A cross-sector representation of issues and concerns relating to the Mental Capacity (Amendment) Bill HL
Summary

The Deprivation of Liberty Safeguards (DoLS) need reform. The Mental Capacity (Amendment) Bill HL introduces the Liberty Protection Safeguards (LPS) through amendments to the Mental Capacity Act 2005. It aims to provide the legal safeguards required under the European Convention on Human Rights for people who lack the capacity to consent to their care or treatment.

We share the consensus that reform is necessary. However, significant areas of concern to social care providers in relation to LPS remain even after being discussed during the first day of the Lords Committee Stage (5 September 2018). These include:

- A lack of focus on the face of the Bill on the views of the person being assessed, the importance of their wishes, and the necessity to make paramount their views and to consult both them and those who care for them and know them best.
- The likelihood of conflicts of interest caused by placing LPS assessment responsibilities on registered managers. Proposed new responsibilities include identifying objections, arranging assessments, the process for deciding whether an appropriate person and/or an advocate (IMCA) needs to be appointed and who should act as the appropriate person.
- The conflict of interest and the necessary objectivity and independence that care home managers will have placed on them.
- Even if the conflict of interest could be mitigated, which we do not consider it can be, the cost to, and capacity of, providers to fulfil this responsibility, including new workforce requirement have been ignored.
- The implications of transferring responsibility for dealing with the backlog of DoLS assessments from local authorities to providers.
- Potential expansion of the role of regulators in relation to LPS in care homes and other community settings.
- Confusion arising from the creation of three disparate systems for managing the LPS, in care homes, community care settings and hospitals.
- Lack of clarity about how providers should balance the best interests of the individual against the need to protect others from risk when they conflict.
- Ongoing concerns about the lack of definition or acceptability of the term ‘unsoundness of mind’.
- Significant concerns about the lack of consultation with the sector.

We are calling on Government to go back to first principles and to align the Bill with the recommendations of the Law Commission’s extensive review of this topic.
**1. Liberty Protection Safeguards**

The Mental Capacity (Amendment) Bill HL is intended to reform the process for authorising arrangements which enable those who lack capacity to consent to care or treatment to be deprived of their liberty for that purpose. It will affect the human rights of over 300,000 citizens in England and Wales with conditions such as dementia, learning disabilities and brain injuries. The arrangements created by the Bill will replace the existing Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS).

<table>
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<tr>
<th>Summary of key changes</th>
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<tr>
<td><strong>From</strong></td>
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<tr>
<td>Deprivation of Liberty Safeguards</td>
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<td>Apply to people with a ‘mental disorder’.</td>
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<td>Apply where there is a risk of harm to self.</td>
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<td>Apply in hospitals and care homes.</td>
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<td>Based on the person’s best interests and on whether the arrangements are necessary and proportionate relative to the likelihood and severity of harm to that person.</td>
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<td>Supervisory bodies are local authorities and, for hospitals in Wales, Welsh health boards.</td>
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<td>Six assessments arranged and commissioned by the local authority carried out by specialist professionally qualified staff.</td>
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<td>Local authority drafts and grants a setting-specific authorisation of arrangements giving rise to a deprivation of liberty.</td>
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2. Issues for the provision of care

2.1 Introduction

Across the sector there is a general consensus that the existing DoLS arrangements are unwieldy and should be replaced. However, there are widespread concerns that aspects of the current proposals erode the safeguards that currently protect people who lack capacity to make decisions about their care and treatment, for instance through the lack of weight given by LPS to the views of the person being assessed and their family. This may sit uncomfortably in services with a culture focussed on respecting the rights and choices of people receiving support. It also reinforces those cultures which ignore individual choices without reference to P (i.e. the individual) and others.

The Bill's Committee Stage in the House of Lords quotes the view of the Association of Directors of Adult Social Services (ADASS), citing similar concerns from the Care Provider Alliance (CPA) and Care Quality Commission (CQC):

"Whilst registered care providers have previously been required to assess individuals, to determine that they can meet the person’s needs and to undertake care planning, they have not been required to assess to protect people’s liberty. Planning Care and assessing whether deprivation of liberty is in a person’s best interest when they are unable to decide for themselves are very different things. ADASS therefore believe this to be a new activity, requiring new skills and resources. We have real concerns relating to a) care home capacity, b) care home staff competence, c) perverse incentives and potential conflicts of interest, d) additional cost (for training and additional capacity) and e) whether and how such costs will be resourced."

These concerns are reinforced by those who represent people who use care services, residents and relatives and carers.

2.2 The rights of the person

Disabled people and their families are especially worried that there is no requirement to consider the persons own wishes. This would be enough of a concern if there was an independent assessor. Without a skilled advocate, as a basic right, some disabled or older people have expressed concerns that their basic human rights could be eroded.

The issue of who is consulted, what views are paramount and who can represent the person detained, was of grave concern. One parent of a young adult with learning disabilities and autism said:

"Families still have precious little influence in the care of their loved ones. Access to the Courts is expensive and time consuming – and providers know that. These

1 https://hansard.parliament.uk/Lords/2018-09-05/debates/B2A2668D-7BEC-4629-9FD1-
amendments will make a poor situation even worse and make abuse of power by providers much more likely.”

2.3 Conflicts of interest

There are significant concerns about the conflict of interest associated with placing LPS assessment responsibilities on registered managers. These responsibilities include:

- Identifying that deprivation of liberty exists or may arise, in contrast to restrictions or restraints which are lawful, if approached from a human rights perspective within the MCA (see MCA ss. 4, 5 and 6).
- The skills involved in identifying possible objections, which may well be by a non-verbal person. In some cases people will not have family or carers representing their interests.
- Commissioning assessors, with no set criteria except having identified that they have the ‘appropriate skills’ (which need definition).
- Deciding whether an advocate (IMCA) needs to be appointed and who should act as the appropriate person.
- Arranging a pre-authorisation review.
- Drafting a legally compliant authorisation document for the attention of the local authority.

The Bill puts responsibility on the registered manager for the LPS application, including the requirement that they identify the right representation and support for the person from an appropriate person (who will often be a family member) and/or IMCA and identifying who that appropriate person should be for those who lack capacity to request it for themselves. These and similar new responsibilities create an unacceptable conflict of interest for providers. The registered manager, who is usually responsible for maximising service take-up, will also be responsible for determining whether the person is objecting to the placement and whether the placement is right for them (and identifying alternatives). This manager is likely also to be responsible for ensuring economically viable staffing levels and ratios: the proposals expect them to add to their staffing and administrative costs by recommending less restrictive options within a care plan and encouraging the use of independent advocacy to challenge arrangements. These proposals are clearly open to the creation of perverse incentives towards finding similar restrictions appropriate for many dissimilar users of services, and minimising opportunities for external scrutiny, whether by the new Approved Mental Capacity Professional or an advocate.

By the same token, it is unclear how providers can protect themselves from allegations that they are depriving an individual of their liberty, when this person may not be appropriately placed and thus more likely to require restraint or restriction than if somewhere else, in order to fill a service vacancy. Managers who have acted with integrity may face unnecessary challenge because they are working in a system which is fundamentally compromised.
2.4 Costs, capacity, training and skills

We have concerns over how well the impact on services has been considered, including the consequences on the quality of support provided to people who use services.

- The Government has costed the delivery of LPS at £0 to social care providers.\(^2\) This assumes that there is no additional staff time requirement or any need for staff to acquire further skills, that care homes will already possess all the information needed and that it is of sufficient quality and quantity and in the appropriate form to support LPS applications. The only learning requirement will therefore be a half day for the registered manager to make themselves familiar with the new policy. While the impact assessment identifies costs for training doctors and social workers, there are no identified training costs for registered managers.

- This is clearly unrealistic. These inappropriate new responsibilities will impose a resource burden on providers. Providers do not generally gather and assess evidence of ‘unsoundness of mind’ or formally document tests of necessity and proportionality. A half-day to become familiar with the LPS process does little to prepare registered managers to undertake robust, high quality assessments which may ultimately be challenged in court. Some larger organisations may decide to implement training programmes and quality control of assessments at their own expense, but there would be a significant cost attached to this and it is certainly not feasible for smaller providers.

- Furthermore, in a sector where there is currently a 23% turnover in registered managers and 27% with care staff\(^3\) each service will need to be able to call on a number of people who can undertake LPS assessments in order to cover for turnover and absences. Given the vacancies within the sector training costs will be ongoing and highly resource intensive.

In reply to the high levels of concern reported in the House of Lords Committee stage on 5 September 2018 – by the Association of Directors of Adult Social Services, the Relatives & Residents Association, the Care Provider Alliance and many charities, as well as peers who expressed surprise at the sudden appearance of this enhanced role for care home managers, as they put it, ‘between the Law Commission’s draft bill and this Bill’ – Lord O'Shaughnessy on behalf of Government replied\(^4\):

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\(^4\) Hansard as cited, Column 1826 ff.
“Care home managers are already required to make applications and to consider capacity and restriction. Effectively, the new model recognises what they are doing but also allows for a further escalation to put to a responsible body the approved mental capacity professional, where required. That is not the case if it is already required. This is not an entirely new function that has been developed—rather, it is recognising actions that are already taking place and making sure that they are recognised while retaining proper opportunity for escalation as well as independent accountability.”

This appears to misrepresent the position under DoLS. For example, care providers are not now expected to have the knowledge and skills to decide whether someone is deprived of their liberty – it is part of the Best Interests Assessor’s professional role to decide whether deprivation of liberty is occurring or likely to occur. Currently, the care home manager simply has to consider whether there is a risk that restrictions in the care plan might amount to the ‘acid test’ as clarified in Cheshire West⁵, and complete a form asking for independent assessments to be commissioned by the local authority.

CQC guidance⁶ is clear that the provider is expected to request the local authority to commission assessments simply when it ‘appears likely’ to them that someone may be deprived of their liberty and no less restrictive care plan can easily be identified. The task of deciding on the legal status of the care in European Court of Human Rights (ECtHR) terms, as well as commissioning and evaluating assessments, is a far cry from this.

Indeed, it is a crucial element of the current best interests assessment – carried out by a trained and experienced professional – to decide both if there is a deprivation of liberty as clarified by the Supreme Court and also whether the proposed deprivation of liberty is, in practical terms, necessary to prevent harm to the person, and proportionate to the risk and seriousness of the identified harm to that person.

It is currently unclear, in the Bill, exactly what the ‘necessity’ and ‘proportionality’ criteria refer to. The entirely reasonable aim is to close an identified gap in the existing provision, with regard to the risk of harm to others from the actions the person lacking capacity, but it is essential to recognise the complexity of the demand on registered managers working in the sector.

- The tension in moving from assessment of the person’s best interests, within a test focusing entirely on their wishes and needs, to one balancing wider considerations of potential risk to others, will require complex and nuanced decision-making and information which is generally (that risks being) outside the manager’s expertise and experience.
- Care home managers are now to be expected to commission and evaluate, or even carry out, capacity assessments in a crucially important context – possible deprivation of liberty – although case law shows how complex and intricate such assessments can be.

⁵ https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf
• They are even to be expected to decide both on the nature of the ‘unsound mind’ affecting the person, and also on which legal framework – Mental Health Act 1983 or Mental Capacity Act LPS – is appropriate for protecting their rights when deprived of their liberty. In a care home, the role of the MHA is very limited, but it is worth noting that, under DoLS, only specific, highly trained and experienced professionals can currently carry out these assessments in care homes as well as hospitals. The proposals risk taking us back to hospitals unilaterally making decisions to restrict liberty.

• The care home manager has to identify whether the person is objecting: recognising objection can be complex and subjective for those with a conflict of interest and limited expertise.

• Similarly, the care home manager is now to be expected to decide when/if to ask the local authority (LA) to instruct an IMCA: this has explicitly fallen outside their responsibilities up till now, since only an LA or NHS body can lawfully instruct an IMCA. This again points up the issue of conflict of interest: why should a care home manager voluntarily bring in someone who may criticise their care plans, approach and priorities?

• Registered managers will be faced by real conflict of interest and are unlikely to have the requisite background or training to implement liberty-oriented practices without the important spur of independent assessment, as now, backed up by conditions where the best interests assessor (BIA) thinks this appropriate to lessen the impact of detention.

One of the immediate effects of introducing the LPS framework, is that it may transfer to care homes most of the work required to clear the present backlog of DoLS applications. This will create an acute short-term capacity issue for some providers.

3 The cost to, and capacity of, providers to fulfil this responsibility

As demonstrated, there are many taxing new roles expected of the registered manager. The training burden for them – and their deputies, replacements, and the reviewers required before submitting draft authorisations – cannot conceivably be met within half a day as suggested in the impact assessment. BIAs and DoLS medical assessors all have extra training built on top of their existing qualifications and experience: they all have mandatory refresher training annually.

4 Care Quality Commission (CQC) and Care Inspectorate Wales

It is clearly intended that the regulator will no longer be sent every authorisation though CQC is envisaged as keeping its requirement to monitor and report on how the new system will operate, as it currently does for DoLS (though no longer through a dedicated annual report, but in a far shorter chapter of its annual State of Care reports).

It appears from brief references in the Lords’ Committee Stage that CQC will be an essential part of ensuring that managers avoid conflict of interest and properly protect the rights of those using their services. If the great additional responsibilities discussed above become part of the role of a registered manager, it will be inevitable that detailed individual assessment processes must be checked and monitored during inspection visits by CQC in England and CIW in Wales. The infrequent pattern of inspections make this another unrealistic expectation.

Currently, the inspectors (who have no role to inspect the DoLS services provided by local authorities) limit inspection to ensuring that conditions, if set, are being complied with, that dates for requesting new authorisations are diarised and met, and that staff have a general understanding of the remit of DoLS. They explicitly do not read through and assess the documentation on which the authorisation is based.

In the proposed scheme, they will have to do this, to ensure, for example, that objection has been properly identified even if somewhat subtle, and that conflict of interest with other parts of the registered manager’s role have not swayed the assessment process.

The ensuing additional length of inspections in care homes will add significantly to the costs both of the regulator and of the provider, who will spend longer hosting inspectors and explaining their decision-making, rather than providing care services.

5 Deprivation of liberty in community settings

There is a lack of clarity over the extent to which LPS extends beyond care homes and hospitals to include obligations for providers of care to make authorisations and assessments in a wide range of settings including shared lives, supported living and domestic settings. If the obligations do extend, there are concerns related to the different processes that will apply in shared lives, supported living and domestic settings, as opposed to care homes, which include:

- Shared lives carers and supported living and homecare staff are not currently specifically written into the assessment process.
- In supported living, the provider of care and the provider housing may not be the same organisation.
- In both domestic and supported housing settings there may be multiple organisations providing care to different individuals.
- The impact assessment does not reflect the time commitment and cost of the new duties to providers; this could prove a barrier to entry of very small innovative providers to the market.
- The concept of deprivation of liberty for a person living in their own home is quite different to that of living in a care home or hospital, particularly if other individuals are living with the person whose liberty is being determined. Given that we cannot have the locking of external doors in a domestic setting regarded as a deprivation of liberty rather than a sensible precaution against burglary, the terms ‘unsound mind’, ‘necessary and proportionate’ must be clearly defined.
Many organisations manage both community and care home services. This means that the registered manager of a care home, has to get to grips with a far greater responsibilities for managing the deprivation of liberty assessment process, may simultaneously be the manager of a supported living or shared lives provision, where the rules are completely different.

Part 6 of the Bill makes provision for the appropriate authority to visit the place where arrangements giving rise to a deprivation of liberty are carried out. In the case of shared lives, or a family home, rather than a service location, the right to a private and family life of the shared lives carer must be respected alongside the need to protect the liberty of the person receiving support. CQC has always been clear that it has no rights to enter a private abode to inspect provisions and services. This potential problem must be clarified in legislation rather than left to the new code of practice, though examples of how it might impact service users could usefully be included in statutory guidance.

6 Risk of harm to others

Unlike DoLS, which is always based on the best interests of the individual, LPS may result in a person being deprived of their liberty solely where there is a risk of harm to others. Much greater clarity is needed about the circumstances in which authorisation will be granted to deliver care or treatment that may not be explicitly in the best interests of the person.

It is also questionable whether providers are well-placed to undertake an assessment in these circumstances. They are often not in a position to assess this type of risk (for instance a care home application due to domestic violence that is a consequence of a person's mental health), to identify whether less restrictive alternatives are available and therefore to make a judgement about the necessity and proportionality of the proposed placement. However, this is what the LPS proposals require them to do.

7 Terminology

7.1 Unsoundness of mind

The term ‘unsound mind’ has replaced ‘mental disorder’ to bring LPS into line with article 5 of the European Convention on Human Rights (ECHR) which relates to the right to liberty and, when this right is limited, to the right of appeal to a court within a clear transparent legal procedure.

However, there is a significant level of discomfort with this term which many people view as stigmatising and indeed offensive. Furthermore, this is not a term used in modern psychiatry so is likely to lead to debate, dispute and case law about which conditions are included or excluded. We echo the concerns expressed during the second reading of the Bill8:

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8 https://hansard.parliament.uk/Lords/2018-07-16/debates/DCE2DAC6-770A-42BB-ABD7-CB4ADB0D40EA/MentalCapacity(Amendment)Bill(HL)?highlight=mental%20capacity%20amendment%20bill%20committee%20stage#contribution-3498FB1B-1E16-47AE-B614-D016791C04C2 column 1102
‘Article 5(1) of the European Convention on Human Rights uses the phrase “unsound mind”. The same paragraph also talks about vagrants. It was first drafted in 1950, nearly 70 years ago. It is not used professionally now and the profession believes that it has no place in a piece of modernising legislation; it creates unease among individuals, advocates and the sector alike. Article 5(2) calls for a detainee to be informed of the reason they are to be deprived of their liberty. Rather than having to refer elsewhere, how much more straightforward would it be to have this in the Bill?

While being sympathetic to the requirement to align concepts with those in the ECHR, and indeed to the judgements of the European Court of Human Rights (ECtHR) we suggest that this cannot be assumed to include the use of outmoded and stigmatising terminology.

It was suggested in the Bill’s Committee Stage in the House of Lords that ‘any disorder or disability of the mind’ is a well-understood clinical descriptor and would be preferable to the suggested ‘unsound mind.’ The wider MCA refers to ‘an impairment of, or disturbance in the functioning of, the mind or brain’, and this should surely form the basis for finding an acceptable term for a mental disorder of a nature or degree to warrant depriving someone of their liberty.

7.2 The name ‘Liberty Protection Safeguards’

We appreciate that this title, together with ‘LPS’ as its acronym, does not occur in the Bill, and was adopted somewhat reluctantly by the Law Commission for the lack, as they put it privately, of any better suggestion.

The term is clearly to be preferred to ‘deprivation of liberty safeguards’ (DoLS), with its many negative and misleading connotations. But we share the concern expressed in the wide-ranging House of Lords discussion by Baroness Finlay that the inclusion of the word ‘Safeguards’ leads to confusion with the wider remit of adult safeguarding, which often has a far more risk-averse approach to the care of people who may lack capacity than the Mental Capacity Act. Baroness Finlay suggested that ‘With the confusion between safeguarding and deprivation of liberty, I wonder whether that is the right word and whether we should be talking about “liberty protection assessments” or something else.’

We support her wish to find a term that accurately reflects the MCA’s empowering ethos.

Conclusion

A great many organisations have supported the Law Commission throughout its careful, consensual deliberations to find a replacement legislative framework for DoLS. We concur with the desire to find a framework that gives the necessary protection for the rights of extremely vulnerable people who use services. We appreciate the thrust to lessen the costs and burden particularly on local authorities.

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9 Hansard as cited, column 1836
10 Hansard, as cited, column 1818
However, it is unacceptable simply to transfer those costs and burdens into the independent care sector as will happen should the care home proposals proceed unchanged. The sector is already under considerable strain, as discussed elsewhere on many occasions. These proposals would undoubtedly lead to many smaller providers leaving the sector, larger ones imposing considerable increases in fees to meet the increased administrative and ongoing training/management requirements, and an increased incentive towards risk-averse, restrictive care plans.

The current proposals risk predictable and avoidable damage to the human rights protections necessary when a person who lacks capacity is deprived of their liberty. We encourage further debate in the hope of finding a shared way towards, as suggested in the Bill’s Committee Stage in the House of Lords 11, a framework that is ‘clear, compassionate and contemporary.’

This document has been produced to inform the policy process. Nothing contained within it constitutes advice, and should not be relied on for legal or commercial purposes. Please direct queries in the first instance via email to research.policy@vodg.org.uk

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 Care Association Alliance
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 National Care Association
 National Care Forum
 National Dignity Council
 Shared Lives Plus
 Registered Nursing Home Association
 Relatives & Residents Association
 United Kingdom Homecare Association
 Voluntary Organisations Disability Group

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11 Hansard, as cited, column 1821