Approved Mental Capacity Professional, the reviewer is required to certify personally that it is reasonable to conclude that the conditions for an authorisation are met. They must review the information available to the responsible body and determine whether or not the responsible body’s decision to authorise arrangements is a reasonable one to come to on the basis of that information.

The Approved Mental Capacity Professional

The Approved Mental Capacity Professional is a new role which is intended to build upon the existing best interests assessor role. The Law Commission argues, however, that the existing requirement of a best interest assessment in every case is simply no longer sustainable (and

is not being delivered in practice), especially given that the new scheme would extend beyond hospitals and care homes. Instead, the report concludes that the only practical alternative is to focus this role on certain defined cases.

The Liberty Protection Safeguards requires a referral to be made to an Approved Mental Capacity Professional if:

- it is reasonable to believe that the person does not wish to reside or receive care or treatment at a particular place; or
- the arrangements are regarded as necessary and proportionate wholly or mainly by reference to the likelihood and seriousness of harm to others.

In all other cases there would be a power to refer cases to an Approved Mental Capacity Professional.

The Approved Mental Capacity Professional's role is to determine whether or not to approve the arrangements. They must meet with the person, and can consult other key individuals. The written approval of the Approved Mental Capacity Professional would enable the authorisation of arrangements by the responsible body. The Approved Mental Capacity Professional's cannot be someone who is involved in the day-to-day care or treatment of the person. The Liberty Protection Safeguards aim to put Approved Mental Capacity Professionals in a similar position legally to Approved Mental Health Professionals. They would act "on behalf" of the local authority but would be independent decision-makers who could not be directed to make a particular decision.

Local authorities would be responsible for the approval and ensuring there are sufficient numbers of Approved Mental Capacity Professionals. A regulation-making power allows, amongst other things, bodies such as the HCPC to be prescribed to approve courses for Approved Mental Capacity Professionals. The draft Bill does not specify which professionals could or could not undertake the new role; this would be a matter for Government. But it would be possible for the same professionals who are able to be best interests professionals to continue to be eligible to be Approved Mental Capacity Professionals, and for existing best interests assessors to be transferred over into the new role.

The authorisation

An authorisation can have effect immediately, or up to 28 days later. Once an authorization has been given, the responsible body must produce an "authorisation record" which is required to include matters such as details of the arrangements authorised.

Under the draft Bill an authorisation does not provide statutory authority to deprive a person of their liberty; instead, a new section 4AA of the Mental Capacity Act would provide a defence to civil or criminal liability in respect of acts done pursuant to an authorisation. This defence does not cover the provision of medical treatment or restricting contact with third parties, since "arrangements" cannot extend to these matters. This is so that care and treatment providers cannot be given power to do things that go beyond effecting a justified deprivation of liberty, unless they have the power under the general law. The defence under section 5 of the Mental

Capacity Act would continue to cover treatment and contact decisions.

An authorisation can last for an initial period of up to 12 months and can be renewed for a second period of up to 12 months and thereafter for periods of up to three years. A responsible body can renew an authorisation, rather than initiating a fresh authorisation, if it reasonably believes that:

- the person continues to lack capacity to consent to the arrangements;
- the person continues to be of unsound mind; and
- the arrangements continue to be necessary and proportionate.

An authorisation ceases to have effect (before the expiry date) if the responsible body if it knows or ought reasonably to suspect that:

- the person has, or has regained capacity, to consent to the arrangements;
- the person is no longer of unsound mind; or
- the arrangements are no longer necessary and proportionate.

However, in the case of people with fluctuating capacity, the Liberty Protection Safeguards enable arrangements to remain in place during limited periods of capacity to consent or object to the arrangements, provided that:

- the periods of capacity are likely to last only for a short period of time,
- the person remains at all times “of unsound mind” for the purposes of Article 5, and

- the authorisation of arrangements remains necessary and proportionate.

Reviews

The responsible body must set out in the authorisation record the fixed dates or prescribed intervals for reviews. The responsible body is required to keep an authorisation under review generally, therefore putting it in a position to undertake a review at any time in between the planned review dates if circumstances change. There would be a duty to hold a review:

- on a reasonable request by a person with an interest in the arrangements which are authorised;
- if the person becomes subject to the Mental Health Act; or
- if the responsible body becomes aware of a significant change in the person’s condition or circumstances.

Rights to advocacy and an appropriate person

Under the Liberty Protection Safeguards there is a duty to appoint an advocate unless there is an appropriate person to represent and support the person to whom the arrangements would apply throughout the duration of an authorisation. The appropriate person replaces the relevant person’s representative under the DoLS.

An “appropriate person” cannot be someone who is engaged in providing care or treatment to the person in a professional capacity or for remuneration. The appropriate person must be appointed to act as such unless they do not consent, or the person whom they would represent and support does not consent or (if that person lacks capacity to give or withhold

consent) it would not be in their best interests to be represented or supported by that other person. The appropriate person has a right to advocacy support.

If there is no appropriate person, an Independent Mental Capacity Advocate must be appointed. Under the draft Bill, the responsible body must appoint an advocate unless the person does not consent, or (if the person lacks capacity to consent) unless being represented by an advocate would not be in the person's best interests. This is intended to ensure that advocacy is provided automatically and on an opt-out rather than an opt-in basis.

Rights of legal challenge

Under the Liberty Protection Safeguards the right of legal challenge is to the Court of Protection. But the Law Commission further recommends that the Government should review this matter (as part of its existing programme of reform) and consider whether a tribunal might be more effective. The Commission argues that this should be undertaken with a view to promoting the accessibility of the judicial body, the participation in the proceedings of the person concerned, the speedy and efficient determination of cases and the desirability of including medical expertise within the panel deciding the case.

Monitoring

The draft Bill gives Government regulation-making powers to require prescribed bodies to monitor and report on the operation of the new scheme. This would provide flexibility, enabling the Governments to continue to provide for the current prescribed bodies (such as the CQC) to

undertake the role and/or to prescribe other bodies, for instance Ofsted and Estyn in respect of some or all 16 and 17 year olds, or Safeguarding Adults Boards. The draft Bill would also enable the regulations to provide for the body to visit only certain types of institutions or to visit certain types of institutions more frequently than others. The regulations could also introduce "light-touch" forms of regulation, such as gathering information, interviewing people, surveys and reporting on certain types of deprivation of liberty.

Mental Health Act interface

The Law Commission argues that the "fusion" of mental health and mental capacity legislation (as provided for by the Mental Capacity (Northern Ireland) Act 2016) potentially represents the future direction for mental health law reform in England and Wales. It strongly recommends that Government should review mental health law, with a view to the possible introduction of mental capacity-based care and treatment for mental as well as physical disorders.

In lieu of this, the draft Bill provides that the Liberty Protection Safeguards cannot be used:

- to authorise arrangements carried out in hospital for the purpose of assessing or treating mental disorder, and
- to authorise arrangements which are inconsistent with any requirement under one of the "community powers of the Mental Health Act (such as guardianship or a community treatment order).

Wider reforms of the Mental Capacity Act

The draft bill includes wider reforms to the Mental Capacity Act. These reforms are intended to provide Article 8 rights and improve decision-making under the Mental Capacity Act – regardless of whether a person is being deprived of their liberty. The draft Bill contains three reforms in this respect:

First, the best interests checklist in section 4 of the Mental Capacity Act is amended to require greater weight to be given to ascertainable wishes and feelings. The draft Bill would require that the decision-maker must, first of all, “ascertain, so far as is reasonably practicable” the person’s wishes and feelings. It further requires that, in making the best interests determination, the decision-maker “must give particular weight to any wishes or feelings ascertained”. The draft Bill also places additional requirements on professionals to explain their decisions not to give effect to a person’s wishes and feelings.

Second, the draft Bill would restrict the availability of the defence contained in section 5 of the Mental Capacity Act; where someone acting in a professional capacity or for remuneration does an act pursuant to a “relevant decision”. The defence would not be available unless a written record has been made of the “required information”.

A relevant decision for these purposes is:

- moving the person to long-term accommodation;
- restricting the person’s contact with others;
- the provision of serious medical treatment;

- the administration of “covert” treatment; and
- the administration of treatment against the person’s wishes.

The information to be recorded is:

- the steps taken to establish that the person lacks capacity;
- the steps taken to help the person to make their own decision;
- why it is believed that the person lacks capacity;
- the steps taken to establish that the act is in the person’s best interests;
- a description of the person’s wishes, feelings, beliefs or values ascertained wishes and feelings for the purposes of the best interests determination and, if the decision conflicts with them, an explanation of the reason for the decision;
- that any duty to provide an advocate has been complied with; and
- that the act would not be contrary to an advance decision.

Third, Government is given regulation-making powers to establish a supported decision-making scheme. Such a scheme would enable a person to appoint a supporter to enable them to make their own decisions wherever possible.

Advance consent

The draft Bill would enable a person to give advance consent to specified arrangements that would (but for that consent) give rise to a deprivation of liberty. If advance consent is

given, the arrangements would not amount to a deprivation of liberty and therefore the Liberty Protection Safeguards would not apply.

The person must clearly articulate the particular arrangements to which they are consenting. In line with the law on advance decisions to refuse treatment, advance consent would remain valid unless:

- the person withdraws their consent when they have capacity to do so;
- there are reasonable grounds to believe that circumstances exist which the person did not anticipate at the time of giving the advance consent and which would have affected their decision had he or she anticipated them; or
- the person does anything else clearly inconsistent with the advance consent remaining their fixed decision.

Interim and emergency deprivation of liberty

As noted above, the system of urgent authorisations would be abolished. Instead, the draft Bill gives statutory authority to deprive someone of liberty temporarily in truly urgent situations and in sudden emergencies, but only to enable life-sustaining treatment or to prevent a serious deterioration in the person's condition. Apart from those cases, it would not be permissible to impose a deprivation of liberty on someone until the proposed arrangements have been authorised.

Unlawful deprivation of liberty

The draft Bill provides that where care or treatment arrangements are put in place by, or on behalf of, a "private care provider" (defined as,

broadly speaking, the managers of private care homes and independent hospitals) which give rise to a deprivation of liberty (and have not been authorised), the person may bring civil proceedings against the provider. The provider would not be liable if it reasonably believed that the arrangements did not give rise to a deprivation of liberty or the deprivation of liberty was authorised.

Coroners

The draft Bill would amend the Coroners and Justice Act 2009 to provide that the duty to hold an inquest would not apply automatically to people subject to the Liberty Protection Safeguards. The Law Commission also recommends there be additional safeguards in place when a death is attributed to a lack of care.

Conclusion

The publication of the Law Commission's final report marks the completion of its review. It is now for Government to decide whether and how to take forward the Law Commission's work. The report argues that the project represents a major and unique opportunity to overhaul the legal framework and address the current problems. The Law Commission argues that its recommendations would create a clear and accessible scheme for authorising arrangements which would give rise to a deprivation of liberty, which is capable of delivering practical and effective Convention rights.

Liberty Protection Safeguards - a view from carers of HL

Mr and Mrs E

This is a large and extensive piece of work by the Law Commission which will take some time to absorb in its entirety but it does appear for the most part to put individuals without legal capacity to make decisions about their care arrangements at the heart of the decision making process rather than being sidelined by DoLS since they became a 'tick box' exercise after Cheshire West.

The amendments proposed to section 4 of the Mental Capacity Act where the decision maker must ascertain the person's wishes and feelings about decisions around their care and give 'particular weight' to those wishes and feelings and then justify the decision making process is an important amendment. Input into the decision making process by the person their families and carers has often been overlooked or glossed over giving the impression of a best interest's decision that is either patronising or paternalistic. Understanding the communication methods of, for instance, a non-verbal person will take a considerable amount of time. Much better then to take seriously the information provided by those that know the person best and for the decision maker to trust and believe what they are told instead of the opposite that so often occurs. Having to justify the steps undertaken and explain why a particular course is not followed will hopefully focus decision makers more appropriately on the individual and '*stop flawed decision making by professionals*'.

We have long campaigned for advocacy provision under DoLS to support a family member / carer at the start of the authorisation process but currently this only comes if that person is appointed RPR this being right at the end of the process. There has never been any

support to understand and be properly involved at the beginning so any challenges that a family wish to make have to come after a decision is made so always feeling at a disadvantage and on the 'back foot'. The provision of advocacy for those people deemed to be an 'appropriate person' at the start of the process is a very welcome part of the Liberty Protection Safeguards.

We have also lobbied that Best Interests Assessors should be truly independent of the authorising authority but we are always told this is impractical. The Liberty Protection Safeguards appear to herald the demise of the BIA in favour of the AMCP who will not necessarily be involved with every case. If it really is the case that there is a reduced workload perhaps there is a stronger case for the AMCP being independent.

It always appears to families and carers that there is something fundamentally wrong when the detaining body which is sanctioning a placement that amounts to a deprivation of liberty, appointing its own employee to ratify a decision and for some years past, not providing the information or support to challenge the decision.

Recommendations 37 & 38, which refer to the Learning disability /autism exception, are extremely concerning. It seems to us that either a person has a mental health problem that is serious enough to be detained or not, just the same as someone without LD or autism. There is absolutely no reason at all to detain someone in a psychiatric unit if that is not the case just because they have a LD / autism. What this provision seems to mean is that the state can't be bothered to find appropriate accommodation

for an individual's needs and '*we can use this tool to keep someone under our control*'.

The person is not in the right place so therefore their care arrangements aren't appropriate or proportional and we need proper scrutiny in the parliamentary process that will stop medical professionals having this unfettered control.

It would be good to think that 'care arrangements' would consider the 'degree and intensity' of restrictions, something that seems to have been overlooked in most cases since *Cheshire West*. It cannot be right for instance that a person with learning disabilities who receives support to go out from his residential placement to do social things like the pub, restaurant, cinema etc, to keep them safe while doing the same things that anyone with capacity would have to leave their home to do, is deprived of their liberty. This is an enablement and the deprivation would be if people were not allowed to do these things.

The role of the state in regard to family care: big brother or care supporter?

A parent's view of the Law Commission's *Mental Capacity and Deprivation of Liberty* Report

Gordon R. Ashton OBE

My perspective

As a lawyer I am protective of human rights but find the present legal obsession with the deprivation of liberty of an incapacitated person worrying. We all have our human rights but these must be balanced against the rights of others and our responsibilities to them. Adults who lack capacity cannot recognise or meet their obligations and often depend upon involuntary

family carers who surrender their own rights to deliver personal care. Achieving the best achievable care regime should be the priority and some deprivation of liberty may be a price worth paying for this.

Our son Paul had severe learning disabilities with challenging behaviour but remained in our care until he was an adult. He died in 2005 at the age of 28 years in health authority care due to a lack of supervision whilst in the 'Bournewood Gap' (although it had not then been identified). We would have been appalled if he had not had his freedom restricted and the subsequent DOLS procedure would not have saved his life. More recently I have overseen the care of a mother who died in a nursing home at the age of 97 years and am now supporting a wife in the early stages of Parkinson's disease. I consider that the extent to which the authorities become involved is a matter for me dependent upon the need for support and any such involvement should be based on co-operation not compulsion.

As parents of a disabled child whose liberty inevitably had to be curtailed my wife and I were more concerned about the detailed care arrangements than any deprivation of his liberty. I have often written about the delicate balance between empowerment and protection because it is seldom possible to achieve both, and this seems to have evolved into tension between human rights and necessary care provision. Scarce resources that should be directed towards the delivery of quality care are being diverted into justification for that care.

This is an issue of little relevance to the majority of those involved. The real issue is not deprivation of liberty but whether the particular care regime is appropriate for the individual and

the best that can reasonably be provided in the circumstances. I am concerned about the effect on family care of state monitoring and supervision when much needed practical support is so often lacking due to inadequate funding.

The Law Commission proposals

I am broadly in favour of the Law Commission's proposed *Liberty Protection Safeguards* as a replacement for DoLS and the paper based Court of Protection approval procedure, but am concerned that this will apply to care at home even if the authorities have no input. Anyone providing intensive care in a family or other domestic setting may be surprised to find that this administrative procedure must be undertaken to authorise their care because many such situations will involve a deprivation of liberty under the most recent interpretation. It could be the parents of a learning disabled adult child, the daughter of an elderly parent with dementia, the spouse of a brain injured person or the sibling of a person with a mental illness. It is not clear whether the carers should themselves request that authorisation, for example when a child with learning disabilities attains 16 years of age, or simply wait for the social services department to identify the situation and trigger the procedure.

There is a danger that this would be seen by these involuntary carers as supervision without support, or a case of 'Big brother is watching you!' As family carers struggling to cope we would have been discouraged and even antagonistic if despite the lack of support the authorities had thought fit to carry out an annual investigation into whether we were inappropriately depriving our son of his liberty.

We were coping as best we could and had responsibilities to our daughters as well as needing to maintain the home.

Much depends upon the approach of the authorities. This should not be: 'We do not approve of what you are doing!' but rather: 'How can we support you to do things better?' A positive outcome may be achieved by the provision of more support but if this cannot be financed the response of the carers may be: 'If you think you can cope better perhaps you should take over!' The professionals must not assume that they know what is best when the carers are the ones with hands-on experience. In so many cases family care is likely to be the best available option and the carers will have found ways to cope even if this involves limitations on the freedom of the person cared for. To challenge this is playing with fire because the lives of the carers must be respected too.

The new Code of Practice should provide clear guidance on these matters. I also hope that when a family care regime is deemed unduly restrictive because of other pressures in the household there may be an obligation on the authorities to provide the extra support that is needed. Otherwise the relationship between the authority and the carers is likely to be damaged and if pressure is imposed they may decide to relinquish their role. Indeed the prospect of removal is the only sanction available to the authority and that is likely to be a more expensive option and to the detriment of all concerned except in cases of abuse.

Perhaps we expect too much from the mental capacity jurisdiction? Its original purpose was to facilitate decisions for individuals who lacked the capacity to make those decisions, not to

regulate the care provided for them. Those decisions should be made in their best interests but in practice this means choosing from the available options, if indeed there are choices available. We must be realistic and accept that we live in a world of best available care rather than ideal care. The idealists now suggest that the wishes of the individual should be identified, however incompletely formed, so that they can be met, but none of us has the right or power to achieve what we want. In reality it comes down to what family or the state is able and willing to provide and this depends upon the resources, both personal and financial, that are available.

Initial thoughts on the Law Commission's Liberty Protection Safeguards

Christian Walsh, (BIA/DoLS Lead for Leeds City Council)

As with the majority of people working in Adult Social Care, I am aware that I have been patiently (actually impatiently) waiting for the proposals to be published by the Law Commission. In truth, being patient over something that could have such a positive impact on vulnerable people is a small price to pay, particularly when the current system is irreversibly broken. As Paulo Coelho, a Brazilian writer, once said: **"Why is patience so important? Because it makes us pay attention."**

Having read the proposals, I am instantly aware that I will need to keep returning to them on a regular basis and consider what all of the changes could mean in practice for health and social care organisations. Therefore, the following views will only cover a limited number of the changes proposed by the Law Commission, particularly those which I feel could have implications for a Local Social

Services Authority (LSSA) in its proposed new role as the Responsible Authority.

Firstly, I do have a degree of sympathy with the Law Commission in regards to the unenviable task of devising something that is cost-effective, less-complex and offers accessible and effective safeguards for P. Having not had the opportunity to assimilate all of the proposed changes, I am aware that the devil will be in the detail when it comes to gauging the wider mood of how acceptable the proposals will be to health and social care and those professionals who will have to practically apply the new safeguards.

There are, though, aspects of the proposed changes that I am confident will be welcomed. For example, I cannot see a Local Social Services Authority (LSSA) complaining about the proposal to lower the age that the safeguards would apply to, i.e. from 18 to 16, nor do I expect them to weep into their budget sheets at the thought of health becoming responsible for their own authorisations. After all, protecting P's Human Rights should be everyone's responsibility. I also agree with the widening of where P can be deprived of their liberty and feel that this proposal finally means that no-one is left without safeguards as a result of a particular type of residence or due to cash-strapped LSSAs not being able to apply to the courts for authorisation.

Similarly, I think that the proposal not to allow the safeguards to be applied in psychiatric hospitals to the majority of Ps is also a sensible solution to an issue that has caused great confusion amongst Approved Mental Health Professionals (AMHPs) and mental health assessors. Although I am aware that practice varies across the country, the above change

does reflect the situation in my own area where it has become a very rare occurrence for a P (who lacks capacity) to be in a psychiatric hospital and not subject to the Mental Health Act 1983 while being treated there.

The portability of an authorisation record is something that will also be welcomed by LSSAs as a means of reducing costs but also in ensuring that P's rights are always safeguarded wherever they are subject to arrangements that may give rise to a deprivation. From P's perspective, they will not need to be assessed unnecessarily. Meanwhile, assessors can consider promoting their wider community access without the fear of P being unlawfully deprived and a subsequent legal challenge. Equally, I can see the benefits of the authorisation having a longer period of renewal where this is felt to be appropriate and after the first two authorisations. Such an approach will reduce state interference unless it is deemed appropriate and necessary while continuing to offer P the safeguards that anyone else would have access to.

The addition of authorising P's transport arrangements to and from a specified place will also be welcomed by those responsible for implementing P's care and treatment. However, I do hope that the Code of Practice will specifically and clearly set out the responsibility of other agencies that would need to be involved should issues arise. The addition of 'harm to others' is also a positive change in my opinion, particularly as it provides a more robust legal framework around something that regularly occurs in practice. The Approved Mental Capacity Professional (AMCP) role will be crucial here, as this particular power could attract

additional pressure from other professionals and agencies, i.e. the criminal justice system. For example, I am aware of MAPPA and Probation Service meetings where pressure has been applied upon Adult Social Care to apply the current DoLS legislation to individuals as a means of solely managing the risks they pose to others.

After reading the proposals a few times, I can see some progressive ideas within the assessment process. I am pleased to see that they have addressed the issue of a P's fluctuating capacity, as this has been a problematic issue since the MCA 2005 was first implemented. This proposed change may also allow professionals to manage such situations with greater clarity and confidence. Equally, I can see why the Law Commission has recommended the replacement of the term 'best interests' with that of 'necessary and proportionate,' especially since I agree that the former has become a tokenistic gesture in some assessments, i.e. resource led decisions. However, there is a need not to move too far away from the person centred element that the concept of Best Interests has attempted to instil in assessors, albeit in limited ways at times. I do, though, agree with the emphasis upon 'proportionality' and for assessors to ensure that they are not solely focusing on the risks involved and, subsequently, why the authorisation is 'necessary.'

This is why I fully support the idea of P's deprivation being authorised at the start of the process and believe that it should be seen as an integral part of any care planning. This is in stark contrast to the current system where P's deprivation is often an after-thought and there is a higher risk of it just being 'rubber-stamped', as

recognised in the Law Commission's Proposals. Such an approach will clearly be strengthened by the fact that assessors must take into account P's past and current wishes and feelings while also being required to demonstrate why they could not be pursued at the time.

One proposed change that does make me a bit uneasy is the new 'Independent Reviewer' role. There are some commentators, and indeed, colleagues of mine, who have expressed their concerns over the possible difference in the level of scrutiny that will be applied by the Independent Reviewer and that provided by an AMCP. The scrutiny required for this role could perhaps be even more critical than that needed for the AMCP one and will be an area that any Responsible Authority will need to pay close attention too when setting up its internal procedures and structures.

Perhaps those existing BIAs who are not required to become AMCPs could be the ones to fill the 'Independent Reviewer' role, as they will already have the experience of assessing such arrangements and in challenging the views of others, even those they may work with. Indeed, such an option may be attractive to those LSSAs who have trained a high number of BIAs, particularly as such a role could be incorporated into existing job descriptions.

What does trouble me, though, is how independent they will be when they could well be in the same team/area/service as the assessor who has deemed P's arrangements to have engaged Article 5 and has assessed them as being necessary and proportionate. This contrasts to an AMCP who will have the statutory legislation firmly behind their role to remain independent and refuse an authorisation

where they deem it appropriate to do so. How will this work in practice for the Independent Reviewers? In particular, this could be a challenge within a social care environment where risk aversion and over-protectionism can often dominate a team/individual's approach to assessments and the implementation of care packages.

The level of independence required and an explanation as to what the term 'certify personally' will mean in practice is crucial, if this role is not to be seen as being tokenistic. This is particularly relevant when it is noted that such individuals will be able to decide if a referral to an AMCP is required or not. Also, there may well be eyebrows raised when it is realised that this is at the end of the process and that there will not be any other form of independent scrutiny apart from the appropriate person/IMCA who is consulted as part of the assessment process.

The role of the AMCP is an interesting one, with the proposals seemingly suggesting that they will only be required to consider specific cases and that these will be in the minority. For example, where the person is objecting to the arrangements, where the issue is about preventing P from harming others while there will also be a power to automatically refer to an AMCP where it is felt to be required. As an experienced AMHP, I can see the benefits of having such a role for such complex cases, especially as the independence and issues relating to vicarious liability are already understood by LSSAs and colleagues working within hospital/health settings. Although the first two areas where an AMCP will be required are quite self-explanatory, the third one may

need a more cautious approach from LSSAs and CCGs during any initial implementation period if they are to ensure that any untoward or excessively restrictive care plans are properly scrutinised.

There are many aspects of the Law Commission's proposals that I still need to read in more detail, whilst I also need to go back over those areas I have discussed above. In particular, I am conscious of wanting to understand more about the reviews and renewal processes for those people deprived under the Liberty Protection Safeguards. Similarly, I am keen to consider the role of Advocacy and the Appropriate Person roles and whether involvement will ensure that the safeguards are consistently and properly applied by the relevant Responsible Authority. Most of all, I am keen to consider the proposals to amend s 4 and s 5 MCA 2005, particularly in regards to assessing whether they offer P enough protection of their Article 8 Rights.

It is likely that other DoLS Leads will have different views about the proposals and may think that they do not provide P with sufficient legal safeguards, especially the different levels of scrutiny that have been proposed. However, what has been proposed by the Law Commission, is, in my opinion, a better foundation to work from than the situation that nearly all LSSAs currently find themselves in. For me, how the proposals will be implemented on the ground will always be the real **'acid test'** for those responsible for managing the safeguards. It is, though, currently out of our hands while we wait for the Government to respond to the Law Commission's proposals. **I guess more patience will be required!!**

The Liberty Protection Safeguards: a clinician's response

Robert Wheeler, Consultant Neonatal & Paediatric Surgeon; Director, Department of Clinical Law; University Hospital of Southampton

The LC report will be welcomed by hospital doctors and nurses. Clinicians are well aware that their history is littered with examples of incapacitated patients' liberty being egregiously overwhelmed by malicious regimes. The LC proposal is an opportunity for us better to protect liberty.

UK Hospitals were perplexed when law ostensibly founded on residential arrangements was applied to the acutely ill. The proposals set out in the LC report hands much of the daily activity that enables patients' liberty to be protected to the clinical staff; whilst ensuring that the resources to deal with those whose liberty is genuinely threatened are conserved. Easily absorbed (as it could be) into existing clinical pathways, the new approach to protecting liberty will slice through the delay in authorisation process. The present delay, contrary as it is to our patients' welfare, has been very difficult to reconcile with good clinical care.

It is always hard to predict how easily legal aspirations will translate in to clinical guidance. If the recommended fusion of the Codes relating to mental capacity and liberty is achieved, a resultant unified Code of Practice promises to be a document which is straightforward for us to work from.

The Liberty Protection Safeguards: a psychiatrist's response

Dr Gareth Owen, Clinical Senior Lecturer/Honorary Consultant Psychiatrist, Mental Health, Ethics and Law Research Group, King's College London, Institute of Psychiatry, Psychology and Neuroscience

The *Deprivation of Liberty Safeguards* were not scrutinised or debated by parliament. They were rushed through the legislative process and they created a mess when they arrived in health and social care in 2009.

The Law Commission's proposed *Liberty Protection Safeguards* restarts the process. The report admirably succeeds in making what has become an extraordinary complex area of law succinct and intelligible and it proposes some much-needed simplifications to the steps (the flow diagram on page 51 cannot be criticised for being overly complex). There are some very progressive proposals (still in search of an evidence base) such as advance consent and supported decision-making and there is also some refreshing honesty about state interests in relation to deprivation of liberty - with the report's recommendation that the best interests test for deprivation of liberty be replaced by a necessary and proportionate test.

On pages 29-30, the report gives a very significant reference to the NHS Act 2006. It outlines how the secretary of state is required to promote a comprehensive health service, designed to secure improvement:

1. In the physical and mental health of the people of England and Wales; and
2. In the prevention, diagnosis and treatment of illness

What the report does not say is that this is an amendment introduced by the controversial Health and Social Care Act 2012. The original wording in the NHS Act 2006 goes back to the founding of the NHS in 1948 and states that the Secretary of State has a duty to secure or provide (not merely promote) health services throughout the country. If the *Liberty Protection Safeguards* became law the state would not be 'promoting' liberty interests (that would have little meaning) but putting a duty on the courts to secure them. Yet England and Wales has got itself into accepting that the Secretary of State has a duty merely to promote health services. Surely, we all want to avoid a situation where England and Wales secures liberty safeguards in health and social care but does not necessarily secure health and social care services – that would be right to liberty run amok!

From a psychiatric perspective, a key feature of the *Liberty Protection Safeguard* scheme is that "mental health arrangements" in hospital cannot be authorised under it. My reading of this recommendation is that it is the Law Commission running up against an old and firm policy position concerning treatment of "the mental health patient" that derives from a day when social norms constricted the scope of who was a "mental health patient" much more than they do today. Today, very large numbers of patients in general hospitals and or in older adult wards (whether medical or psychiatric) are "mental health patients". Obvious examples are people with dementia, delirium and its combination with depression. People with these conditions have recognised mental health diagnoses and treatment/care needs which the NHS is increasingly realising.

Of course, today we also have the UKSC's *Cheshire West* judgment which significantly resets a social norm on deprivation of liberty in health and social care contexts. You only have read the Percy report of 1957 on deprivation of liberty (which championed legal informality) to see how radically this norm has shifted. In applying rule of law principles to health and social care, the UKSC significantly expanded liberty interests into an area where, historically, they have tended to be lightly applied with a clinical and social ethic of care more widely accepted.

The Law Commission report is reflecting the reset social norm when it comes to deprivation of liberty in a healthcare context but it is not reflecting modern concepts of who is a mental health patient. The scheme, as a result, creates an anomaly and a situation where, by excluding inpatient "mental health arrangements", it would force an increase in the use of the Mental Health Act. That is a concerning consequence because it is not driven by clinical need or by medical ethics but rather by a drive for legal compliance with the ECHR and the CRPD. This is very likely to be unwanted by clinicians, patients and their families and it will impact in the general hospitals and in older adult psychiatry inpatients settings particularly.

Reflecting upon this I was reminded of a funny story about Stanley Baldwin - a former Prime Minister famous for having few firm beliefs. The story goes like this: Baldwin was asked toward the end of his life whether he had read any philosophical books which had deeply affected him. To the questioner's surprise Baldwin answered firmly in the positive citing "Ancient Law" by the Victorian Jurist Henry Maine. He

described how that book's great historical sweep had had a profound influence on him with its description of grand societal movement from hierarchy and command toward equality, freedom and consent; from custom and tradition toward rational reflection and from status to contract. It was this idea, he said, that had guided his approach to politics. And then Baldwin paused, or perhaps stumbled in an attempt at recollection of this many volume work, "or was it the other way round?".

If the Law Commission report does go to parliament it needs full parliamentary debate, informed not only by legal expertise but also by mental health expertise and experience of what is going on across the NHS particularly since the Health and Social Care Act 2012. But, in a highly complex area such as this, some humour may also help!

Liberty Protection Safeguards: A response

Dr Lucy Series, Cardiff Law School

The Law Commission's final report on mental capacity and deprivation of liberty was based on a very wide consultation and careful consideration of the lessons learned under the Mental Capacity Act 2005 deprivation of liberty safeguards (MCA DoLS). Nobody can be in any doubt that the Mental Capacity Act 2005 deprivation of liberty safeguards are in dire need of replacement. The Liberty Protection Safeguards (LPS) proposed by the Commission are in many ways a vast improvement upon the DoLS.

At the operational level, they simplify the processes required for authorisation, they

reduce duplication in assessments, they tie up bizarre loose ends such as conveying and what happens when an authorisation is no longer needed because a person has died. They address the situations of those in supported living and 16 and 17 year olds in care. The proposals for advance consent, to streamline some statutory advocacy, and to introduce a clear offence for private care providers unlawfully depriving people of their liberty, are welcome.

Whether the system will cope with the scale of authorisations required in the wake of *Cheshire West* remains to be seen, and is largely contingent on the resources available for implementation. Few can doubt, however, that the system will cope *better* under the LPS than under the DoLS.

The Commission has clearly thought carefully about resources during the consultation. Proposals for a wider 'supportive care' framework have been slimmed down, the proposal for an automatic review by a court or tribunal – which would have absorbed huge public and private resources – has been revised. One key professional resource under the LPS is referral to an Approved Mental Capacity Advocate (AMCP), and this resource is effectively rationed for situations of conflict. Proposals to widen the range of medical personnel authorised to conduct mental health assessments are estimated to reduce costs from £102 to £15 per assessment. The duties of the 'responsible body' (replacing the supervisory body) will now be distributed across hospitals, CCGs, Local Health Boards and local authorities,

taking some pressure off local authorities (in England, at least). Many of these are sensible compromises for the limited resources that are presently available across the health and social care sector.

I am particularly excited by proposals to amend the best interests test under s4 MCA, to establish a clearer duty to attempt to ascertain P's wishes and feelings, and put 'particular weight' on those wishes. This does not go as far as some reformers (including myself) might like in putting the paternalistic baggage of 'best interest' behind us, but it is a very welcome development. I am also excited by the proposal of a power to introduce regulations for a supported decision making scheme. Inspired by the United Nations Convention on the Rights of Persons with Disabilities (CRPD), many countries around the world are implementing such schemes. It is a sensible use of Parliamentary time to get the power to make regulations into the Act now (as who knows when there will be an opportunity in the future), so that a consultation on it can take place in the future when people have had greater opportunities to reflect on what would work in England and Wales. The scheme as a whole falls short of the radical vision of the UN Convention on the Rights of Persons with Disabilities, at least as articulated by the Committee on the Rights of Persons with Disabilities,¹ but its influence has been felt.

The Commission proposes that the increasingly complex interface issues between the Mental Health Act 1983 (MHA) and the MCA be addressed by placing detention for treatment for

¹ Committee on the Rights of Persons with Disabilities, *General comment No 1 (2014) Article 12: Equal*

recognition before the law (2014) UN Doc CRPD/C/GC/1.

mental disorder squarely outside the MCA scheme. This will almost inevitably result in an increase in detentions under the MHA. Those who favour the safeguards of the MHA, mostly lawyers, will argue that this will benefit those detained for treatment for mental disorder. However, there is widespread resistance to the use of the MHA for certain populations, notably adults with learning disabilities and people with dementia, despite the MHA offering more robust safeguards that gives stronger powers to families. I was interested to see the Commission float the possibility of ‘fusion’ law, combining the MCA and the MHA into a single statute, based on the MCA’s principles (as they have in Northern Ireland).² This seems to be increasingly the direction of travel for campaigners in the UK; I’ll save my thoughts on this for another time, but suffice it to say I harbour suspicions that more people could be detained more easily under fusion law.

As with previous consultations by the Law Commission on the MCA³, and the government’s *Bournemouth* Consultation,⁴ there was widespread support for a tribunal rather than the CoP to be the destination of appeals. This reflected a desire for a more accessible and cost-effective avenue for a legal review. The Commission has left this question open, but emphasised that

hiving off deprivation of liberty cases for consideration by the Mental Health Tribunals raises thorny questions about devolution in Wales (the tribunals are devolved; the CoP is not) and how we separate the entangled questions of health and welfare decisions and deprivation of liberty. For my part, I would be concerned to see a new ‘interface’ arise, replete with satellite litigation over the appropriate remit of the court and tribunal. As we argued in a recent report on participation in the CoP, another way forward is to rip up the CoP rules and practices and start again, ensuring they embed the tribunal principles of participation, accessibility and cost effectiveness, not only for detention cases but also for the other cases it hears.⁵ I was also interested to see the proposal that the Mental Health Tribunals could have some limited powers to decide MCA matters, which will inevitably continue to arise in that jurisdiction.

Rights and safeguards

When we look to the history of the DoLS, we can discern two distinct policy rationales underlying judgments. The first is to address situations of conflict – situations like *Bournemouth*⁶, *Neary*⁷ or *Manuela Sykes’* case⁸ – where the person, or their carers or family, objects to their confinement in a particular setting. *Cheshire*

² Mental Capacity Act (Northern Ireland) 2016 SI 2016/18

³ Law Commission, *Mentally Incapacitated Adults and Decision-Making: An Overview*, (Law Com No 119, HMSO 1991); Law Commission, *Mentally Incapacitated Adults* (Law Commission No 231, HMSO 1995).

⁴ Department of Health, *“Bournemouth” Consultation: The approach to be taken in response to the judgment of the European Court of Human Rights in the “Bournemouth” case* (2005); Department of Health, *Protecting the Vulnerable: the “Bournemouth” Consultation: Summary of Responses* (2006)

⁵ Lucy Series, Phil Fennell and Julie Doughty, *The Participation of P in Welfare Cases in the Court of Protection* (School of Law and Politics, Cardiff University, Report prepared for the Nuffield Foundation 2017)

⁶ *HL v UK* [2004] 40 EHRR 761

⁷ *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP)

⁸ *Westminster City Council v Sykes* [2014] EWHC B9 (COP)

West, however, was not about situations of conflict, but situations where a person's care involved 'continuous supervision and control' and they were 'not free to live'. The clear policy intention behind Lady Hale's decision was to ensure that these individuals have an 'independent check' on their care.

Across all situations, including those where there is no conflict, the detained person will have the safeguards of assessments by two assessors, including at least one 'new' assessment of whether their detention is necessary and proportionate. They will also have support and representation from an advocate (on an opt-out basis) and an 'appropriate person' (replacing the Relevant Person's Representative). The LPS uses conflict – specifically an objection by the person – as a pivot for a *duty* to involve an AMCP, with a *power* to involve an AMCP where the family (but not the person) objects.

Having rejected a system of automatic review, the 'special procedural safeguards' to ensure a person is enabled to exercise their rights of appeal are similar under the LPS to the DoLS: it falls to the advocate and the appropriate person to assist the person in seeking a court review, regardless of their prospects of success. I confess that I am doubtful that under this system we will see a marked improvement in the ability of P to exercise rights of appeal; family members (who will largely be the 'appropriate person') find it difficult to challenge decisions for a number of reasons, advocacy resources to

bring a challenge are very stretched. I would have preferred the duty to refer conflicts to court to be placed squarely on the 'responsible body', with advocates and appropriate persons as a back-up option if they fail to do so. We shall have to keep an eye on the appeals statistics.

One of the main criticisms of the DoLS was that the 'supervisory body' was not sufficiently independent of commissioning arrangements, and therefore had a conflict of interest in how it operated the safeguards.⁹ The *Neary* case is of course the example *par excellence* of how these functions can influence each other to the detriment of the detained person. This concern is not addressed by the LPS, if anything it is exacerbated by the desire of the Commission to strengthen links between 'the commissioning of the arrangements and responsibility for the authorisation'. Arguably this could import the human rights values of the LPS into the commissioning process itself, but it also means that the independence of the authorising body may still be compromised.

Although the Commission has proposed that AMCPs must be independent of the care arrangements of P, as Mark Neary points out in a recent blog post on the LPS¹⁰ the reality is that those commissioning care, conducting assessments, the 'independent reviewer' and the AMCP themselves are likely to be colleagues and may potentially have close working relationships. The LPS does not establish a Chinese Wall between these functions, but it is hard to see how they could do so. Accordingly,

⁹ Paul Bowen, *Blackstone's Guide to The Mental Health Act 2007* (OUP 2007); Lucy Scott-Moncrieff, 'Two steps forward, one step back' [2007] *Journal of Mental Health Law*, 107-14.

¹⁰ Mark Neary, 'The Very Protective Safeguards' (*Love, Belief and Balls*, 14 March 2017).

the role of independent advocates, and the accessibility of the court or tribunal, will be absolutely vital safeguards in situations where this independence is potentially compromised. For this reason, we should keep a watching brief on the Parliamentary passage of the LPS to ensure these provisions are not diluted in any way.

Into the realm of politics

Although there are many elements of the LPS that are welcome, and will be widely embraced, there are parts of the scheme that may present challenges as it moves from the arena of legal enquiry into national politics. One obvious challenge is austerity – it may be tempting to reduce costs by reducing access to independent advocacy, means testing legal aid for appeals, or indirectly rationing legal resources by making the court or tribunal inaccessible to most. We must maintain pressure to ensure these vital safeguards are preserved or strengthened.

Another challenge will be the proposed conditions for authorisation. Article 5(1) only permits detention in certain circumstances, the relevant circumstance here being phrased by Article 5(1)(e) as ‘unsoundness of mind’. Under the MHA a person may only be detained on grounds of ‘mental disorder’, but this is said to exclude certain groups who have a ‘pure’ brain disorder such as a brain injury (I confess I’m a bit baffled about the source of this view, but I defer to the mental health lawyers on this). This was therefore regarded as too narrow for the LPS, which were also to apply to people with a pure brain disorder. Yet the alternative provided by s2 MCA – an impairment or disturbance in the

functioning of the mind or brain – was too broad, potentially encompassing individuals historically excluded from detention legislation, such as people with problems with alcohol or drug abuse. So the Commission plumped for ‘unsoundness of mind’, since (by definition) it overlaps perfectly with the scope of Article 5(1)(e). The trouble is, although this Goldilocks reasoning will make sense to human rights lawyers, it is likely to be poorly received by those subject to the scheme and their families. A very strong motivation for the introduction of the DoLS in the first place, rather than the expansion of the MHA, was lobbying from families keen to avoid its stigma. It seems possible that they, and those subject to the scheme, would view assessments and authorisation based on ‘unsoundness of mind’ as an equally, if not more, stigmatising designation.

Another potential challenge is the proposal to replace the best interests test with a ‘necessary and proportionate’ test. The best interests test retains a popularity in England and Wales comparable to the monarchy – however outdated and illiberal reformers view it as, it retains an aura of friendly paternalistic benevolence and has widespread appeal. The majority of consultees supported its retention. The Commission gives two reasons for not including it. The first reason is that best interests seems to imply a *choice* between options, yet in reality a choice is often not available because the commissioning body will only fund one option and nobody acting under the MCA (be they assessor, AMCP or court) can compel them to do otherwise.¹¹ The second reason is a desire to be more honest that the LPS

¹¹ *N v ACCG and others* [2017] UKSC 22

– like the DoLS before it – will be used in some situations where the *real* motivation is public protection.

I confess I am not convinced by either of these reasons – necessity and proportionality *also* imply a choice. What happens when an assessor concludes that the proposed arrangements are *not* necessary or proportionate? We end up in the same dead end as the best interests test. And whilst I recognise that the DoLS have been used for public protection purposes, I am not sure that we want to more deeply entrench that into the scheme. As Mostyn J observed in one of the few published judgments in this area¹², the MHA and its Code offers far more robust safeguards for these kinds of interventions, and in my view it would be desirable to address these issues under that scheme.

That being said, I can see attractions for a necessity and proportionality test. Although in a technical sense necessity and proportionality were included in the DoLS scheme as part of the best interests test, the reality is that these principles are often given little attention. The result is that ‘best interests’ is often used to justify interventions that are not really about addressing a serious specified risk, but about something more akin to *optimisation* of the person or their circumstances. In effect, best interests has a much lower threshold for interventions that conflict with the person’s rights to self-determination. Take the case of *Northamptonshire Healthcare NHS Foundation*

¹² e.g. *J Council v GU & Ors (Rev 1)* [2012] EWHC 3531 (COP)

¹³ [2014] EWCOP 2

Trust v ML (Rev 1).¹³ ML was discharged from hospital by a mental health tribunal because he didn’t pose enough of a risk to warrant detention under the MHA, but the CoP sanctioned proposals for him to be detained in a hospital for up to two years, for a deeply invasive behavioural intervention whose prospects of success were uncertain, to afford him a ‘greater potential than his present situation is enabling him to realise’. For all its fluffy connotations (perhaps because of), and for all the very real problems with risk as a criterion for intervention¹⁴, it is my view that ‘best interests’ has far more coercive potential. It is possible that the shift to necessity and proportionality may raise the threshold for intervention, which in my view would be desirable. However, we must ensure that the improved emphasis on the person’s own wishes and feelings is not lost by this change, and I would welcome a clearer recognition of their place in this analysis.

Another possible hostage to fortune is the proposals for ‘domestic deprivation of liberty’. On this issue, the Law Commission are in a difficult situation.

Following *Cheshire West* there has been ongoing litigation about the potential scope of circumstances where a person might be considered deprived of their liberty. In *Ferreira*¹⁵ the Court of Appeal narrowed this for many hospital settings, but the question of to what extent the ‘acid test’ applies in situations where a person is cared for by their family remains

¹⁴ George Szmukler and Nikolas Rose, ‘Risk Assessment in Mental Health Care: Values and Costs’ (2013) 31(1) *Behavioral Sciences & the Law* 125-140.

¹⁵ *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31

unresolved.¹⁶ The scope of Article 5 cannot be settled by the Law Commission, it falls to be settled in the courts. It is possible that the courts will decide that it extends to family based care settings. Already, it seems, some local authorities are assessing 'community deprivation of liberty' for family carers.¹⁷ Thus the Law Commission was faced with a choice: to propose a framework that did not apply to domestic settings, requiring authorisation by the Court of Protection in those situations, or to extend their administrative framework to cover family based care. This would in theory reduce the intrusiveness (and cost) of authorising any deprivation of liberty found to occur in the family home, but it raises profound socio-political questions about the effects of extending a detention framework to those settings.

The Commission has proposed that the LPS will apply to any 'arrangements' that may constitute a deprivation of liberty; they are not (like the DoLS were) linked only to certain forms of care provision. In itself, this is sensible – the ecosystem of modern social care is highly complex, and distinctions between formal and informal care settings increasingly blurred. However, this means that the LPS will potentially apply to care by families, in the family home. This could be viewed as a sensible future-proofing of the LPS scheme, given the uncertain state of the case law. It is also comparable to guardianship in not being tied to a particular form of care, which many critics of the DoLS have argued for. However, although these are reasonable considerations from a legal

perspective, I have very serious reservations about the use of the LPS into family based care.

My primary concern is that (in my view) the primary function of Article 5 is to act as a restraint on the authority of clinical and welfare practitioners. The use of a detention framework in familial settings effectively flips that logic on its head; instead, it becomes a tool by which professionals can extend their surveillance and regulation of family life, and it calls into question the legitimacy of care provided by families. I do not doubt that there are some families whose quality of care or even their intentions are questionable, or care that is potentially very restrictive, but that is what safeguarding and robust care planning is for, and I cannot see any policy reason why Article 5 would assist here. Instead, it may do a great deal of damage to relationships between families and professionals. Disabled people and their families already sacrifice a great deal of privacy and autonomy when they ask for assistance from the state; this would further entrench that pattern.

My secondary concern is political. At present, human rights are in a very vulnerable state – both nationally and internationally. Domestically, this has largely been driven by a media war on human rights that characterise them either as a charter for criminals and terrorists, or as 'human rights gone mad', with fictional stories of immigration deportations being cancelled because of a person's cat. It is reported that Theresa May, our current Prime Minister, will fight the next general election on withdrawal from the European Convention on

¹⁶ *SRK v Staffordshire CC* [2016] EWCOP 27; *Secretary of State for Justice v Staffordshire CC* [2016] EWCA Civ 1317.

¹⁷ Mark Neary, *Lady Hale Comes to Cowley* (*Love, Belief and Balls*, 23 March 2017)

Human Rights.¹⁸ It seems entirely possible to me that 'domestic DoLS' could become the next immigration cat story for elements of the media that are actively hostile to the MCA and human rights, especially if families themselves turn to the media with stories of being accused of depriving their relatives of their liberty. I do not think it is an exaggeration to say that this could have very serious widespread repercussions for human rights in the UK and – if we withdraw from the ECHR – even beyond. In fairness to the Commission, this is not a situation of their making; they are proposing what may seem to be the most practical solution to the possibility that the acid test will be applied in the family home by the courts. Yet I worry that this will be lost on the media, and moreover the existence of such a framework may embolden the courts to find the existence of deprivation of liberty in family settings. I confess to a nervousness of even writing these fears down, but I believe we need to tread very carefully indeed in this area.

And finally, I want to discuss proposals for limitations to s5 and s6 MCA – the 'general defence' which means that those performing acts of care and treatment have a defence against possible liability for acting without consent. The scope of the general defence is presently unclear. There is a steady drumbeat from the Court of Protection maintaining that serious medical treatments or welfare interventions that have given rise to objections by the person or conflicts with family probably require authorisation from the court or else might constitute a violation of human rights.

However, the legal basis for this requirement, and its scope, is uncertain.¹⁹ The Commission has proposed to limit the use of the general defence in certain situations, including where conflicts or objections have arisen. I support this. However, the safeguard they propose is a requirement for a written record containing certain information pertaining to the assessment of mental capacity, making best interests decisions and ensuring other statutory duties are complied with. The problem is, I am not convinced this offers an especially robust safeguard in such situations. It offers no independent oversight or review function. It offers no tools to help the person or their family challenge the decision in court (except advocacy, which should have happened anyway). And if the record doesn't exist, who will know and who will challenge? What's more, by formalising this 'safeguard' it will place such interventions *without* court sanction on a firmer legal footing than they currently are.

Having spent several months now delving into the original Law Commission proposals for the MCA, and reading the debates that took place during its Parliamentary passage, I believe that the general defence under the MCA was not initially intended as a tool for use for interventions where the person themselves clearly objects outside of emergencies (by the Commission at least; a different pattern was emerging in the courts). Yet neither statute nor Code explicitly prohibited this use, and there is language in the Code that seems to endorse

¹⁸ Christopher Hope, '[Theresa May to fight 2020 election on plans to take Britain out of European Convention on Human Rights after Brexit is completed](#)' (*The Telegraph* 28 December 2016).

¹⁹ Alex Ruck Keene, 'Powers, defences and the 'need' for judicial sanction' (2016) *Elder Law Journal*, Autumn, 244; Lucy Series, Phil Fennell and Julie Doughty (2017) n 5.

these uses. In *N v ACCG and others*²⁰ Lady Hale still views s5 MCA as granting a very broad general authority to act, but commented that if there is a dispute then it may be necessary to apply to court. I believe that we need a proper public consultation on the question of how far it is permissible for health and social care practitioners to effect serious interferences with bodily integrity and rights to home, family and private life under the MCA without some procedural safeguard offering independent scrutiny or support to challenge a decision. In a way, we could view *Cheshire West* itself as trying to fill that regulatory gap. Families are increasingly calling for procedural safeguards to protect against moving loved ones into formal care settings.²¹ I believe that we should use this opportunity created by the Commission to lobby for a better and more effective safeguard, and to have a full and transparent conversation about the potential for coercion under the MCA.

²⁰ [2017] UKSC 22

²¹ They have produced the draft Disabled People (Community Inclusion) Bill 2015, known as the 'LB Bill'. The draft bill is linked to a campaign for justice

following the death of Connor Sparrowhawk, a young man with autism who drowned whilst de facto detained in an assessment and treatment unit. See proposed section 5(2)(c) of the [draft Bill](#).

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