



advice and support for older age

**Independent
Age**

The Law Commission

Mental Capacity and Deprivation of Liberty: A Consultation Paper

Independent Age submission

2.11.2015



About Independent Age

Independent Age is a growing charity helping older people across the UK to live more independent, fulfilling lives.

Founded over 150 years ago, we are an established voice for older people and their families and carers, offering free advice and information and providing services, such as befriending, to promote wellbeing and reduce loneliness.

In addition to this, we use the knowledge and understanding gained from our frontline services to campaign on issues that affect older people, like poverty, loneliness and carers' rights.

For more information, visit our website www.independentage.org

Speak to one of our advisers for free and confidential advice and information. Lines are open Monday to Friday between 10am - 4.30pm. Freephone 0800 319 6789 or email advice@independentage.org

Independent Age is also a member of the Care and Support Alliance: a consortium of over 75 organisations that represent and support older and disabled people campaigning to keep adult care funding and reform on the political agenda.

Registered charity number 210729

Introduction

Independent Age welcomes the proposed new approach to safeguarding as a sensible and well-considered replacement to the system of Deprivation of Liberty safeguards (DoLS).

10 As the consultation acknowledges, in recent years the DoLS system has been the subject of severe criticism from Parliamentarians, the judiciary and the health care sector. As a House of Lords committee concluded in 2014 the law is not 'fit for purpose' and we believe it is not delivering the safeguards it needs to for older people and their families. Furthermore, the 2014 ruling by the Supreme Court, the so-called Cheshire West case, has widened the definition of DoLS creating considerable added strain on the legal system.

20 At a time when our society is rapidly ageing and many more people may experience reduced mental capacity through dementia and other health conditions, it is essential that we have proper safeguards for authorising the limitation of adults' liberty. We need a system that can authorise care and treatment for adults that are not able to consent to this treatment being put in place, and crucially, the system needs to accord with existing human rights legislation. In this regard we are pleased that the consultation takes account of existing legislation, specifically the Mental Capacity Act and the Care Act, in its attempt to simplify the law.

Although we accept care staff in many cases display limited knowledge of the Mental Capacity Act, we believe that the consultation is right to work from the principles underpinning the Act. This will still make the new legislation more familiar and comprehensible to many people in the sector.

30 We hope that over time a familiar language will emerge relating to principles of autonomy and empowerment, which both professionals and families will feel confidence using. After all, we agree with the Commission that the DoLS are 'not meaningful for disabled people and their families'.

Protective Care

- 40 • *Protective care* is intended to deliver improved health and care outcomes, whilst removing unnecessary bureaucracy and ensuring compliance with human rights law. It establishes different approaches in different settings, including hospitals, care homes, supported living and shared accommodation, and in some cases, family and other domestic settings. It would apply to people aged 16 and over¹.
- Broadly speaking, *protective care* has three parts: **the supportive care scheme**, the **restrictive care** and treatment scheme and the **hospitals and palliative care scheme**².
- **Supportive care** is designed as a protective outer layer to the system, which would operate far more broadly than DoLS. It is designed to provide

¹ Outline of the proposed protective care scheme, Law Commission, 2015

² Ibid

50 protection (mainly by way of additional advocacy and emphasis on care
planning) for those in care homes, supported living or shared lives who
lack the capacity to decide on their care and accommodation. It is
especially aimed at ensuring that adults don't necessarily require
deprivation of liberty authorisation except where it is unavoidable³.

- **Restrictive care** is the aspect closest to the current DoLS scheme but is framed more widely to ensure that it covers more people, across care homes, supported living and shared lives (including domestic settings). The safeguards include increased provision for advocacy, which will be the responsibility of the Approved Mental Capacity Professional (AMCP)⁴.
- **A separate hospital scheme and palliative scheme** will mean a doctor would be able to authorise a DOL for up to 28 days, with certain safeguards in place, before a referral can then be made to an Approved Mental Capacity Professional in accordance with the **restrictive care** scheme⁵.

70 We welcome the Law Commission's emphasis on a scheme that both provides specific safeguards from abuse but also aims more broadly to achieve improved benefits and outcomes for persons who experience restrictive care. We especially support the plans to engage Article 8 of the European Convention on Human Rights, relating to private and family life, and not just the narrow focus of Article 5 on the right to liberty, which was the exclusive focus of the DoLS.

80 We are also pleased that the new scheme is designed to prioritise that prevention in order to reduce the need for more restrictive forms of care in future. Similarly, we support the new scheme of Protective Care maximising the use of less restrictive approaches to safeguarding where this is appropriate, in a way that is consistent with the Mental Capacity Act. We also support the change in name from Deprivation of Liberty Safeguards (DoLS) to Protective Care to reflect the more positive principles of the new approach in policy.

90 We fully support proposals to reduce the levels of bureaucracy and complexity currently involved in DoLS. From our experiences on our advice service we agree with a view expressed in the consultation document: that Deprivation of Liberty is seen as a 'technical legal solution to a technical legal problem and not something that will benefit the relevant person in any tangible way'. Most damaging of all we believe the current DoLS scheme doesn't obviously get viewed as having anything to do with the quality of care the service user experiences.

We agree that the new scheme of Protective Care should apply to hospitals, care homes, supported living, shared lives and domestic accommodation. As our population ages and care needs become more varied it is only right that such a scheme takes account of the different settings in which a person receiving care may experience restrictions on their freedom. As a result, we endorse the proposal to introduce a system of 'supportive care' for people who lack capacity

³ The Law Commission Proposals for Deprivation of Liberty, Browne Jacobson LLP, 2015

⁴ Ibid

⁵ Ibid

100 living in a care home, supported living and shared lives accommodation. We agree with the 'more streamlined scheme ' proposed for hospital and palliative care settings including the proposal to grant doctors the right to authorise a Deprivation of Liberty for 28 days following initial emergency treatment. We strongly support the subsequent appointment of a Responsible Clinician and the Local Authority being made aware of the DOL and the potential need for the Approved Mental Capacity Professional to authorise the extension of the DOL if the 28 day limit is exceeded.

Supportive Care

110 We are encouraged by the Law Commission's proposal to introduce 'a protective outer layer' of protection for people living in, or moving into, a care home, supported living or shared lives accommodation'. We believe that the distinction between those people who qualify for DoLS and those who do not qualify means that some people on the one hand experience a very complex system. Whereas other people who fall short of DoLS, currently receive no support. We therefore support the tiered approach to Supportive Care and Restrictive Care. We hope that the new scheme of Supportive Care will prove successful in overcoming the criticism of less restrictive forms of care under the present system, for example criticisms that have been made by the Care Quality Commission.

120 As Supportive Care is designed as 'a preventative set of safeguards' for people who are not yet subject to restrictive forms of care, the proposal that the assessment for the new scheme can be undertaken by 'anyone that the local authority thinks is appropriate, including social workers or nurses already working with the person' is, on balance, fair.

130 The Law Commission is right to suggest that an assessment should in most circumstances have taken place under others forms of legislation, for example, the Care Act 2014. The Supportive Care system could therefore be integrated within other assessment frameworks. The Care Act is a very recent piece of legislation but concerns have already been raised by a number of organisations regarding its successful implementation. Taking this into account, the first phase of the Care Act reforms should be closely monitored to ensure that the assessment processes being implemented as part of the Care Act 2014 could in fact accommodate the proposals under a new Supportive Care scheme.

140 Furthermore, the consultation specifically refers to circumstances in which self-funders might find themselves subject to safeguards following the introduction of a cap on care costs and support they may then go on to receive from Local Authorities.

As the second phase of the Care Act reforms have now been postponed until April 2020, we would urge the Law Commission to give special consideration to the way in which self-funders could in future be protected under restrictive forms of care. If the proposals set out in the Law Commission consultation are taken forward, the Government will need to carefully monitor the impact of the Supportive Care scheme to make certain that the care and support system can cope with additional demand.

150 **Advocacy Services**

We welcome the recommendation that a Supportive Care plan would automatically involve an independent advocate or an appropriate person to be assigned in all cases. The Local Authority would have the discretion to appoint an Approved Mental Capacity Professional (AMCP) to oversee the case.

160 In the consultation the Law Commission states its belief that existing health and social care legislation, principally the Care Act and Mental Capacity Act, already provide for the delivery of advocacy services which could in future go on to accommodate new duties under the Protective Care scheme.

Despite existing legislation providing for advocacy services, as the new scheme places such high importance on provision of advocacy, we believe that relevant Government Departments will need to make adequate resource provision for advocacy at a time of severe financial pressure on local government.

Furthermore, the employment and training of AMCPs will also be essential to realising these ambitions.

170 We support the new scheme keeping under review 'the person's health and care arrangements, and whether a referral to the restrictive care and treatment scheme is required'. Similarly, we agree that the care plan should detail any restrictions imposed on the person and record their capacity and decisions based on best interests. We like the fact that the proposed scheme is appropriately concerned with 'supported decision making', which the current system typically neglects.

Restrictive Care

180 We welcome the second, more restrictive level of safeguards within the proposals for a new system of Protective Care. The examples the Law Commission has set out, illustrating when a restrictive care authorisation would be necessary, seem appropriate. We especially support robust safeguards, beyond those included under Supportive Care, for people who experience significant restrictive care. We agree that the new scheme applying to people 'who lack decision-making capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain' is appropriate and consistent with the Mental Capacity Act.

190 We support the proposal that in effect the Best Interests Assessor becomes the new role of an Approved Mental Capacity Professional (AMCP). We agree that this change should be achieved without significant administration or expense. We support this proposal, as we believe that this new role will reduce levels of bureaucracy within the current system and create a single point of contact for people and their families who are subject to this authorisation.

200 We are in full agreement that this role requires any person occupying it to undergo education and training leading to full qualification and continuing professional development. We also welcome the Law Commission's decision that professionals already working with the individual can undertake assessment for the restrictive care and treatment plan, as long as it is properly overseen by the

Approved Mental Capacity Professional (AMCP). We agree with the proposal on account that it will allow the AMCP to concentrate on cases which would benefit from independent oversight; particularly when a disagreement regarding restrictive care emerges between professionals and family members. Similarly, we support the proposal that regular reviews of restrictive care take place involving family members. We know that this can cause much distress for the families of older people and the availability of independent expertise will be most welcome. Despite the burden on the Court system under the current system we support the proposal for the right to appeal to a tribunal with a further right of appeal to the Court of Protection or the Upper Tribunal. We believe this is necessary for there to be confidence in the new system.

We support the decision that once authorisation has been granted that a different AMCP keep the case under review. We believe that in the interests of impartiality this is the right decision. We welcome the creation of this role as a means of introducing greater independence into the process of how restrictive care orders are authorised and kept reviewed over time. We agree with the view expressed in the consultation that it is not appropriate for a Local Authority to oversee authorisation of DoLS while remaining responsible for commissioning of care services. We do, however, support the Local Authority remaining responsible for advocacy services and for appointment of the AMCP. We also endorse the decision by the Law Commission to provide the AMCP with the right to authorise a 7-day restrictive care and treatment authorisation in urgent cases.

In order to authorise the Deprivation of Liberty we agree that the AMCP must be provided with objective medical expertise independent of the detaining institution. We hope that this proposal will give older people and their families' greater confidence in the authorisation process. We also support the proposal that any deprivation of liberty in a domestic setting also be subject to the same safeguards as under Restrictive Care. This will mean the authority to award the deprivation of liberty resides with the AMCP. We recognise the difficulty in achieving a workable solution to such cases but believe that the proposal is sensible and will reduce pressure on the Courts.

For more information on this response, please contact Adrian McDowell at policy@independentage.org