MENTAL CAPACITY AND DEPRIVATION OF LIBERTY – LAW COMMISSION PROPOSALS

	PROTECTIVE CARE SCHEME					
	Supportive Care Safeguards (SC)	**Restrictive Care and Treatment**			**Additional information**	**Comments, Queries, concerns**
		Some restrictions (RC a)	Deprivation of Liberty (RC b)			
			Long term settings	*Short term settings*		
	"The provision of supportive care may help to ensure that an assessment takes place, proper care and support is in place and the need for more restrictive forms of care and treatment is prevented or at least delayed" (6.99) "The focus is on reinforcing existing mechanisms (5.9)	"Our intention is to develop a concept wider than deprivation of liberty, which also takes into account the article 8 rights of individuals" (7.20)	"An authorisation of DoL does not require the person to be deprived of their liberty.....Article 5 safeguards would still be provided. Therefore issues of fluctuating capacity and changes to the person's regime will not necessarily affect whether the person receives the safeguards" (7.169)	"We consider that advance decision-making should be given more of a central role in hospital and palliative care" (8.3) "Hospital patients are more frequently admitted in emergency situations and for specific forms of intervention. Admissions ordinarily involve shorter stays and are based on the assumption that the person will return home as soon as possible" (8.5)		
	SUMMARY OF SAFEGUARDS					
	1. Capacity assessment, and if incapacity, best interests assessment 2. Clarity in care plan re lack of capacity, best interests and basis upon which accommodation provided 3. Appointment of someone to act as an advocate – could be paid advocate or appropriate person to ensure access to review and appeals process 4. LA discretion to	1. Capacity and best interests assessment overseen or undertaken by independent AMCP 2. Care plan instrument for authorising restrictions 3. Separate AMCP responsible for ongoing monitoring and review – can delegate 4. Appointment of advocate or appropriate person 5. Right of P, family or advocate or care provider to ask for a review 6. Right to appeal (see	1. Capacity and best interests assessment overseen or undertaken by independent AMCP 2. Care plan instrument for authorising DoL 3. Must include objective medical assessment 4. Separate AMCP responsible for ongoing monitoring and review – can delegate 5. Appointment of advocate or appropriate person/relevant person's rep 6. Right of P, family or advocate or care	1. Responsibility of hospital managers and clinicians to identify patients (8.23) 2. Registered medical practitioner examines P and certifies in writing to hospital manager (8.24) 3. Can apply for 28 days 4. Manager to appoint a separate responsible clinician to oversee treatment, notify LA, reviewing that conditions for DoL remain met in 28 days 5. Appoint an advocate and relevant person's representative		

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	appoint an AMCP 5. LA to keep P's health and care arrangements under review	below private/public law)	provider to ask for a review 7. Right to appeal (see below private/public law)	6. Beyond 28 days, AMCP assessment and authorisation as in previous column		
FEATURES OF THE DIFFERENT SCHEMES						
SETTINGS	Care homes, supported living, shared lives	Care homes, supported living, shared lives	Care homes, supported living, shared lives, **family and domestic settings**	[Acute] hospitals, hospices		**SC**. Where do sheltered housing, assisted living etc sit in relation to definition of supported living? (4.19) They often aim to provide support but not care
WHICH DEFINITION OF MENTAL INCAPACITY	MCA one: "people who lack decision-making capacity as a result of an impairment of, or disturbance in the functioning of the mind or brain" (7.13)		Not clear whether it's the MCA one or the DoLs one. "Disability or disorder of the mind or brain" – so would exclude addictions and temporary impairments?			
CRITERIA FOR INCLUSION	1. At point of entry, P lacks the capacity to "consent to living arrangements" (5.10) "for the purpose of being given particular care or treatment" (6.15) 2. Also applies if P's cognition declines in situ but not clear what P needs to lack the capacity to decide to trigger supportive care (6.2)	1. Would apply to P moving into or living in one of the above settings. 2. P's care and treatment arrangements are becoming sufficiently restrictive or intrusive that there is a clear need for additional safeguards or oversight" (7.21) 3. P must "lack the capacity to consent to the relevant care and treatment" (7.27, 7.30) **Non-exhaustive list of restrictive care and treatment (7.31**):	As in restrictive care AND meets the Supreme Court acid test	The person lacking capacity should be considered deprived of their liberty if: 1) they are not free to leave the hospital upon expressing a wish to do so or attempting to do so, or as a result of another person expressing a wish or attempting to remove them; and 2) they are subject to continuous supervision and control		**SC 1.** (6.2) For those already living in supported living such as HWC whose mental capacity declines, at what point should Supportive Care kick in? What would P need to lack the capacity to do? Any mental incapacity arising from an impairment or disturbance in the functioning of mind or brain which makes them vulnerable, irrespective of what they lack the capacity to do? **SC2**. Is "for the purpose of care and treatment" too narrow in the context of HWC? (6.15)(Probably

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		1) Continuous or complete supervision and control 2) The person is not free to leave 3) The person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted 4)Barriers are used 5) P's actions are controlled by various specified means 6)Any care or treatment P objects to 7) Significant restrictions over diet, clothing or contacts				necessary wording because of the wording of the ECHR or some other relevant legislation) **RC a and b.** No: 2 in list should be clear that it means permanently **RC a & b.** Should no: 3 of the list of restrictions include tracker devices? RC a. "Sufficiently restrictive" presumably means that any one or more of the restrictions in the non-exhaustive list applies? **SC & RC.** Is the distinction between consent to "living arrangements" and to "relevant care and treatment" sufficiently clear?
Approved Mental capacity Professional (AMCP)		Best Interests Assessor to become **"Approved Mental Capacity Professional"** with wider responsibilities". "They will be acting as independent decision-makers on behalf of the local authority" (7.106 & 7.111) **Responsibilities** <u>Assessments and care planning</u> Overarching responsibility for assessments. They should have the power to make conditions to the authorisation in the form of clear instructions and make recommendations to public authorities about care plans where they don't have the power to decide themselves (7.129		If DoL needed for longer than 28 days AMCP would need to assess and authorise for up to 12 months		**RC.** Is it sufficiently clear exactly what the AMCP can decide and what they cannot? i.e. the dividing line between AMCP's decision-making powers and responsibilities, and those of the local authority? **RC.** The power to delegate the monitoring of conditions to a health or care professional may well end up the default position and may not actually be done, despite

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		& 135) Ongoing oversight and reviews The AMCP taking responsibility for reviewing P's care and treatment should be different from the one who authorised the restrictions (7.161) Responsibilities include: 1. Ensuring compliance with Care Act, MCA and continuing healthcare regs 2. Ensuring regular review meetings 3. Ensuring provider gives appropriate consideration to a supported decision 4. Ensuring an advocate or appropriate person has been appointed 5. Duration of restrictive care and treatment would be set by AMCP, not to exceed 12 mths (7.78) 6. Discretion to discharge someone from restrictive care and treatment scheme 7. Monitoring compliance with the conditions they set (7.136) but could delegate 8. Discretion to appoint a relevant person's representative 9. Monitoring relevant person's representative (9.67)				the safeguard offered by the existence of an advocate or appropriate person.
Assessments	LA to arrange a capacity assessment – could be part of assessment under Care Act and could be delegated	"If any form of restrictive care and treatment is proposed, then an assessment should be initiated" (7.27) in order to confirm that P lacks capacity to consent and proposed care is in their best interests (7.29) Best Interest Assessor/AMCP to be given overarching responsibility for all	As in previous column but must include separate medical assessment to confirm disability or disorder of mind or brain. Can use existing medical evidence.	Registered medical practitioner undertakes assessment and certifies DoL in writing to manager		

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		restrictive care and treatment assessments but would be given wide discretion as to how this oversight should be implemented. (7.67 & 7.73) Could delegate and just quality assure, or do it him/herself				
Care Plan	Care plan to include record of capacity, best interests assessment and any restrictions	Care Plan is vehicle for authorising the restrictive care and treatment and should say so expressly Can authorise restrictions for up to 12 months or up to 7 days for urgent authorisations, with option to extend for further 7 days pending full assessment (7.204)	Care plan is vehicle for authorising the restrictive care and treatment including the DoL. Needs to be explicit about the particular deprivations authorised (7.167, 7.168, 7.169) AMCP would need to certify in care plan that objective "medical expertise" had been provided and that the DoL was in P's best interests. Preferably medical expert to be independent of detaining body. (7.189) Purpose would be to confirm that P is suffering from a disability or disorder of mind or brain and lacks capacity to consent to proposed care and treatment (7.190)	Hospital manager to appoint a responsible clinician (8.25), different from the one who authorised the DoL, and is the one who is also responsible for P's clinical care (8.29) Care plan can be amended as circumstances change and include provision for transfers, conveying someone between places etc (8.27)		**SC.** Is it conceivable that someone who lacks the mental capacity to agree to the move/living arrangements would also not require some restrictions and therefore fall under restrictive regime? No – only if one of the restrictions in the non-exhaustive applies
Monitoring and reviews	**Reviews** Local authorities should be required to keep under review the health and care	**Reviews** AMCP and LA must review care and treatment following a reasonable request by P, a family member or carer, or an advocate or appropriate person (7.165)				

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	arrangements for any person who falls within supportive care. This would include ensuring that a care plan and proper capacity assessments have been undertaken (6.51)	Also presumably at intervals specified in the authorisation by the AMCP and at the end of the authorised term.				
Independent advocacy	Independent advocate or appropriate person to be appointed by LA to ensure that P has access to relevant review and appeals process	Independent advocate (formal) or an appropriate person and/or relevant person's representative (personal relationship). Where formal advocate, should also be opportunity for appropriate person so family input. AMCP to have discretion to appoint a relevant person's representative in addition to appropriate person if it would improve P's outcomes (9.58)		Relevant person's representative should be appointed (8.26) in addition to or instead of a formal advocate.	Suggestion that the role of advocates across the various laws where they're included are aligned based on the Care Act. See p 120 9.15 – 9.18 for functions.	Slightly different roles of these people under the different protective care schemes strikes as confusing. Some of the distinctions are "head of the pin" stuff
Tenancies	Different formal and informal options when P lacks capacity to sign. Decision-maker should record basis in care plan					
Responsibilities of the local authority	1. Keep care arrangements under review and whether restrictive care needed 2. Discretion to appoint an "AMCP" 3. Appoint advocate or appropriate person	1. Appoint an AMCP 2. Approve AMCPs and accept applications for protective care (7.109) as supervisory bodies 3. Undertake assessments if asked to do so 4. Where dol, LAs and health boards would be detaining authority 5. Discretion to discharge person from restrictive scheme 6. To ensure authorisations are "duly made" and founded on the necessary assessment (7.111) 7. Required to refer people subject to restrictive regime to First tier tribunal if there has been no application made to the tribunal within a specified period of time (11.42)		To be notified of a DoL and appoint an AMCP if DoL required beyond 28 days		**RC a & b.** Not convinced that the respective powers and responsibilities of the LA and AMCP are clear **RC.** Don't understand under what circumstances LA would be required to refer to First Tier tribunal
REFERRALS	Proposal that registered care providers should be required to refer an individual for an	Proposal that registered care providers should be required to refer an individual for an assessment under the	Proposal that registered care providers should be required to refer an individual for an assessment under the	Hospital Managers and clinicians to identify patients to whom criteria apply	SC 1. Law Com argues that Public Law is limited on the extent to which	SC 1. Supportive care is intended to cover self-funders. With funding reforms postponed till at

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	assessment under the relevant prospective care scheme if P meets relevant criteria. (6.108)	relevant prospective care scheme if P meets relevant criteria. (7.21) Includes self-funders moving into one of the included settings (and presumably if once there, restrictions need to be put in place)	relevant prospective care scheme if P meets relevant criteria. (7.21) Includes self-funders moving into one of the included settings (and presumably if once there, restrictions need to be put in place)		it may place duties on purely private bodies, and includes housing associations in that category. But some lawyers argue that HAs count as public bodies for ECHR purposes	least 2020, should there ideally also be a requirement on housing providers to make referrals?
APPEALS	**Public or private law?** Assessments and care plans to record what options have been considered and reasons for decisions reached (6.59 – 6.61)	Presumably as in previous column Right to apply to a First Tier Tribunal to review cases under restrictive scheme (11.39)			Issue of public or private law is relevant in determining which legal route to take in the event of serious challenge – judicial review (public law) and CoP (MCA Private law)	SC. This area strikes a quite confusing to someone without a legal background because very often both the duties under the Care Act and best interest decision-making under the MCA apply to a decision.
SUPPORTED DECISION MAKING	A new legal process should be established under which a person can appoint a supporter in order to assist them with decision-making. Supporter must be able, willing and suitable. AMCP to have the power to displace the supporter if necessary. (12.27)					
BEST INTERESTS	S4 of MCA should be amended to establish that decision-makers should begin with the assumption that the person's past and present wishes and feelings should be determinative of the best interests decision					
ADVANCE DECISION-MAKING			P could make an advance decision allowing him/herself to be deprived of liberty under certain circumstances (13.24). Should be restricted to a defined event of relatively limited duration, and consent must be valid and applicable to the relevant care and treatment (13.27) Donees of LPA should not have power to consent in advance to a DoL (13.31) (13.35)			
		The restrictive care and treatment scheme and hospital scheme would not apply in cases where they would conflict with a valid decision of a donee or advance decision. (13.36)				

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REGULATION	To be overseen by LA (14.15)	Proposal to extend CQC's remit to include supported living, shared lives and other domestic settings when restrictive care and treatment, including a deprivation of liberty, is in place in the context of Convention against Torture.(14.15) AMCP to be regulated separately. The health and care professional council should be required to set standards for, and approve the education, training and experience of AMCPs (7.112)			Also suggestion of sharing intelligence between regulators including HCA in the case of housing (14.17)	R 1. It is not clear whether CQC would be responsible for monitoring all aspects of "care and treatment" in supported housing where restrictive care applies or only the "torture" aspects
INQUESTS			The Criminal Justice Act 2009 should be amended to provide that inquests are only necessary into deaths of people subject to DoL authorisation at the time of their death if there is a duty under Article 2 to investigate (15.63) (i.e. where "the evidence suggests a possible breach of the state's substantive duty to protect the life of those in its direct care" 15.51)			
PAYING FOR CARE AND TREATMENT			"In our view, as a matter of principle it seems unfair that a person who lacks capacity who is being deprived of their liberty by the state is also charged for that accommodation..." (15.71) The discussion around this seems only to apply to residential care and it is not a firm proposal but put forward in the form of a question – see 15.73			To my mind this is a bad idea: 1. Would introduce a perverse incentive to be classified as DoL 2. Would re-introduce a cliff-face in what is really a spectrum 3. Slippery slope to supported living settings. If LAs paid for accommodation in these, would be registrable as care homes. To my mind, what is anomalous is free mental health aftercare.