CIH briefing paper

Law Commission consultation on mental capacity and deprivation of liberty safeguards – impacts for housing

Summary

The Mental Capacity Act 2005 was introduced to protect and empower people who lack mental capacity to make decisions about the care and treatment they receive. The Deprivation of Liberty safeguards (DoLS) were introduced as an amendment to the Mental Capacity Act in 2007, to establish a process through which action in respect of care and treatment that involved deprivation of liberty could be authorised.¹

DoLS was intended to apply to action taken in care homes and hospitals, but a number of court cases (most notably the Cheshire West judgement[ii]) led to the extension of the process to interventions that deprived people without capacity of their liberty within supported living and community settings. At the same time as this expansion of its remit, the administrative process of DoLS was criticised for its complexity, and the increase of cases has led to calls for a significant review and simplification of the process.

Consequently the Law Commission developed the proposals considered in this paper, to establish an alternative system - termed protective care – which would encompass supported living, shared lives accommodation and family/ domestic settings, as well as care homes and hospitals. Protective care would encompass:

- **supportive care** in respect of people living in or moving to care homes, supported living and shared lives accommodation;
- **restrictive care and treatment** which would also apply in care homes, supported living, shared lives where care and treatment was becoming more restrictive and intrusive, and where deprivation of liberty occurs in family and domestic setting.;
- a scheme for short term interventions in **hospitals** which may include palliative care (not explored in this paper).
This paper explores the impacts of the Law Commission’s proposals for supported housing and housing with care models, and seeks comment on potential issues arising for housing. This is not a summary of the full paper which can be found here. Following the consultation the Law Commission will put forward recommendations and a draft Bill in 2016.

Please send comments to sarah.davis@cih.org by 30 October 2015.

**Law Commission proposals – Protective Care**

The system proposed by the Law Commission is broader in scope than the deprivation of liberty safeguards. Its intent is to be more in line with that of the Mental Capacity Act itself, which looks at being empowering for people, specifically:

- Maximising decision making capacity
- Focusing on the best interests of the person
- Taking least restrictive intervention

Hence the role of independent advocacy and support for the person lacking capacity is a key feature in the proposals. The proposals also include a stronger focus on the previously expressed wishes and feelings of the person in consideration of best interests.

It aims to be preventative by putting in place low level early actions that can help to prevent escalation to more restrictive interventions, and to improve outcomes by making the process easier to understand and apply for all concerned, including families and carers.

**Supportive care**

**Criteria:**

This would apply where people are vulnerable but not yet subject to a deprivation of liberty or other restrictive form of care and treatment. The proposal is that this would cover people who may lack capacity to consent to their living arrangements, and who are living in or moving into a care home, supported living or shared lives accommodation. It does not apply to family/ domestic settings.

It applies

- At the point of entry, the person lacks the capacity to consent to their living arrangements, for the purpose of being given particular care or treatment.
- If the person is already in the accommodation and their capacity declines in terms of assessing the impact of their accommodation on their care and health needs.
The definition of supported living arrangements referred to is that within regulations of the Care Act 2014:

- Premises which are specifically designed or adapted for occupation by adults with needs for care and support to enable them to live as independently as possible; and
- Premises which are intended for occupation by adults with needs for care and support (whether or not the premises are specifically designed for that purpose), and in circumstances in which personal care is available if required; however, this does not include adapted premises where the adult occupied those premises as their home before the adaptations were made.

[Care and Support and After-Care (choice of accommodation) regulations 2014]

**Safeguards**

The supervising body overseeing supportive care is the local authority, which would arrange for an assessment of a person’s capacity to consent to their living arrangements. This could be done by a nurse, social worker or other professional already working with the individual. It could form part of an existing assessment process – such as that under the Care Act 2014 – as long as this was clear and explicit.

The supervising body would also need to keep the case under review and monitor compliance with any restrictions attached.

The assessment would be based on the definition of mental capacity under the Mental Capacity Act – ‘people who lack decision making capacity as a result of an impairment of or disturbance in the functioning of the mind or brain’

Where capacity is assessed as lacking, an assessment of the person’s best interests is undertaken. The care plan should be clear and explicit on lack of capacity, the best interests of the person, the restrictions agreed, and the legal arrangements under which living accommodation is provided.

The supervising body can appoint an independent advocate or appropriate person to help the individual to access the review and appeals process.

The supervising body might also appoint an Adult Mental Capacity Professional - AMCP. (Under the Mental Capacity Act, this is the best interests assessor which the proposals suggest should be a key role and renamed to reflect the revised role)

Registered care providers to be required to refer an individual for an assessment where the person meets relevant criteria.
Restrictive care and treatment

This is the element of protective care that more directly replaces the current DoLS safeguards although it focuses on restrictions and intrusiveness rather than solely deprivation of liberty. It aims to balance the deprivation of liberty with the right of individuals to a private family life.

Criteria:

It applies to people who lack capacity to consent to care and treatment, and who are living in or moving into care homes, supported living, shared lives and are receiving some form of restrictive care and treatment.

It also applies to a person who is deprived of their liberty in a family/domestic setting.

Restrictive care and treatment includes (not exhaustive):

- The person being subject to continuous or complete supervision and control
- The person not being free to leave

[NB The above constitute the acid test for deprivation of liberty, including in a domestic environment]

- Not allowed either to leave the premises where placed unaccompanied (including the requirement to have permission to leave) or unable to leave without assistance due to physical impairment.
- Barriers are used to prevent the person to access certain areas of the premises [would this include the use of technology to track a person’s movement or alert staff to their movement to leave the premises?]
- A person’s actions are controlled (whether or not within the premises) by physical force, use of restraints or the administration of medication for purposes of such control – other than in emergencies
- Any care and treatment to which the person objects verbally or physically
- Where there is sufficient restriction on the individual’s diet, clothing, contact with/ access to community, individual relatives, carers or friends. This includes having to ask permission, other than generally applied rules, e.g. visiting hours.

Safeguards

The local authority is required to appoint an Approved Mental Capacity Professional (AMCP) to act as independent decision-makers on behalf of the authority.

Where a deprivation of liberty is involved the local authority and health boards are the detaining authority.
The AMCP’s responsibility will be:

- to oversee the assessment process
- to undertake or arrange for best interests assessment
- to set out the duration of authorisation (not to exceed 12 months) and any conditions to it
- to obtain medical evidence to support deprivations of liberty explicitly.

The care plan is the vehicle to log and authorise the restrictive care and treatment and any deprivation of liberty.

The role of the AMCP is also central to reviewing and monitoring, although it should be a different professional to the one authorising the restrictive care and treatment. That AMCP should ensure:

- Monitoring and reviewing of the arrangements
- Compliance with the relevant legal requirements
- Appropriate consideration given to supported decision making by the person affected
- The appointment of an advocate or appropriate person to be involved with the person’s care.

The person, family member or advocate/appropriate person can request a review, and the local authority or AMCP must do so where the request is reasonable.

Registered providers of care should be required to refer a person (including those who are self funding) for assessment if the individual meets the criteria. [Should housing providers also be able to/required to make referrals?]

**Mental capacity and tenancies.**

The protective care system potentially involves someone moving into accommodation who may lack capacity to consent to their living arrangements.

In such cases it is often general practice for housing providers to seek a signature on the person’s behalf, such as through a Lasting Power of Attorney or Court of Protection. The Law Commission is concerned that this might cause problems for the person in question. It argues that common law rules provide approaches that seek to balance the needs of the person lacking capacity to protection with the impacts for the landlord, and as such, that unsigned tenancies are not a significant risk. It does stipulate that the care plan should be used clearly to record the basis on which the accommodation has been arranged.

It invites comment on what changes, if any, might be needed to provide greater certainty for the person lacking capacity and for the landlord, and what difficulties arise where a done or deputy signs on behalf of the person, and how these might be addressed.
Regulation.

Any deprivation of liberty where the state agrees requires oversight – the regulator of DoLS is the Care Quality Commission. Under the protective care system, the Law Commission proposes that the CQC should be the regulator to monitor restrictive care and treatment, including where this takes place in supported living settings and in domestic/family settings, and invites comment on this.

Charging for accommodation where the person is deprived of their liberty

The Law Commission raises the question about fairness of charging someone for accommodation when they have been deprived of their liberty, and the accommodation has been arranged by the state. This seems to be applied particularly to care homes and the comparison is drawn with detention under the Mental Health Act (paragraphs 15.71-15.73). Comments are invited about this, and there may be significant implications for supported housing schemes if alternative arrangements might be free of charge.

Questions:

The Law Commission invites views on:

- whether the scope of protective care should extend to include this range of settings, and if the definition of supported living as above is appropriate for the scheme?
- whether changes are needed to provide greater protection and certainty for people who lack capacity and their landlords in respect of agreeing tenancies, and what difficulties arise when tenancies are required to be signed by a done or deputy?
- the difference regulatory approaches that might be most appropriate to supported living and other domestic and family settings?
- mechanisms to refer people who may benefit from supportive care safeguards but who are not in receipt of care (who should make these, to whom – GP or local authority?)

In addition we would appreciate comments on the following to expand on/clarify these questions:

- Given that the introduction of the cap on care costs has been postponed, self funders may still fall outside of the scope of local authority involvement. What should the responsibility be for housing providers in terms of referral of residents they believe may be eligible for assessment and safeguards proposed under supportive care or restrictive care and treatment?
- How will the system impact on sheltered/retirement housing and supported housing where the focus is providing housing and support rather than care?
Will these be considered as family/ domestic homes and therefore excluded from supportive care?

- How clear is it in application to people who have chosen to move into their supported housing and then subsequently lose capacity?
- What are the implications for housing with care (extra care, etc) in particular with the different arrangements that exist in terms of who provides care (which may or may not be the housing provider).
- How can the housing provider ensure that care providers are taking appropriate action in respect of people’s liberty/ referrals for authorisation to intervene?
- What housing design or management practices might constitute restrictions on people’s liberty? Where these exist what actions have/can be taken by landlords to refer residents or change the potential restrictions?

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1. European convention on human rights establishes three elements to deprivation of liberty: the objective element of confinement in a restricted space for a non-negligible length of time; the subjective element that the person has not validly consented to that confinement; the detention being imputable to the state.

2. Cheshire West and Chester Council v P; the Supreme Court ruled that P was subject to continuous supervision and control and was not free to leave (the acid test of deprivation of liberty) and that the deprivation could occur in a homely environment as well as in an institutional setting if the placement was at the instigation of the state.