Response to the Law Commission consultation - Mental Capacity and Deprivation of Liberty

1.0 VoiceAbility: About us

1.1. VoiceAbility is an independent national advocacy and user participation charity which works to enable people who face disadvantage or discrimination to exercise their rights to be heard, to be equal and included in society, and to live free from abuse. We work with people who need the greatest support to realise these rights, including people with learning disabilities, autism, mental health needs, older people and people with physical and sensory impairments. In 2014/15 we worked with 24,765 people in over 70 local authority areas. Disabled people and carers play the majority role in the governance of our organisation and our work is directed by people who use our services.

1.2. We provide advocacy services required by statute and those which extend beyond the statutory provisions. Our statutory advocacy includes Independent Mental Capacity Advocacy (IMCA), which encompasses support in relation to the Deprivation of Liberty Safeguards, Independent Mental Health Advocacy (IMHA), Advocacy under the Care Act, NHS complaints advocacy and children’s advocacy. Our non-statutory advocacy services includes one to one professional advocacy, peer and citizens advocacy.

1.3. At the invitation of the Department of Health, we provided advice to Government on the development and drafting of Regulations and Statutory Guidance in relation to advocacy under the Care Act (2014).

2.0 Introduction

2.1. It is vital that the Law Commission’s proposals strengthen rather than dilute people’s ability to have their voice heard and rights respected. We welcome the recognition of the importance of advocacy to achieving this and ensuring that people’s rights in domestic and international law are respected. We are concerned that the final proposals are well designed to achieve this and that they allow for adequate provision for advocacy. Following some preliminary comments on the overall scheme, we outline where the provisional proposals require alteration in order to ensure this and indicate other key areas in which we endorse the provisional proposals or believe that they must be modified.

2.2. Our responses to the specific provisional proposals where we have the most relevant experience and evidence are detailed below. These responses draw on the experience of people who use services - including those who are or have been subject to DoLS, independent advocates, relatives and carers.
2.3. We believe further consultation on the draft legislation will be crucial given the importance of the issues and the likely changes from these provisional proposals to the draft legislation.

3.0 Simplification

3.1. We agree with the Law Commission that “[t]he reformed system should be clear and accessible for all, including the users and professionals who have to apply it”. Working daily with people who are subject to DoLS, we recognise that in order to achieve this it is insufficient for legislation to be well designed: It must also be well implemented. Problems with both have beset the DoLS. We recognise that the Law Commission’s responsibility is primarily to recommend on legislation rather than to advise on the manner of its adoption. However, without extremely well designed and executed implementation (including leadership, guidance and training) and adequate funding, any new legislation - however carefully crafted – will result in a net increase in the existing problems. This risk is heightened by the perception that the provisionally proposed system may itself be complex especially for people moving between different elements of it and for their families. In relation to advocacy, where we have examined the Impact Assessment in greatest depth, we believe that the costs of the provisional proposals are substantially understated.
4.0 Provisional proposals on the protective care scheme

**Provisional proposal 2-1:** the Deprivation of Liberty Safeguards should be replaced by a new system called “protective care”.

**Provisional proposal 2-2:** the introduction of protective care should be accompanied by a code of practice, and the UK and Welsh Government should also review the existing Mental Capacity Act Code of Practice.

**Provisional proposal 4-1:** the scope of protective care should include hospital, care home, supported living, shared lives and domestic accommodation.

**Provisional proposal 8-2:** a person may be deprived of liberty for up to 28 days in a hospital setting based on the report of a registered medical practitioner. A responsible clinician must be appointed and a care plan produced. Further authorisations for a deprivation of liberty would require the agreement of an Approved Mental Capacity Professional (currently a Best Interests Assessor).

**Question 8-3:** is the appointment of an advocate always appropriate in all hospital cases, or is there a need for an alternative safeguard (such as a second medical opinion)?

4.1. We support the principles underlying the Commission’s provisional proposals on protective care but are concerned that they may in practice be overly complex.

4.2. We suggest that the terminology of protective care should be more empowering in keeping with the approach adopted by the Mental Capacity Act. Whilst the different tiers may potentially benefit some groups of people the distinction between the tiers needs to be clarified. We appreciate that the provisional proposals may be simpler for providers but they will be more complicated for service users (especially if they move between the tiers of protective care) families, advisors and assessors and that this risks undermining one of the aims of the proposed reforms.

4.3. We support the principle that supportive care is intended to establish a preventative set of safeguards that reduce the need for intrusive interventions in the longer term, but believe the provisional proposals are far more complex than they need be.

4.4. The provisional proposals go some way to defining potential cases for restrictive care, however more granular definitions are needed for terms such as ‘high care needs and ‘limited ability’.

4.5. More especially, we support provisional proposal 2.2 and agree that any new scheme should be accompanied by a Code of Practice. The provisional proposals are complex in concept and terminology and a new code should provide clarity for professionals and families/carers alike. In the light of 10 years of experience and practice we believe a
review of the existing Mental Capacity Act code of practice is long overdue and fully support the proposal to update the Code of Practice.

4.6. We believe the scope of the protective scheme, as outlined in provisional proposal 4-1 is broadly correct. We welcome the inclusion of supported living in the scope of the provisional proposal but believe further thought is needed regarding how cases of deprivation of liberty could be authorised and administered for people in domestic settings. The provisional proposals raise significant questions around rights of access for practitioners, monitoring and regulation. Carers have fed back that this would place an additional burden on the family/carer at a time when they are already under considerable stress. Advocacy practitioners and carers argue that a DoL should never be the first option for statutory services and that there should be a duty on statutory services to always consider the provision of community support services to end the DoL. Advocates have also raised concerns as to whether it would create more problems around Article 8 than it solves.

4.7. We are concerned by provisional proposal 8-2, that a person may be deprived of their liberty for up to 28 days in a hospital setting based on the report of a registered medical practitioner. There appears to be no impetus for medical practitioners to recognise the new DoLS and many are in need of greater understanding about best interests decisions. We therefore believe this time frame should be reduced and that an independent safeguard, in the form of an independent advocate, should be available to support a person shortly after their admission (ref question 8-3). We believe an independent advocate is always necessary and appropriate in hospital cases. A second medical opinion would not fulfil the same functions as an advocate.

We believe that it is crucial that an advocate should be available to support the person with their care and support plan. In our experience the window of opportunity whereby a vulnerable person might return home from hospital is small and is increasingly being missed. Faced with huge pressures to speed up the discharge process vulnerable adults are often being placed in residential settings without due consideration being given to supporting their return home. This is resulting in unnecessary deprivations of people’s liberty and costly subsequent legal challenges. Advocates and family members play an essential role in ensuring this life changing moment in someone’s care pathway is centred around them. They provide a significant safeguard to that person’s rights and play a critical role in scrutinising a care planning process that is under significant pressure.

4.8. We would also highlight that restrictive care which is below the threshold for a DoL also occurs in acute hospitals and there appears to be no provision for advocacy for individuals in this situation.
5.0 The Supervisory Body and Best Interests Assessor

Provisional proposal 7-16: the new scheme should establish that the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) acts on behalf of the local authority but as an independent decision-maker. The local authority would be required to ensure that applications for protective care appear to be duly made and founded on the necessary assessment.

Question 7-19: should there 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?

5.1. We recognise the desirability for arrangements for people whose liberty is compromised to be integrated within mainstream arrangements for planning, providing and monitoring their care and support, except to the extent that different or extra protections are required. We understand the logic to uprating the role and professional standing of BIAs into the Approved Mental Capacity Professional (AMCP) role, as cited in the provisional proposals, bringing them in line with the AMHP under the MHA. In other words, they will be acting as independent decision-makers on behalf of the local authority.

5.2. We are, however, concerned that the ability of AMCPs to challenge the LA or the proposed care plan may be overestimated in the provisional proposals. Our reasons for this are as follows:

- AMCPs caseloads are likely to be high
- The power to delegate the monitoring of conditions to a health or care professional could become a default position (given financial and personnel limits), leaving limited oversight and direct input may be provided by the AMCP
- The lack of independence of the AMCP role
- Insufficient provision as to how the decision of an AMCP can be challenged
- Ambiguity over 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.

5.3. In short, whilst recognising the value of uprating the AMCP role, we consider that it would be a mistake to over-estimate the freedom of the role from the financial and organisational constraints, views and decisions of the local authority. As a result we believe the provisional proposals need amendment to recognise the constraints on the ability of the AMCPs in their role to safeguard and challenge for the person. Given these points, strong support for the person will also need to come from professional advocates and appropriate persons. To achieve this, these roles must be adequately resourced and supported.
5.4. VoiceAbility believes that amendments to the provisional proposals are needed in order to strengthen the level of oversight and scrutiny of decision-making within the Restrictive Care and Treatment scheme. In ‘Re Steven Neary; LB Hillingdon v Steven Neary (2011)’, Peter Jackson J highlighted the requirement of Supervisory Bodies to “scrutinise the assessment it receives with independence and a degree of care that is appropriate to the seriousness of the decision and to the circumstances of the individual case that are or should be known to it”. We acknowledge the challenges faced by Supervisory Bodies and question whether they are well positioned to provide the level of independent scrutiny that Justice Jackson highlights. We are concerned that the Law Commission’s provisional proposals do not provide for a sufficient level of scrutiny and oversight of an AMCP’s assessment relating to Restrictive Care.

5.5. VoiceAbility welcomes the role of the AMCP being aligned with the status of the Approved Mental Health Professionals (AMHP). We note with caution however that the AMHP’s application to detain a patient under the MHA must be supported by two separate medical recommendations. This appears to us to provide an important level of check and balance before a patient is detained.

5.6. Particularly where the AMCP is undertaking the assessment for Restrictive Care themselves, VoiceAbility feels that at least one other social care or health professional (of an appropriate level of training) should be required to support that assessment. We also feel that there would be merit in that professional being from a separate social care/healthcare team in order to provide a further level of independent scrutiny. Without further oversight in this area we are concerned that too much power is being concentrated into the hands of a single professional who is both assessing and deciding upon levels of care that are likely to breach that person’s Article 5 and/or 8 rights without a proportionate level oversight.

5.7. On the question of a right to request an alternative assessment VoiceAbility considers there to be ample provision within the existing proposals to accommodate this. Namely, that it will not be the same AMCP who authorised the initial restrictive care arrangement that will arrange a review (7.159) with the Local Authority, following a reasonable request from the person, appropriate person or advocate (7.163). This area might be further strengthened if provision was included for a specialist assessment to be completed as part of the review process in situations where it was felt that further expertise was required in relation to the person’s needs. For example where the person had a diagnosis of Korsakoff’s Syndrome a professional with a suitable level of training and experience could be requested to provide an assessment (as part of a review).

---

6.0 Advocacy

Provisional proposal 9-1: an independent advocate or an appropriate person must be appointed for any individual subject to protective care. The individual must consent to such support or if the individual lacks capacity to consent, it must be in their best interests to receive such support.

Provisional proposal 9-2: the provision of advocacy should be streamlined and consolidated across the Care Act and Mental Capacity Act (in its entirety), so that Independent Mental Capacity Advocates would be replaced by a system of Care Act advocacy and appropriate persons.

Question 9-3: should the appropriate person have similar rights to advocates under the Care Act to access a person’s medical records?

Question 9-4: should Independent Mental Health Advocacy be replaced by a system of Care Act advocacy and appropriate persons?

6.1. We welcome the Law Commission’s recognition that independent advocacy must continue to play a central role in the new scheme. The importance of this has been highlighted given that Local Authority action where the Mental Capacity Act applies has been found to breach human rights law. For example in London Borough of Hillingdon v Neary & Anor² failure to refer the family to an IMCA under s39D was held to contribute towards a violation of Article 5 ECHR. In addition Baker J’s judgment in AJ v A Local Authority³ confirmed that there is an unqualified right of access to the Court. There is thus a duty of empowerment to enable a right to be exercised and not simply a duty to make a best interests decision.

Without the support of an independent advocate people who are deprived of their liberty under the proposed protective care scheme may not be able to exercise their rights under Article 5(4). The case study in Appendix 1 illustrates the impact of this on the individual and the severe criticism to which the local authority was subject to for their breach of Article 5.

6.2. VoiceAbility welcomes provisional proposal 9-1 and agrees that an independent advocate or an appropriate person must be appointed for any individual subject to protective care.

It is important that the person is able to maintain as much decision-making power as possible and so her/his choice of appropriate person should be respected wherever

²[2011] EWHC 1377 (COP)
³ AJ v A Local authority http://www.bailii.org/ew/cases/EWCOP/2015/5.html
possible in a similar fashion to under the Care Act provisions. An independent advocate should be provided if there is no-one willing and able to be an appropriate person that the individual is content to have act in this way for him or her. The intention here should be to ensure that support and representation is available whilst avoiding an individual having a particular representative foisted upon them against their will. It is important that this does not descend into an ‘opt in’ service which leaves the very people who most need it – and cannot ‘opt in’ – without support. Clarity is needed about who will make the best interests decision to appoint an advocate if the individual lacks capacity to make this decision.

6.3. The provisional proposals suggest an increase in the number of people who will be entitled to advocacy support, thereby giving them safeguards that are presently not in place. This is to be welcomed.

6.4. For clarity, we have assumed that when the provisional proposal refers to an appropriate person/individual that they have adopted the term as defined in the Care Act and that the appropriate person is highly likely to be a family member. Due to the wording of the Law Commission report, there has been some confusion in the use of the term ‘advocate’ which appears to sometimes refer to an independent advocate (i.e. a paid professional) and sometime to friend or family member acting as a supporter and representative. Further clarification is needed that it will be an Appropriate Person OR an Independent Advocate, or where additional safeguards are needed, an Appropriate Person AND an Independent Advocate. As outlined, this will very much depend which tier of the protective care scheme the person is in and what level of safeguards they need.

6.5. Provisional proposal 9-2 has been the subject of much debate. We believe that it could be beneficial and appropriate to merge the functions of advocacy across the two Acts so that the same advocate can continue to practice in circumstances that are covered by either of the Acts.

6.6. We agree that the role of the Care Act Advocate is very clearly expressed in Regulations and is further ahead than other statutory forms of advocacy in terms of modern disability rights thinking. It is explicitly framed in terms of rights, there are clear duties to support a person in their decision making, the situations when an advocate should challenge on behalf of the person are much more explicit than IMCA and they are framed in terms of whether the person wants to challenge a decision. The Regulations and Guidance bring together the best elements of instructed and non-instructed advocacy, to allow for the fact that some people may be regarded as lacking capacity but still be able to express a clear objection to their treatment, whilst others may not be able to communicate to their advocate a desire to challenge a decision but the advocate needs to be empowered to take action if they have concerns.

6.7. We feel that there could be benefits in streamlining and consolidating the advocacy role in the Care Act and Mental Capacity Act and replacing it with a single, overarching advocacy role, as detailed in the Care Act regulations (but making sure
there was nothing lost from the IMCA role), which could then support both the Mental Capacity Act and the Care Act, as it would be easier to understand and might possibly be easier to enforce as a right.

6.8. As we understand it, the situations that require an individual to be referred for an advocate, clearly laid out in both the Mental Capacity Act and Care Act, would not alter. However this may need to be looked at as in introducing the Care Act some overlap with the Mental Capacity Act did occur in the following areas: safeguarding, care reviews and change of accommodation, which is often a decision taken within the care & support planning process. Whilst this does not affect the advocate’s role, it does have implications for those who instruct advocates and for commissioning. We believe that this is a good opportunity to bring some clarity to this and that these issues are not insurmountable to resolve.

6.9. We welcome the provisional proposals for more people subject to Continuing Health Care decisions and self-funders to receive advocacy support. It is important, however, that all people who are entitled to advocacy support under the current legislation must remain under future legislation.

6.10. Consideration may need to be given as to the term used for this overarching advocate’s role so that referrers and decision makers do not exclude a person who would be entitled to advocacy because of its name. Any changes to a scheme brings with it inherent risks of a reduction in referrals as professionals get to grips with the new scheme. After 10 years of the IMCA service, with an increase in instructions year on year, this is of particular concern.

6.11. On balance though we feel this overarching advocacy role may be beneficial with the right arrangements under-pinning it, but that these must include adequate implementation - recruitment, training, practice guidance, commissioning and awareness raising. The resources required for this may not be forthcoming, based on historical evidence, and are not included in the impact assessment. In the absence of positive responses to the issues of resources and the impact assessment the advantages may be outweighed.

6.12. Whilst there are certainly benefits to the continuity of support to the person that could be provided by provisional proposal 9-2 what is not clear is whether streamlining the advocacy role will improve people’s access to advocacy. We would strongly support consideration being given to making it possible for family members to approach an advocacy service directly when their relative is subject to restrictive care. This would be in line with the House of Lords MCA Select Committee recommendation 24: 'We recommend that the Government consider the establishment of a form of self-referral for IMCA services to prevent the damaging delay that occurred in the case of Mr Steven Neary'.

6.13. We believe that an appropriate person should have similar rights to advocates under the Care Act to access a person’s medical records (ref: question 9-3) provided it is in
6.14. There is currently no guidance available for Appropriate Individuals. We would strongly support the development of such guidance which should be available in accessible forms and should cover their role and responsibilities, processes (using case studies as examples) and support that is available to them.

6.15. As to whether Independent Mental Health Advocacy should be replaced by a system of Care Act Advocacy and appropriate persons (Ref: question 9-4) whilst greater integration and consolidation of advocacy roles within legislation might be achieved, as the interface with other forms of advocacy is far less, so also is the potential gain.

There could be advantages in unifying the advocacy roles within the Care Act, Mental Capacity Act and Mental Health Act into one overarching advocacy role forming a modern understanding of advocacy but the advantages might well be outweighed by the practice and commissioning difficulties. These include:

- **The IMHA role is a specialist role that comes within the Mental Health Act.** The eligibility criteria for an IMHA is very clear i.e. most patients are eligible for an IMHA where the framework of their care is governed by this Act. Integration could introduce complexities to eligibility and risk creating gatekeeping which would in effect deny people access to their rights and limit such protection to the individual that the MHA currently provides.

- **The differing environments within which the respective advocates work (i.e. IMHA’s largely work in hospital environments where as Care Act advocates work mainly in community settings) means that the skills that are honed are very different in each case.** Integration could lead to a loss of this expertise and specialism that could reduce the quality of the safeguards provided.

- **It would be a challenge for any advocate to have the same level of understanding and expertise across all three Acts as opposed to the one, or possibly two, Acts they currently practice under.** It would need significant investment in training. The demands on professionals who combined roles across all domains would arguably be greater with implications for recruitment, training and salary that ought to be considered in the Impact Assessment.

- **There are distinct differences between the role of a nearest relative and that of an appropriate individual with a clear conflict of interest which would need to be addressed if the two roles were integrated.** A nearest relative has specific rights which enable them to apply for the person’s detention, object to it or discharge and all 3 of these decisions may be in direct conflict with the person’s wishes and feelings which the appropriate individual would be expected to help amplify.
6.16. Particularly in relation to IMHA, should the legislative provisions for advocacy be integrated, it would be important that the Government are advised to make clear (e.g. through secondary legislation and or statutory guidance) that integration at a service or individual professional level does not necessarily need to flow from legislative integration.

6.17. **Impact Assessment⁴ - Advocacy**

We believe that the Impact Assessment has underrepresented the costs of independent advocacy. If we have understood it correctly it appears that the costs for advocacy under option 2 – the preferred one - are modelled on option 1. In option 1 a total of 8 extra WTE advocates are needed nationally. This compares with 301 new WTE BIAs. This seems to be a significant underrepresentation and appears to be based on proportioning down e.g. the number of people “taking up” advocacy. The Impact Assessment proposes that only 10% of those eligible for an independent advocate (we interpret this to mean Paid Rep as well) under DoLS “will choose to take up this right to advocacy” (page 17). Given that we are talking about people who lack capacity, and there is no mention of advocacy support for RPR’s/appropriate persons anywhere in the proposals either, this is a huge concern.

Another area of concern are the assumptions around training (page 16/17). All advocates are required to get the City and Guilds, Level 3 Independent Advocacy Qualification (IAQ). This consists of 4 core units and at least one specialist unit. The specialist units include those on the MCA, DoLS, IMHA, Children and Young People’s advocacy and Care Act Advocacy. The cost of the core units and one specialist unit is between £1,800 - £2,000 per advocate, with a further £550 - £850 per additional specialist unit. This means that the Impact Assessment figure of £350 to train each new advocate (ie a person with no advocacy qualification) is significantly under resourced.

---

7.0 Relevant Persons Representative

Provisional proposal 9-5: a “relevant person’s representative” should be appointed for any person subject to the restrictive care and treatment scheme (or the hospital scheme) and who is being represented by an advocate. The person must consent to being represented by the representative, or if they lack capacity to consent, it must be in the person’s best interests to be represented by the representative.

Provisional proposal 9-6: where there is no suitable person to be appointed as the representative, the person should be supported by an advocate or appropriate person.

Provisional proposal 9-7: the Approved Mental Capacity Professional (currently best interests assessor) should have discretion to appoint a representative where the person is being supported by an appropriate person.

Provisional proposal 9-8: the Approved Mental Capacity Professional (currently best interests assessor) should be required to monitor the relevant person’s representative and ensure they are maintaining contact with the person.

Question 9-9: does the role of relevant person’s representative need any additional powers?

Consultation question 9-10: should people always where possible be provided with an advocate and a relevant person’s representative, and could these roles be streamlined.

7.1. The Law Commission provisionally propose that people subject to supportive care should have the right to be supported by an advocate or an appropriate individual. The appropriate individual’s role came into being with the Care Act in April 2015. There is currently no guidance to enable them to understand their responsibilities for facilitating the person’s involvement and supporting them to make choices and decisions which can include appealing a decision or making a complaint if the person wishes. This is an omission. Given that a person may well move between supportive care and restrictive care we also believe any guidance should include information on the protective care system.

7.2. The provisional proposals acknowledge that the appropriate individual could also be appointed as the RPR. Although the responsibilities are similar they are distinct. The RPR’s role, which is voluntary, can be complex. Often it is a family member who undertakes the appropriate individual’s responsibilities, as indeed is the case with the RPR role too. Frequently they are people who are experiencing quite stressful circumstances, who may themselves have disabilities or difficulties understanding the convoluted care and legal processes, people who may well be scared of courts, or frightened of rocking the boat.
Without access to support, many family members may feel daunted or be unable to provide the representation, support and protection required for a person’s rights. For this reason the 39D advocate is particularly valued when their role is to support the RPR.

7.3. Feedback from families/carers and individuals has highlighted that when a 39D advocate becomes involved it is often the first time someone has taken time to explain the MCA to them, including the DoLS, the assessment process, how to request a review and make an appeal (see case study). As evidence to the House of Lords Select Committee on the MCA recorded ‘There is a need for good information for families so they understand their role and the persons' rights’ and ‘There is no substitute for a skilled advocate able to interpret complex information for families’. This support can include the provision of information, telephone calls or meetings, depending on the circumstances and the needs of the RPR. We have been told by relatives that knowing this support was available made the difference between taking on this responsibility or not. This underlines the need for independent advocacy if more relatives are to take on the RPR role.

7.4. We have been made aware, by both relatives and professionals, that RPR’s may not always be informed of their right to be able to request the support of an independent advocate, even though such support is welcomed when provided. Despite clear guidance in the DoLS Code of Practice which states that ‘It is the responsibility of the Supervisory Body to instruct an IMCA if the relevant person or their representative requests one’ many Supervisory Bodies fail to do so. This was recognised by the Social Care Institute for Excellence in their guide ‘IMCA and paid relevant person’s roles in the Mental Capacity Act Deprivation of Liberty Safeguards’ which advises that ‘Good practice is for supervisory bodies to instruct 39D IMCAs at the start of all standard authorisations where a person has a family member or friend appointed as their representative.’ In other words, a presumption in favour of a person being appointed an advocate.

7.5. In a number of VoiceAbility services, with the support of the commissioner and the Supervisory Body, we have piloted an opt-out system whereby an appointed RPR is automatically referred to a 39D advocate. In those areas over the last 18 months out of 1722 referrals only 43 have declined to receive any support from an independent advocate. The case studies of Edith (Appendix 1) and Alison are from areas where there are automatic referrals and highlight the empowering role of the independent advocate in ensuring there are safeguards around the person and their rights are upheld. The Law Commission’s consultation document (para 9.28) rightly identifies that there are issues with Supervisory Bodies appointing 39D advocates. We believe there is a strong case in ensuring that the individual receives this safeguard and that

---


this is made clear in legislation that any individual deprived of their liberty automatically has a 39D advocate, whatever their circumstances and regardless of whether there is a RPR or appropriate person in place.

7.6. Provision for the appointment of an independent advocate also needs to be made where there is a conflict of interest, for example if a representative/appropriate individual is either unwilling or unable to initiate a challenge (ref: AJ v A case). Following AJ this situation would now require that a Paid RPR (independent advocate under the provisional proposals) was appointed and the family member (RPR) step down.

Case example - Alison

Alison, a woman in her 40s with a learning disability, was placed in a setting some 90 miles from her home town and family, and a standard authorisation for deprivation of liberty was issued. A number of previous placements had broken down and there was a history of a troubled working relationship between her parents and the local authority in the shape of the relevant social services department responsible for placing Alison.

A 39D IMCA referral was made in order to support the Relevant Persons Representative (RPR), Alison’s mother. The RPR was concerned that Alison was very unhappy in her new placement and that this was in large part due to the distance from her parents and her familiar surroundings. The RPR also had concerns about the environment into which Alison had been placed.

The IMCA met with the RPR to help her better understand the Mental Capacity Act (MCA) and, in particular, the Deprivation of Liberty Safeguards (DoLS). He went through all of the DoLS paperwork with her and helped her to understand her role as RPR. He supported the RPR to identify the key issue as she saw it (namely the expectation that the local authority should have done more to identify other options and enable Alison to live in an appropriate setting closer to her parents). As part of helping the RPR to understand her role - this included how to ask for a review, make a complaint, or challenge the DoLS in the form of a section 21A appeal at the Court of Protection. As the latter route for challenge became the most appropriate route the IMCA explained to the RPR that she would most likely be asked to act as Litigation Friend and outlined the implications of this.

The IMCA was able to put the RPR in touch with a solicitor experienced in MCA law, who spoke with her and agreed to take on the case. A section 21 (A) appeal was submitted to the Court of Protection and the RPR was appointed as Litigation Friend. The case is still in progress and the IMCA has remained available to the RPR for support, however his support is now rarely needed. The RPR reports that she is happy with the work being done by the solicitor thus far and feels that her daughter’s objections are finally being taken seriously.

The case highlights how support provided by the 39D IMCA enabled a family member to feel more confident in their role as Relevant Person’s Representative. The IMCA helped them to better understand Alison’s rights under the MCA and the complexities of the DoLS system as well as how and when to initiate an effective challenge at the Court of Protection which is now before a judge. That the RPR felt suitably prepared to act as Litigation Friend enabled Alison to be supported through the Court process by the person who knew her best – her mother. Support was provided in a highly cost-effective way. Furthermore, there was no need for the Official Solicitor to get involved which avoided the need for Alison having to meet yet another paid professional asking her questions about her life.
7.7. We agree with provisional proposal 9-5 that an RPR should be appointed for any person subject to the restrictive care and treatment scheme (or the hospital scheme) and who is being represented by an independent advocate.

7.8. VoiceAbility welcomes the provisional proposal to discontinue the Paid RPR role in favour of appointing an independent advocate where there is not a suitable person to act as an RPR.

7.9. We agree with provisional proposal 9-6 that where there is no suitable person to be appointed as the representative, the person should be supported by an independent advocate or an appropriate person. In practice, however, if there is no suitable person to act as the RPR it will often be the case that there is no suitable person to act as an appropriate person.

7.10. We welcome the provisional proposal 9-7 that the AMCP should have the discretion to appoint a representative to support an appropriate person but that that representative must be made aware that they have the right to request and receive the support of an independent advocate and should be informed of how they can do this.

7.11. VoiceAbility supports provisional proposal 9-8 whereby the AMCP should be required to monitor the relevant person’s representative and ensure they are maintaining contact with the person. Clarity on what ‘regular contact’ means is needed so that RPRs know what is expected of them.

7.12. Additional powers for the RPR: VoiceAbility believes that the RPR should have the right to access key relevant information such as care and health records in order to best support P - when the person consents or when it is deemed in the persons best interests if they lack capacity. The information holder should balance the person’s right to privacy with what is in their best interests, and only disclosing as much information as is relevant in the circumstances.

7.13. Feedback has also highlighted the need to revise the Guides for Relevant Persons Representatives’ placing greater emphasis on principle two of the MCA, and encouraging supported decision-making before moving to a best interests decision. In particular, following the AJ v A local authority case it must be made clear that the RPRs role is to help amplify the voice of P and that they must be willing and able to help P to appeal if they object.

7.14. Consultation question 9-10: VoiceAbility supports the view that a person should always have the support of an RPR, who is themselves offered the support of a 39D advocate. The RPR should be offered the support of a 39D advocate as an opt-out system. This has been shown to work effectively in areas where it has been adopted. We believe this is a vital component in ensuring a person has support for decision making as

---

7 DoLS guide for Relevant Persons Representative:
embodied in MCA principle 2 as well as facilitating their Article 5(4) rights to appeal against their detention when this is needed and safeguarding their Article 8 ECHR rights.

7.15. VoiceAbility feels that in most cases it is likely that the role of Appropriate Person and the RPR could be carried out by the same person (provided they are offered the support of an independent advocate, see above) but that this must not be assumed. VoiceAbility supports the Law Commission’s proposals to give discretion to the AMCP to appoint a separate RPR where this is seen to be in the person’s best interests. We feel that the proposals would benefit from further clarity as to what indicators the AMCP might use to determine when this might be necessary.
8.0 The Right to Appeal - First-tier Tribunal

Provisional proposal 11-1: there should be a right to apply to the First-tier Tribunal to review cases under our restrictive care and treatment scheme (and in respect of the hospital scheme), with a further right of appeal.

8.1. We agree that a first-tier tribunal system has many benefits including being more accessible, its ability to bring about a person’s participation and the flexibility and informality of its processes. However, we also have some concerns given the context of the Mental Capacity Act - particularly DoLS cases which can be quite complex in nature involving capacity assessments, best interests determinations and considerations of article 8 issues and not just the determination of whether the criteria for detention are satisfied.

8.2. Advocacy practitioners and carers have fed back that it would need to be extremely clear which issues could be dealt with by a Tribunal and which must go to the Court of Protection if additional barriers are not to be created. It is conceivable that cases may need to go to both a Tribunal and the Court of Protection which might result in the duplication of work and lack of continuity. Questions have been raised about the resource/cost implications; in taking practitioners away from front line practice in order to meet tribunal requirements, in setting up a whole new structure or in modifying one (if the remit of mental health tribunals were extended), in the length of hearings which it was felt would be likely to be longer than a mental health tribunal hearing and of raising awareness of a new system. A further question was raised to the effect of ‘what can the tribunal do if its judgements are not carried out’? What power would it have?

8.3. Ideally, what we would like to see is a move towards “Tribunalism”, creating a tier within the Court of Protection which has the ability to act more swiftly, with reduced administrative requirements and using practices and procedures similar to that of a Tribunal. We would welcome the opportunity for professional advocates to support people within this new tier (if a new tier was possible) or at a (Mental Capacity) tribunal. We believe that the role of the advocate in this instance would need clarification and guidance and could be an expansion of the role of the advocate within the Mental Health Tribunal\(^8\) particularly as there is no mention of legal representation with respect to the Mental Capacity Tribunal. We believe clear guidance however should be available for people on their rights to both legal and advocacy representation, how legal representation would be funded and how the two work together.

---

\(^8\) The role of the advocate within a first trier Tribunal (mental health) Hearings
http://www.mentalhealthlaw.co.uk/Practice_Note:_Role_of_the_Independent_Mental_Health_Advocate_in_First-tier_Tribunal_(Mental_Health)_Hearings
9.0 A Supporter

Provisional proposal 12-1: a new legal process should be established under which a person can appoint a supporter in order to assist them with decision-making. The supporter must be able, willing and suitable to perform this role. The Approved Mental Capacity Professional (currently best interests assessor) would be given the power to displace the supporter if necessary (subject to a right of appeal).

9.1. The proposal that people could appoint a ‘supporter’ to assist them with decision making is an interesting one. There is a risk, as the Mental Health Foundation’s report ‘Making Best Interests Decisions’ shows, that practitioners too quickly move to a Best Interests decision rather than trying to support the person to make the decision for themselves in accordance with the second principle of the MCA.

9.2. Both the appropriate individual’s and the independent advocate’s role under the Care Act is focused on assisting a person with making a decision. Within the RPR role we believe that greater emphasis should be placed on involvement and supported decision-making too. In all three the person has the right to choose, or decline, who it is they wish to support them. As noted in section 6 on Advocacy we believe the IMCAs role also upholds supported decision making, whilst acknowledging that their obligation to do so is far less clear cut.

9.3. The feedback we have received from families/carers, and people with support needs, is two-fold:

- They invariably feel they have ‘too many’ different people involved in a person’s life and that creating yet another role, given the safeguards that are already in place around a person, could be confusing and burdensome.

- Many family members are already fulfilling the supporter role as part of their care for a family member. Some are concerned that this proposal regulates a family responsibility and thus changes the dynamic of the relationship including for example giving one relative a distinct status from others or distorting the fundamental voluntary nature of the role. Others however recognise the benefits of their existing involvement being more formally legitimised.

9.4. VoiceAbility fully supports the principle that a person should be assisted to make their own decisions, as far as they are willing and able. We recognise that provisional proposal 12-1 does not seek to limit unnecessarily the kinds of decisions that may be subject to supported decision making and so goes beyond that provided by existing roles/legislation. We do, however, believe that this should not be a one size fits all model and that if people wanted to nominate a supporter it could be a possible option.

---

9Making Best Interests Decisions: people and process - Mental Health Foundation
http://www.mentalhealth.org.uk/content/assets/PDF/publications/BIDS_report_24-02-12_FINAL1.pdf?view=Standard
9.5. There are a myriad of practitioners within existing roles who should be assisting individuals to make decisions. We believe that given the limited resources available there is much that could be gained by improving the understanding and practice of these practitioners of the second principle of the MCA. We would also support the revising of the MCA Code of Practice and guidance for RPRs, as well developing guidance for ‘Appropriate Individuals/persons’.

10.0 Best interests

Provisional proposal 12-2: section 4 of the Mental Capacity Act 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.

10.1. We welcome provisional proposal 12-2. Whilst the best interest checklist was well crafted in the Mental Capacity Act, inherent risk aversion within health, social care and other sectors too frequently results in insufficient weight being given to the wishes and feelings of people subject to the Act. As there is no hierarchy within the section 4 checklist it regularly leads to an undervaluing of the person’s will and preferences and decisions are made that are not right for that individual as a human being.

Consequently, we agree that Section 4 of the Mental Capacity Act should be amended to attach a primacy to a person’s wishes and feelings and 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. We believe that a similar approach should be adopted in revised guidance for the purposes of the best interest check list.
11.0 Conclusion

The Law Commission’s consultation document puts forward a well-considered, but extensive, new scheme. There is much to welcome in the provisional proposals, including that independent advocacy must continue to play a central role in the new scheme and the particular emphasis on disabled people’s wider rights such as the rights protected under Article 5(4) and Article 8 ECHR. We believe however that there needs to be much closer scrutiny of the resources needed for this scheme, or a modified one that might emerge as a result of this consultation. There are inevitably areas that require further thought and with this in mind VoiceAbility would be willing to engage post-consultation and help advise on proposals on advocacy.

For further information please contact:

Phillippa Ashcroft,
Head of Policy & Development
VoiceAbility
Email: Phillippa.Ashcroft@voiceability.org Mobile: 07920 482 036
Appendix 1

Case example - Edith by VoiceAbility and Maxwell Gillott

Edith is a retired professional woman, with a diagnosis of mild dementia and short term memory loss. After she became disorientated one day and was found wandering outside her home, she was admitted to hospital and treated for a urinary infection, as this had made her particularly unwell.

When she was medically fit to be discharged from hospital, the hospital professionals and social services decided that it would be in her best interests to be admitted to a residential home, as she was considered to be vulnerable and at risk if she were to be returned home. It was also uncertain as to whether she would agree to a local authority commissioned care package to support her on return, as in the past, there was some evidence that she had not been co-operative with a small package of support arranged for her by the local authority.

Edith did not have any relatives or close friends who could speak up on her behalf, and regrettably she was not appointed an advocate to support her with this decision. This meant that she was unable to challenge the decision not to allow her to return home and she was placed in a care home against her will.

The local authority failed to seek the authority of the Court of Protection prior to imposing a change of residence on Edith or at any point subsequently.

Although a social worker should then have taken an active role to identify potential care packages available to Edith, to enable her to return home and should have carried out a four weekly review of her placement, this did not occur until much later.

Further, the local authority did not arrange for an authorisation of Edith’s deprivation of liberty until long after she had moved. Even when a BIA and s39A IMCA had been instructed and both had made urgent recommendations to Edith’s social worker that the restrictions of the DoL should be lessened (and the possibility of a return home with care package explored), no steps were taken. Further, the recommendations made by an occupational therapist to increase both social and cognitive stimulation and to involve the Memory Clinic, were not heeded.

Edith continued to tell the care home that she wanted to leave and return home. She felt she was being imprisoned because she was not allowed to go out on her own. Edith became very distressed because she wanted to go home. She had also been moved to a part of the care home which was for people with advanced dementia, who were considerably more disabled than Edith, so that she was not able to form any friendships.

Social services did not review the placement in response to either the concerns which
were raised or to Edith's continuing views and distress.

The situation did not improve. The CQC made adverse findings against the home in which Edith had been placed. At about the same time the person who had acted as an advocate, now adopting the role of Ediths Paid Representative and Litigation Friend, lodged a Section 21(A) appeal with the Court of Protection, challenging the ongoing care arrangements and the Deprivation of Liberty Safeguards. A safeguarding alert made by this representative also highlighted several failings in her care arrangements and immediate measures were implemented to address these.

Following the case being heard in the Court of Protection, the local authority has recently conceded that if the correct procedure under the Mental Capacity Act 2005 had been followed around the time of Edith's hospital discharge and an appropriate care package had been put into place to support her at home, it is highly likely that she would still be living at home now. Had the local authority followed the Mental Capacity Act and ensured that there was independent scrutiny of Edith's deprivation of liberty, (either by court or under DoLs) it is likely that Edith would have had an opportunity to challenge the decision that she should remain living at the home, at a much earlier date.

Because the correct procedure was not followed, this means that Edith was unlawfully deprived of her liberty, in breach of Article 5 of the European Convention on Human Rights. Not only does this mean that she was prevented from returning to her own home, but it also means that she may now have lost her ability to live as independently as she might otherwise have been able. The local authority has agreed to financially compensate Edith for the breach of her Human Rights.

The local authority was criticised earlier by the Court of Protection and required to compensate Edith with a considerable sum in damages.

The case highlights the vital importance of independent advocacy. The provision of advocacy was instrumental in bringing the case to the attention of the Court of Protection that has subsequently led to care arrangements being made that will allow her to return home. The advocate, acting as Litigation Friend, has ensured that Edith’s views have been taken seriously and her article 5 and 8 rights have been upheld.

The case also highlights discharge planning in hospital as a critical juncture in the pathway of care for vulnerable adults. In this case Edith was not supported to be involved in the crucial decision of where she was to live following an admission to hospital. The subsequent decision has had a profoundly detrimental effect on her both physically and mentally. Edith has finally been given the opportunity to return home with support after a lengthy challenge at the Court of Protection.