

LPS – challenges and criticisms

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Introduction

1. This paper sets out some of the concerns about the Mental Capacity Amendment Bill and the LPS framework, as at 18 March 2019. The Bill has not completed its passage through Parliament – so there is still time for some of these problems to be addressed.

Authorisations in care homes: care home managers and access to AMCPs

2. The role of care home managers in authorising deprivations of liberty will be less extensive than in the government's original proposals, but it remains potentially significant, if, as the draft legislation permits (and the impact assessment assumes), the responsible body chooses to rely on assessments by the care home.
3. First, the assessment process in such circumstances will be led by care home managers where local authorities decide that that should be the case. Second, it will be for care home managers, in all care home arrangements, to consult with the cared-for person and others (e.g. a deputy or anyone caring for the person or interested in their welfare). This consultation is particularly important in establishing whether the cared-for person objects to the proposed arrangement.
4. There are two key problems with the continued role of care home managers in the revised MCAB: the potential for conflicts of interest; and a lack of skills and resources to carry out their role.
5. Despite the changes introduced during the passage of the Bill, there remains a conflict of interest between the role of care home managers in the assessment process and the outcome. Care homes have a financial interest in securing placements; the outcome of the assessment may determine whether a placement is secured.
6. In response, the government has pointed to changes to the assessment process and pre-authorisation review. The assessments and review must now be carried out by someone who does not have a financial connection to the care home. That, however, is only a partial answer. Responsible bodies and reviewers are reliant on the information they have been provided.

7. The problem is made worse by the limited role of AMCPs in pre-authorisation reviews in care homes. Unless they have accepted a referral from the responsible body, AMCPs will only review proposed care home arrangements where the cared-for person is objecting to them. It will be for care home managers, during the consultation process, to establish whether the cared-for person is objecting to the proposed arrangements. Care home managers will therefore act as the gateway to the additional scrutiny offered by AMCPs.
8. Conflicts of interest could also affect the assessment process. When arranging assessments, care home managers will have an important role in choosing assessors. The skills and experience necessary to be an assessor remain unclear at this stage. There is a risk, to put it bluntly, that managers will choose assessors who are known to be more likely to authorise proposed arrangements than others.
9. Arranging assessments will, moreover, require appropriate training and experience. The government's impact assessment assumes that only half a day of training will be needed. For the great majority of managers, that is extremely unlikely to be the case. The administrative burden on care homes will also be significant: arranging assessments will be a time-consuming and resource-intensive task.
10. Similarly, the time, resources and skills it will take for care home managers to carry out proper consultation should not be underestimated. Establishing whether a cared-for person is objecting to proposed arrangements will not necessarily be a straightforward task.¹ The person's responses may be ambiguous, or change from day to day, or be difficult to ascertain. Further, there is currently no provision to deal with a scenario in which the cared-for person cannot communicate their wishes and feelings about the proposals.
11. As noted by the JCHR², there is also a practical issue: given that the assessments are to happen before the arrangements are in place, how would the care home manager be able to ascertain the wishes and feelings of a person they may not even have met? It is difficult to see how the wishes and feelings of a person could be properly ascertained without a face to face meeting. That would be a time-consuming task for care home managers. And, if the meeting is a short one, it may be difficult to get a meaningful and reliable understanding of whether the cared-for person is objecting to the proposed arrangements. This aspect of the LPS scheme seems to increase rather than reduce the

¹ See, for example, the evidence submitted by Dr Lucy Series on the MCAB, p.8:

<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/legislative-scrutiny-mental-capacity-amendment-bill/written/91960.pdf>

² Legislative Scrutiny report, para 47

<https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/1662/1662.pdf>

risk that people will be moved into care homes first, and adequate assessments carried out afterwards.

12. Some of these issues may be mitigated by appropriate guidance in a revised Code of Practice. As matters stand, however, they are represent real risks to the adequacy of the protection given to cared-for persons under the LPS.

Access to advocacy and incorporation of a best interests test

13. Access to advocacy will be significantly weaker under the MCAB than the current system, and the approach that has been adopted is problematic in a number of important ways.
14. The first and fundamental problem is that there is no duty to appoint an IMCA. The duty is to 'take all reasonable steps to appoint an IMCA' if certain circumstances exist. Under DOLS, there was an obligation to appoint an IMCA that was unqualified. What does taking all reasonable steps mean? If a local authority can't afford IMCAs for everyone, are they off the hook? Is this watered-down obligation sufficient to comply with the requirements of Article 5, and in particular to facilitate access to the court by those who require support to exercise their rights?
15. A further issue is the incorporation of a best interests test into deciding who gets an IMCA, where the cared-for person lacks capacity to request one. Whether or not to apply to court to challenge a deprivation of liberty is not a best interests decision: see AI v A Local Authority and RD. Similarly, whether a cared-for person should be supported by an IMCA should not be governed by a best interests analysis.
16. It might be said that, if someone is objecting to their care arrangements, it would be unlikely that a decision would be taken that it was not in their best interests for an IMCA to be appointed. However, there is a well-worn argument that the the DOLS process, or the appointment of an RPR or IMCA, causes the cared-for person stress as it makes them think there is a prospect of the restrictions on them being lifted, when, very often, that is impossible (for example because there is nowhere for them to live other than a care home). There is a real risk, therefore, that people will be left 'unbefriended' and unable to challenge or seek a review of their deprivation of liberty.
17. In an open letter to Inclusion London,³ the government suggested that the best interests requirement is in place because it would be wrong to appoint an IMCA where someone was expressly objecting to having one. Given that (a) the person concerned is, by definition, unlikely to have a complete grasp of the role of an IMCA and the circumstances surrounding their care, and (b) any IMCA appointed could take an

³ Available here: <https://www.inclusionlondon.org.uk/campaigns-and-policy/act-now/open-response-to-caroline-dinenage-regarding-the-mental-capacity-amendment-bill/>

independent decision about what level of support to offer the cared-for person, the government's objection is difficult to understand, not least when one thinks about the much more serious consequence to a person who needs an IMCA but is not given one as a result of this provision.

18. As with the appointment of RPRs under DOLS, the first port of call for responsible bodies will be to identify whether there is an appropriate person to represent and support the cared-for person. It is only if there is no appropriate person, and the cared-for person lacks the capacity to consent, that the responsible body must take all reasonable steps to appoint an IMCA (unless satisfied it would not be in their best interests). But RPRs had access to IMCAs to support them in their role, whereas appropriate persons do not. The appropriate person's entitlement to an IMCA only arises if they ask for one. (This is aside from an odd provision that appropriate people who themselves lack capacity could have an IMCA appointed in their best interests – quite how a person who lacks capacity to request an IMCA could be an appropriate person with responsibility for ensuring the cared-for person's rights of access to the court are respected is not explained.)
19. In effect, this means that family and friends will be the starting point and the end point for advocacy. There are no doubt many such people who would do an excellent job. But, as pointed out by Inclusion London in their 5 February 2019 response to the government⁴, there are real problems with this approach. First, the views of friends and relatives are not always the same as the views of the individual. There is a risk that responsible bodies will appoint appropriate persons who support the cared-for person's detention (as happened for example in **AJ v A Local Authority**), and that the cared-for person's objections will be lost without being reviewed by a court. Second, well-meaning relatives and friends may well struggle to navigate the system. Supporting a cared-for person to review or challenge their deprivation of liberty is a difficult task, leaving aside the demands it will place on the time and emotional resources of a family member or friend. Again, the obligation to appoint an IMCA to support the appropriate person is only a duty to 'take all reasonable steps' to do so if requested.

3 year renewals

20. The maximum period for a first LPS authorisation is 1 year. This can be renewed for another year, and thereafter for periods of up to 3 years.
21. Enabling renewals, and in particular the possibility of 3 year renewals, is a significant change from DOLS. As the government has pointed out in response to criticisms, it

⁴ Available here: <https://www.inclusionlondon.org.uk/campaigns-and-policy/act-now/open-response-to-caroline-dinenage-regarding-the-mental-capacity-amendment-bill/>

was proposed by the Law Commission. The Law Commission's intention was to avoid, for individuals with stable or progressive conditions, an annual re-authorisation process that can amount to a rubber-stamping exercise, be of little benefit to the cared-for person, waste resources and generate emotional distress for the person and their family.

22. Choosing any maximum period of authorisation is to some extent arbitrary. Views will differ as to the appropriate maximum, and criticisms can be made of increasing it to 3 years.
23. The key problem with the new system, however, is that it has adopted the Law Commission's extended time period without adopting other parts of the Commission's proposals. In particular, the independent scrutiny of authorisations under the LPS, as well as access to advocacy and court reviews, are significantly weaker than had been proposed by the Law Commission. The Commission's report was clear on the importance of those safeguards in concluding that renewals of up to 3 years were appropriate:

"11.35 [...] It is important to emphasise that – irrespective of the length of the authorisation – the person would always remain subject to a robust system of reviews, have access to advocacy or an appropriate person, and have a right to apply to the court to challenge the authorisation. We consider that our reforms to the review process [...], and the role of the advocate / appropriate person [...], are particularly important in ensuring that the person's circumstances are kept under review on an ongoing basis, rather than solely at the fixed end point of a period of authorisation."

24. This issue is of particular concern in relation in care homes. The responsible body can delegate renewal tasks to a care home manager where they relate to care home arrangements. Conflicts of interest for care home managers will be especially acute in relation to lengthy renewals for long-term residents.

Statutory definition of deprivation of liberty

25. It remains to be seen whether there will be problems with the attempt at the last minute to include a statutory definition of deprivation of liberty within the Bill. The Government's proposal sought to encapsulate Cheshire West and Ferreira in a few sentences, and, if adopted, will inevitably lead to yet more litigation.

4ZA Meaning of deprivation of liberty

(1) In this Act, references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention and, accordingly, a person is not deprived of liberty in any of the circumstances described in subsections (2) to (4).

- (2) *A person is not deprived of liberty in a particular place if the person is free to leave that place permanently.*
- (3) *A person is not deprived of liberty in a particular place if –*
 - (a) *the person is not subject to continuous supervision, and*
 - (b) *the person is free to leave the place temporarily (even if subject to supervision while outside that place).*
- (4) *A person is not deprived of liberty if –*
 - (a) *the arrangements alleged to give rise to the deprivation of liberty are put in place in order to give medical treatment for a physical illness or injury, and*
 - (b) *the same (or materially the same) arrangements would be put in place for any person receiving that treatment.*
- (5) *A person is free to leave a particular place for the purposes of subsections (2) and (3) even if the person is unable to leave that place provided that if the person expressed a wish to leave the person would be enabled to do so.*

26. In the House of Lords, the government explained their proposed definition as follows, noting that its purpose was to ‘provide clarity to people and professionals’:

The clause delivers this by setting out non-exhaustive bounds of the concept of deprivation of liberty – that is, circumstances which do not constitute a deprivation of liberty. This is a matter that I have discussed with a number of your Lordships.

It sets out that a person is not deprived of their liberty if they are free permanently or temporarily to leave the place they are in and would not be subject to continuous supervision if they were enabled to leave if they expressed a wish to do so. A person will also not be deprived of liberty if arrangements are put in place to give medical treatment for physical illness or injury and these are the same as would be put in place for anyone receiving this treatment.

These boundaries to the concept of deprivation of liberty are drawn mainly from existing case law decided by our highest courts. We have taken this approach because it allows case law to evolve and helps ensure the definition remains valid as it does so. It is also very difficult for any positive definition to adequately address the range of cases that may be a deprivation of liberty, particularly while retaining the ability to reflect evolving case law. This clause will be accompanied by statutory guidance, which will be scrutinised by both Houses. We are currently working with stakeholders to compile case studies to illustrate when a deprivation of liberty occurs or does not occur under this definition, so that it will be more usable by practitioners and individuals.

27. The House of Lords however rejected the government’s definition, and chose the following replacement:

4ZA Meaning of deprivation of liberty

- (1) *A person is deprived of liberty if the circumstances described in subsection (2) apply to them.*
- (2) *A person is deprived of liberty if they –*

- (a) are subject to confinement in a particular place for more than a negligible period of time; and*
- (b) have not given valid consent to their confinement; and*
- (c) the arrangements are due to an action of a person or body responsible to the state.*
- (3) For the purpose of subsection (2)(a), a person is subject to confinement where they —*
- (a) are prevented from removing themselves permanently from the place in which they are required to reside, in order to live where and with whom they choose; and*
- (b) are subject to continuous supervision and control.”*
- (2) In section 64(5) of that Act (interpretation) for the words from “same” to the end substitute “meaning given by section 4ZA.*

28. The Joint Committee on Human Rights has sought to persuade the government to use a definition which waters down Cheshire West, and limits the number of people who are potentially deprived of their liberty. The government has refused to do this, saying that Cheshire West represents the law and any statutory definition must reflect it.

Interim authorisations

29. The LPS do not include an equivalent to the urgent authorisation under DOLS, instead they permit reliance on the statutory provisions in s4B to authorise a deprivation of liberty if it is necessary to perform a vital act, pending completion of a LPS assessment. It is problematic that there is no time limit on this interim self-authorisation, which will not, one assumes, entitle the cared-for person to non-means-tested legal aid, even though that may be the only effective way to challenge their detention in a timely manner. If the time taken to complete assessments isn't reduced significantly under the new scheme, which seems a real risk as the numbers of eligible people are not being reduced, there could well be long delays with no access to the court. Given that the ECtHR has said that delays of only a few weeks in enabling someone to challenge a deprivation of liberty violate Article 5(4), this open-ended power is likely to be dramatically reduced by the courts if it is relied on for any longer than very short periods.