

Consultation Response

Mental Capacity and Deprivation of Liberty: a consultation paper

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About this consultation

[Mental Capacity and Deprivation of Liberty: A Consultation Paper](#) considers how the law in England and Wales should regulate deprivations of liberty involving people who lack capacity to consent to their care and treatment arrangements.

The current Deprivation of Liberty Safeguards (DoLS) have been subject to considerable criticism ever since their introduction. In March 2014 two events inflicted significant damage. First, the House of Lords post legislative scrutiny committee on the Mental Capacity Act (MCA) published a report which, amongst other matters, concluded that the DoLS were not 'fit for purpose' and proposed their replacement. A few days later, a Supreme Court judgment (known as *Cheshire West*) widened the definition of deprivation of liberty to a considerable extent. The effect has been to significantly damage the public image of the DoLS and the regime has struggled to cope with the increased number of cases. As a result of these events the Government asked the Law Commission to undertake this review of the DoLS.

We welcome the opportunity to feed our views into this consultation process and in our response have grouped comments under the chapter headings set out in the consultation document, highlighting where we have made responses to the specific questions posed.

KEY POINTS AND RECOMMENDATIONS

- The starting point for reform of the DoLS must be to protect and promote the human rights of those who are deemed to lack capacity.
- While there is undoubtedly a case for reform of the current system we do not support the proposals in their current form because we believe they are in many ways as complex as the system they would replace and depend for their effective operation too much on the provision of more resources - highly unlikely in the current climate.
- Given the valid criticisms of the implementation of the current DoLS regime, adequate resources to ensure effective implementation of any new scheme will be crucial.
- A core principle of the new scheme should be that restrictive care or treatment should only be sanctioned as a measure of last resort. For older people, too often, at the moment it is the first. Decision making must always seek to maximise capacity and independence.
- Just as it is a key principle of the MCA that capacity should be assumed, in our view there should be a similar presumption of liberty.
- While the extension of the new scheme into family and other domestic settings may be beneficial and justified in certain individual circumstances we recommend that further detailed work is done to engage stakeholders on this issue, before any decision is taken to proceed along these lines.
- While there may be theoretical advantages to the supportive care scheme in terms of securing greater compliance with the MCA, we are concerned that they may be outweighed by the added complexity it brings, which is at odds with the overall aim of simplification.

- The difficulty of identifying ‘less restrictive’ options to residential care because of the funding restrictions within the social care sector is a major barrier to improving the current system. We recommend granting the courts the power to veto arrangements that are manifestly not in a person’s best interests.
- We support the proposal for a separate scheme tailored to hospital and palliative care settings. It is imperative that the level of bureaucracy required to comply remains proportionate to the positive benefits that the safeguards can offer.
- The proposed scheme positions access to advocacy as a key safeguard, with an advocate being instructed for all those subject to protective care. While we strongly support this it seems doubtful that current services would be able to meet additional demand without significant additional resources.
- We are sympathetic to the proposed recommendation that any restrictive treatment and care decisions should initially be challengeable in a specialist tribunal, rather than in the Court of Protection.
- We support the proposal to amend the MCA to give greater weight to an individual’s wishes and feelings in a best interest decision, as a welcome step towards the goal of a workable system of supported decision making.
- The current situation in which all those who die while subject to the DoLS have to have their death investigated by the Coroner is causing distress to families. We support the proposal to amend the Criminal Justice Act 2009 to provide that inquests are only necessary into deaths of people where the coroner is satisfied that they were deprived of their liberty at the time of the death and that there is a duty under article 2 to investigate the circumstances of the death.

INTRODUCTION

Age UK is the country's largest charity dedicated to helping everyone make the most of later life. We believe in a world where everyone can love later life and we work every day to achieve this. We help more than five million people every year, providing support, companionship and advice for older people who need it most.

Age UK believes that the starting point for reform of the Deprivation of Liberty Safeguards (DoLS) must be to maximise the enjoyment of human rights for those who are deemed to lack capacity. In the 21st century we ought to view the need to deprive someone of their liberty because their mental capacity is impaired as an extremely serious matter and indeed one that can only be sanctioned as matter of last resort. We certainly should not be accepting care and treatment that amounts to deprivation of liberty as a norm.

A fundamental concern for Age UK is that the proposals to replace the DoLS must not be discriminatory on any grounds including that of age or disability. Older people are more likely than younger people to be subject to an application for deprivation of liberty. The Care Quality Commission’s most recent monitoring report showed that in 2013/14, the rate of applications for people aged 85 and over was far higher than those for people aged 18

to 64.¹ Getting older must not equal a diminished right to freedom. All too often care and support are organised in accordance with a deficit model of ageing which seeks merely to deal with the consequences of lack of capacity and impairment, rather than an approach which seeks to maximise an individual's potential.

It is important not to see the safeguards put in place under the proposed protective care scheme as a sticking plaster for deficiencies and underfunding elsewhere in health and care services. Our recent report, the Health and Care of Older People highlights significant underfunding, and any reform needs to take into account any resourcing implications.² Neither should the safeguards be used as a means to ensure dignity and autonomy after the event, when finding an alternative non-restrictive solution at the outset would have achieved that more effectively. Protecting and promoting human rights must be seen as an integral part of all aspects of the care planning and review processes, regardless of whether or not someone lacks capacity.

CHAPTER 2: ANALYSIS OF THE DEPRIVATION OF LIBERTY SAFEGUARDS

We agree to a certain extent with the conclusions reached by the Law Commission as to the failings of the current DoLS arrangements. In particular we concur that they take an overly narrow focus on article 5, failing to take sufficient account of the person's article 8 right to a private and family life; that there is a disconnect with the style and empowering ethos of the Mental Capacity Act; that the DoLS have serious limitations in scope and flexibility; and that they are complex and overly bureaucratic.

However it ought also to be noted that feedback we have received from older people, families, carers and professionals is that where the DoLS are effectively used, they can lead to positive outcomes. This conclusion is supported by the most recent CQC report on the DoLS which highlights a number of good practice examples including the case of 99 year old Mrs V who was supported to return home from a nursing home that she had gone into following a fall, as a result of a well-conducted 'best interests' assessment.³ At its best the process can allow for proper consideration by families, social workers and care providers of an individual's right to autonomy and, as far as can be determined, their wishes and feelings.

While there is undoubtedly a case for reform of the current system we do not support the package of proposals in their current form because we believe they are in many ways as complex as the system they would replace and depend for their effective operation too much on the provision of more resources - highly unlikely in the current climate. It is also unlikely that they would lead to fewer applications as they take as their starting point the 'acid test' for defining deprivation of liberty set out in *Cheshire West*.

¹ CQC (February 2015) Monitoring the use of the Mental Capacity Act Deprivation of Liberty safeguards in 2013/14.

² Age UK (October 2015) The health and care of older people in England 2015. <http://www.ageuk.org.uk/professional-resources-home/research/reports/health-care-services/the-health-and-care-of-older-people-in-england-2015/>

³ Care Quality Commission (Feb 2015) Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013/14

CHAPTER 3: PRINCIPLES OF PROTECTIVE CARE

Question 3-1 asks whether the Law Commission has identified the correct principles to underpin protective care, namely that the scheme should deliver improved outcomes, and be based in the Mental Capacity Act (MCA), non-elaborate, compliant with the European Convention on Human Rights, supportive of the UN Disability Convention, and tailored according to setting.

We agree that the MCA is the correct gateway for access to protective care with the proviso that its own key principles must be more strictly adhered to under any new system than they are currently. It is particularly vital that the principle of the presumption of capacity is adhered to when assessments of capacity are being made. Assumptions must not be made about lack of capacity to make a particular decision simply because someone is older, is living with dementia or is frail.

Just as it is a key principle of the MCA that capacity should be assumed, in our view there should be a similar presumption of liberty. Any form of restrictive care should only be sanctioned as a measure of last resort. Too often at the moment it is the first. Decision making must always seek to maximise capacity and independence.

Additionally we would like to see an explicit reference to the need for the scheme to be truly person centred and able to meet the needs of people as individuals.

CHAPTER 4: THE SCOPE OF THE NEW SCHEME

The consultation paper acknowledges that the extension of the new scheme into family and other domestic settings would be a contentious step. We acknowledge that there may be individual circumstances in which the safeguards of the scheme would be justified and beneficial; however from our perspective this needs to be done in a way that first and foremost makes sense to older people and their families. In the time available to respond to this consultation it has not been possible to make a comprehensive assessment of older people's views on this sensitive matter but we sense that at least some will resist having their homes labelled as 'gilded cages', despite the protections such a label may afford them. We recommend that further detailed work is done to engage stakeholders on this issue before any decision is taken to proceed along these lines.

CHAPTER 6: SUPPORTIVE CARE

The low threshold for deprivation of liberty established by *Cheshire West* may mean that in reality there would only be a small gap between the supportive care and restrictive care and treatment schemes proposed. In our assessment there are likely to be few older people who lack capacity to make decisions about their accommodation whose care arrangements do not involve a substantial degree of supervision and control, taking them directly into the scope of the restrictive care and treatment scheme. Given this, we question whether, for this group of people, the introduction of a two-tier scheme (or indeed three-tier, as deprivations of liberty will continue to have to be identified within the restrictive care and treatment scheme) is proportionate given that one of the key objectives

of reform is to simplify the process. While there may be theoretical advantages to the supportive care scheme in terms of securing greater compliance with the MCA, this could perhaps be better achieved through other means, such as a greater focus on this area within monitoring and inspection regimes.

CHAPTER 7: RESTRICTIVE CARE AND TREATMENT

Definition of restrictive care and treatment

The consultation asks a number of questions (Qs. 7-4 – 7-5) about the situations in which restrictive care and treatment ought to apply. Generally we support the approach of providing a non-definitive list of circumstances that would constitute restrictive care and treatment as we feel that it is preferable to retain some measure of discretion. This is because it will in large measure depend on individual circumstances. We would reiterate the consultation's assertion that a person's compliance or lack of objection is not relevant to the determination of whether care or treatment is restrictive or amounts to a deprivation of liberty.

Best interests decision making

Best interests assessments are often presented as definitive whereas in reality they are highly arbitrary. The nature of the decisions that are being made is very heavily value-laden but as these will differ between individuals so will the outcomes. Given this, it is essential that best interests decision making gives priority to an individual's wishes and feelings. It also highlights the need for a high degree of supervision and oversight (for further detail on this point see the answer to Q.7-19 below).

We are concerned that in evaluating the risk of harm to the person much greater emphasis is often placed on physical harm rather than mental harm. It is important that decision makers take into account that harm that may be inflicted by overriding someone's wishes and feelings. Furthermore insufficient attention is paid to the magnitude of harm. It is neither possible nor desirable to eliminate all risk via the use of safeguards.

An issue that is frequently raised with us by professionals is the difficulty of identifying 'less restrictive' options to residential care because of the funding restrictions within the social care sector. If someone who has capacity made the decision to leave residential care and return home they would likely be offered some level of home care to facilitate this (albeit at a level that may not fully met their needs), it could therefore be deemed discriminatory that someone lacking capacity is not usually given this option.

The question of what role the court should play in these situations is evidently a difficult one as it is not the role of an unelected judge to dictate to a public body how its resources should be allocated. However while it may not appropriate for judges to make orders compelling public bodies to provide alternative services, in our view they should have a power to veto arrangements that are manifestly not in a person's best interests and send the public body back to the drawing board.

Question 7-7 asks whether the restrictive care and treatment assessment should first require a best interests assessment to determine if receiving the proposed care or treatment is in a person's best interests, before deciding whether it is necessary to authorise restrictive care and treatment. We agree that this is a more logical process and provides greater scope for consideration of the potential impact of a decision on someone's human rights in the round, rather than immediately focusing in on their article 5 right.

Question 7-19 asks whether there should be additional oversight of the role of the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) and a right to request an alternative assessment. As set out in the consultation document the role of the Approved Mental Capacity Professional (AMCP) would be to act as an independent decision-maker on behalf of the local authority (LA), with the LA required to ensure that assessments are 'duly made'. In our view this 'light-touch' approach to supervision of the AMCP role is insufficient, particularly given the wide variation in the quality of current best interests assessments. We have received worrying reports that the quality of assessments has fallen as the numbers being requested post *Cheshire West* have risen.

CHAPTER 8: PROTECTIVE CARE IN HOSPITAL SETTINGS AND PALLIATIVE CARE

Overall we support the proposal for a separate scheme tailored to hospital and palliative care settings. As the paper acknowledges there is often limited time available for decision making in these circumstances and it is essential that the scheme allows professionals to act quickly and flexibly, particularly in the context of end of life care. It is imperative that the level of bureaucracy required to comply with the scheme remains proportionate to the positive benefits that the safeguards can offer.

We stress the desirability of joint decision making about protective care in a hospital context, comparable to the multidisciplinary team approach that is taken to making decisions about NHS Continuing Healthcare. As noted above best interest decisions, particularly in a health context, involve making complex value judgements and a multi-disciplinary team approach is one way of reducing some of the inevitable subjectivity in the process.

We echo the consultation paper's recommendation that advance decision making should be given a more central role in hospital and palliative care. Although this can be a sensitive subject, more effective publicity of advance decision making, including via GPs, social workers and solicitors, may help to facilitate this. Some organisations, including Age UK, are already doing this.

CHAPTER 9: ADVOCACY AND THE RELEVANT PERSON'S REPRESENTATIVE

The proposed scheme positions access to advocacy as a key safeguard, with an advocate being instructed for all those subject to protective care. While we strongly support the intention to broaden access to advocacy we are concerned that the resource implications of this are vastly under-estimated in the consultation paper. Despite the existing rights to independent advocacy under the MCA and now also the Care Act 2014, it can be very

difficult to access. It therefore seems doubtful that current advocacy services would be able to meet additional demand without significant additional resources.

The Law Commission expresses a preference for replacing Independent Mental Capacity Advocates (IMCAs) with a single role of Care Act advocates and appropriate persons to avoid duplication. While reducing the number of individuals who are involved in an older person's care is logical and desirable, concerns have been expressed by advocates working for IMCA services provided by local Age UKs that it could be detrimental to the quality of provision as the expertise required to provide Mental Capacity Act/DoLS advocacy is markedly different to that required for Care Act advocacy.

The consultation paper also proposes to maintain the role of the relevant person's representative for people subject to restrictive care and treatment. In cases where an advocate has been appointed, this would help to ensure that the important role of the family, friends or carers is recognised. However, it is not proposed to maintain the paid representative role as where there is no person suitable to act as the representative, an advocate should be appointed. We support this approach.

CHAPTER 11: RIGHT TO APPEAL

We are sympathetic to the proposed recommendation that any restrictive treatment and care decisions should initially be challengeable in a specialist tribunal, rather than in the Court of Protection. In particular we agree that the diversity of training of a tribunal's members, its ability to bring about the individual's participation and the flexibility and informality of its processes would be advantageous. In addition a locally based tribunal has the potential to increase transparency and accountability and also drive issues of wider workforce training and best practice.

We understand the concern expressed that the tribunal would, at least initially, lack the considerable expertise that has been developed in the Court of Protection and may result in a lower standard of decision making. To mitigate against this risk it is essential that the introduction of a tribunal system is adequately resourced to include adequate training for members, and not viewed primarily as a means of costs reduction.

CHAPTER 12: SUPPORTED DECISION-MAKING AND BEST INTERESTS

In the view of the Convention on the Rights of People with Disabilities (CRPD) Committee, systems of 'substituted decision-making' of which the MCA framework is one, deny legal capacity and should be replaced with systems of supported decision making. The Law Commission's position is not to take an overly rigid view of the CRPD and instead to aim to ensure that the proposed scheme does everything possible to give effect to the wishes of the individual. To aid this it is proposed that the MCA is amended to give greater weight to an individual's wishes and feelings in a best interest decision. We support this approach as a welcome step towards the goal of a workable system of supported decision making.

It is worth noting that the line between capacity to make a decision and ‘wishes and feelings’ is in many ways an artificial one. There will be situations where a person is assessed not have capacity to make a decision based on their ability to retain and weigh complex information but does have capacity to make a decision about how they wish to live their life. For example someone who does not wish to move into a residential care home might not have the capacity to understand fully the consequences of not doing so but will have capacity to decide they want to remain in their own home. In such cases the individual’s capacity to make decisions they can make is often overridden, and the desire to remain in their own home relegated to the status of a ‘wish or feeling’.

CHAPTER 15: OTHER ISSUES

Questions 15-7 and 15-8 concern the current law on the reporting of deaths to the coroners. They ask whether it is satisfactory and if the coroners should have a power to release the deceased’s body for burial or cremation before the conclusion of an investigation or inquest.

Age UK has been contacted by a number of bereaved relatives whose loved ones’ deaths in care homes have had to be reported to the local coroner in these circumstances. They have told us that they have found this experience to be distressing and undignified. While guidance from the chief coroner has clearly set out that in cases where the death is uncontroversial the inquest may be a ‘paper’ one without witnesses having to attend or requiring a post-mortem, adherence to this guidance appears to vary widely across the country. In light of these observations we support the proposal to amend the Criminal Justice Act 2009 to provide that inquests are only necessary into deaths of people where the coroner is satisfied that they were deprived of their liberty at the time of the death and that there is a duty under article 2 to investigate the circumstances of the death.

Question 15-9 asks whether people should be charged for their accommodation when they are being deprived of liberty in their best interests – and whether there any realistic ways of dealing with the resource consequences if they are not charged.

We share the Joint Committee on Human Right’s concerns that the current situation could give rise to inequalities between different groups of people deprived of their liberty and engage article 14 ECHR. In order to address this we reiterate our view that the most important thing to focus on is ensuring that deprivation of liberty under the MCA is only authorised as a matter of last resort. If such an approach can radically reduce the numbers of those for whom an authorisation of deprivation of liberty is appropriate then the resource consequences of removal charges for their care would be more limited.