LIBERTY

PROTECTING CIVIL LIBERTIES
PROMOTING HUMAN RIGHTS

Liberty's submission to the House of Lords Select Committee on the Mental Capacity Act 2005

August 2013

About Liberty

Liberty (The National Council for Civil Liberties) is one of the UKôs leading civil liberties and human rights organisations. Liberty works to promote human rights and protect civil liberties through a combination of test case litigation, lobbying, campaigning and research.

Liberty Policy

Liberty provides policy responses to Government consultations on all issues which have implications for human rights and civil liberties. We also submit evidence to Select Committees, Inquiries and other policy fora, and undertake independent, funded research.

Libertyôs policy papers are available at
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Introduction

1. In October 2012, Liberty wrote to the Joint Committee on Human Rights, asking that an inquiry be established into the position and treatment of individuals under the Mental Capacity Act 2005 (MCA). State arrangements to govern the lives of individuals who lack capacity to make decisions about their care and treatment raise significant human rights issues. The operation of the 2005 Act, as substantially amended by the Mental Health Act 2007, has seen regular engagement as well as breach of articles 3, 5, 6 and 8 of the European Convention on Human Rights (ECHR). During parliamentary scrutiny of the relevant legislation several of the JCHRõs reports called for robust procedures to safeguard the rights of incapacitated individuals. We believe that in many instances the procedural safeguards remain inadequate to satisfy the requirements of the Convention as incorporated by the Human Rights Act 1998 (HRA).

2. We are therefore pleased to have this opportunity, alongside individuals and groups who work in this area, to submit evidence on the operation of the MCA. We hope that, even if the Select Committee will cease to exist once it has published its report, steps will be taken to ensure that some other appropriate body, such as the Joint Committee on Human Rights, will be able to monitor the response to and implementation of the recommendations made by the Committee.

3. The callous treatment of residents at the care home Winterbourne View has brought the vulnerability of those in care into sharp focus. Sadly, this incident does not appear to be isolated. Liberty welcomes the broad scope of this inquiry to review the operation of the framework and address the serious human rights issues which have arisen, in particular, around the use of Deprivation of Liberty Safeguards (DoLS).

4. Liberty believes that the core problems in treatment of incapacitated individuals stem from the legislative framework itself, as well as its implementation. At the very root of the problem is the assumption that safeguards embedded in the Act are adequate. In practice they are not. The MCA permits a range of major life decisions to be made by medical and social care professionals for an incapacitated

individual where deemed in their best interests, from where they should live to major medical decisions and whether to use restraint in their care – without effective external oversight. While recourse may be had to the Court of Protection, in practice families will face a myriad of insurmountable obstacles from significant delays to lack of knowledge of when it might be appropriate to apply to the Court and lack of legal aid to do so.

5. The law on mental capacity has the potential to touch all people at some point in their life; it affects the rights of a huge range of individuals with a wide variety of different conditions, from persons born with learning disabilities; people who develop dementia as they grow older; to persons temporarily or unexpectedly incapacitated by illness or injury. It is therefore essential that the law is constructed to function properly in these different contexts, and that it does function well in practice.

The framework of the Mental Capacity Act 2005

6. The MCA contains a number of progressive elements that are a welcome addition to the UKís legal framework. The principles in section 1 include a presumption in favour of capacity unless proved to the contrary; a requirement to take practicable steps to help a person to make a decision before they can be found to lack capacity; an expression of the principle of ñbest interestsò; and a commitment to the use of minimum restraint. The MCA also effects a sea-change in the philosophy underlying the UK mental health framework through its move away from paternalism, and the recognition that ñ*a person is not to be treated as unable to make a decision merely because he makes an unwise decision.*ó[1]

7. The Act therefore goes some way towards the implementation in UK law of the UN Convention on the Rights of Persons with Disabilities (CRPD),[2] to which the UK is a party. In particular, procedures concerning capacity decisions will engage Articles 12 and 13 of that convention, which address equal recognition before the law and access to justice respectively. However, even on a cautious reading of the Convention, it is unlikely that the provisions of the MCA are sufficient to discharge the UKís obligations under international law. This is discussed further below.

[1] *Mental Capacity Act 2005*, s1(4).
[2] Entered into force 3 May 2008.

Lack of safeguards on the general defence/authorisation

8. Section 5 MCA contains a broad authorisation for a person (D) to act in the care or treatment of a person (P), where that person lacks capacity and D reasonably believes that it is in P's best interests for the act to be done. Section 6 contains a similar authorisation for the use by D of restraint, where the restraint is necessary and proportionate to prevent harm. If the act meets the criteria in the statute, D is protected from liability for an act that would otherwise be unlawful without a person's capable consent. This 'general defence' is the most common source of authority for decisions, particularly medical and welfare decisions.

9. This power has been used to provide authorisation for major decisions on a very wide range of matters which can seriously affect the human rights of the individual concerned. For example, the general power has been used to authorise surgery; the prescription of medicines, including powerful anti-psychotic drugs; decisions about where a person should live; who they should have contact with; and, under section 6, the use of restraint.

10. Such 'best interests' decisions, up to and including those involving restraint, can only be challenged by an application to the Court of Protection. There is therefore a worrying lack of oversight for these frequent, everyday decisions, which may nonetheless have a huge and determining impact on the lives of individuals lacking capacity, particularly when the cumulative effect of many such minor decisions is considered.

11. There is no statutory requirement for the routine internal or external review of these day-to-day best interests decisions, even those which involve restraint. There is no automatic assessment, for example, of the frequency with which restraint is used or the type of restraint employed. The Care Quality Commission's report monitoring use of the DoLS for 2011/12 also expressed concern that restraint was being used without consideration of an individual's capacity to consent to such treatment, and that restraint was often not recognised as such, nor was it adequately recorded.[3] In the absence of adequate reporting and reviewing, it is all too easy for the use of restraint to become routine, with no consideration of means that are less restrictive of the rights of individuals. For example, practitioners report the blanket

[3] See CQC report, Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2011/12, at page 6.

use of restraint, where a policy of restraint is adopted for an entire ward or entire group of individuals.

12. This lack of safeguards is a significant problem of the Act. While the accompanying Code of Practice fleshes out the obligations of those availing of the general defences, including for example requirements to keep records, it seems that often this detail is disregarded in practice. A considerable degree of discretion is given to those who care for individuals lacking capacity, leaving them vulnerable to abuse in the worst cases and, even where treatment is not abuse, risking that their autonomy and ability to make choices about their lives will be unduly limited, in violation of their rights under the HRA and the CRPD.

13. **The MCA should be amended to introduce robust statutory safeguards on the broad powers in sections 5 and 6, which allow carers to act in the best interests of people without capacity, particularly where these involve the use of restraint.**

14. There should be a statutory duty to carry out compulsory, regular reviews of the types of decisions made in relation to each individual; stringent reporting and record-keeping requirements; and, in the case of decisions involving restraint, there should be frequent review of how and how often restraint is being used within an institution. Reporting requirements for the use of restraint should also include a duty to record the less restrictive options that were considered, and reasons why these methods were not employed. These requirements should be on the face of the statute, to emphasise the importance of compliance for ensuring that the restraint or detention is lawful. While similar provisions are currently included in the Code of Practice, anecdotal evidence suggests that these are not always followed. The Committee may also wish to consider recommending that persons working in care homes and hospitals receive particular training before being allowed to use restraint against a person without capacity, or that there should be a system of prior authorisation by a superior within the care home or hospital before restraint may be used.

15. The assessment processes laid out in the Act, such as capacity assessment and best interests assessment, are complex, but they are key steps which must be taken if lawful decisions about the care of persons lacking capacity are to be made. The capacity assessment will determine if a decision is a capable (but perhaps

unwise) one which cannot be impugned, or an incapable and thus invalid one which can be legitimately substituted by the carerôs best interests assessment. The capacity assessment is thus key to the treatment of individuals under the Act and it is essential that they are carried out properly. Yet practitioners report that there is widespread misunderstanding of the importance of individual consent and the requirement for capacity assessments before even minor decisions (for example, to bathe an individual) can be made, and that carers cannot simply leap to doing what they believe is in the best interests of the individual without first establishing lack of capacity.

16. While the principles laid out in the Act are progressive, there is a lack of specificity in the statute,[4] which means that, to a large extent, the procedures used and action taken will be determined by guidance, such as Codes of Practice. The statute does not make clear how these tests are to be applied when carers are faced with the common, but more complex, situation if capacity that fluctuates over time, or steadily deteriorates. This lack of detail in the primary legislation results in an over-reliance on policy and guidance and creates a clear risk that conventions and practices will develop which diverge from the requirements of the MCA itself, with the result that carers will end up acting unlawfully and individuals will not benefit from the protections of the Act. This lack of understanding of what the MCA requires is due in large part to the inaccessible nature of the MCA Code of Practice, which in some parts is scarcely easier to understand than the statute itself.[5]

17. **As a first step, an urgent review and reissuing of the MCA Code of Practice should be carried out, to update the Code and make it more accessible and easier to apply for persons working in this area.**

18. The repositioning of consent and autonomy at the heart of the legislative framework was one of the great achievements of the MCA, but it appears that these values have not yet been fully internalised by those working in the sector. More than

[4] For example, sections 3 and 4 MCA outline the legal tests for capacity and best interests assessments. While the legal criteria are clear, the statute gives no indication of how this test should be carried out in practice, nor how its requirements could be met.
[5] See, for example, paras 6.26-6.34 of the MCA Code of Practice, available at http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf The inadequacy of the Code of Practice has created a demand for unofficial guides to the legislation, which are frequently much more helpful than the official guidance. See, for example, S. Richards and A. F. Mughal, *Working with the Mental Capacity Act 2005*.

five years after enactment of the MCA, it can no longer be claimed that this is merely a problem of implementation.

The Deprivation of Liberty Safeguards (DoLS)

19. One of Libertyøs chief concerns relates to the operation of the Deprivation of Liberty Safeguards (DoLS). It is worth going back to the principles expressed in *HL v UK* ï better known as the Bournewood judgment, which was the trigger for the introduction of the DoLS regime.

20. Mr HL, an autistic man, was readmitted to the Bournewood Hospital in July 1997 after living in the community with paid carers, Mr and Mrs E. Mr HL lacked capacity to consent to readmission, but the decision was taken not to section him under the Mental Health Act 1983 as he had not resisted admission. The ensuing dispute between the carers and the hospital resulted in judicial review proceedings in the UK courts. The carers lost at first instance and in the House of Lords,[6] in the latter case on the basis that the circumstances were covered by the common law doctrine of necessity. This overturned the decision of the Court of Appeal,[7] which had found that Mr HL had been unlawfully detained. The case was then taken to the European Court of Human Rights, which unanimously found that common law necessity did not suffice as a legal basis, and that the detention was both arbitrary and not prescribed by law, and did not comply with Article 5(4). The key passage from the judgment reads:

'the Court considers that the further element of lawfulness, the aim of avoiding arbitrariness, has not been satisfied…In this latter respect, the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted…In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions…As a result of the lack of procedural regulation and limits, the Court observes that the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit…While the Court does not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of

[6] [1999] AC 458
[7] [1998] 2 WLR 764

procedural safeguards is to protect individuals against any "misjudgments and professional lapses…"[8]

21. The DoLS schedule was intended to plug this gap in the UKôs human rights protections. However, it is questionable whether compliance with the requirements of the ECHR has in fact been achieved.

22. The DoLS apply to people in hospitals or care homes who have a mental disorder, who lack capacity to give informed consent to their care and treatment and where the hospital or care home managers consider it in their best interest for them to be deprived of their liberty to receive that care and treatment. In order to deprive someone of their liberty under the Act the hospital or care home manager is required to apply to the local authority for a DoLS authorisation. The supervisory authority is then required, ostensibly at least, to keep that deprivation under review. The individual ï or their deputy ï is technically able to apply to the Court of Protection for their deprivation to be reviewed, although the practical reality of their ability to do so is extremely limited.

23. The *Bournewood* decision was handed down in 2004, when the Mental Capacity Bill (now Act) was before Parliament. The Act was therefore passed in the knowledge that the new regime was not ECHR-compliant. The Mental Health Act 2007 was thus used to amend the 2005 Act to patch over this gap in human rights protection that had been identified in the MCA and introduce the present regime of Deprivation of Liberty Safeguards (DoLS), contained in Schedule A1.

Poor implementation

24. Since the DoLS came into force a number of issues have arisen. Research ï most recently in the *Winterbourne View Hospital Report*[9] ï has shown, among other problems, unexplained low rates of applications to local authorities, complete lack of awareness from care providers about the Safeguards and an inability to identify when an authorisation is even required under the MCA.

25. The evidence suggests that, because the DoLS mechanism is not being used appropriately, huge numbers of people across the country continue to be detained

[8] Judgment of the Court, *HL v UK*, ECtHR, [2004] ECHR 471, para 119 onwards.
[9] Available at http://hosted.southglos.gov.uk/wv/report.pdf

unlawfully, in the sense of Article 5 ECHR, without legal authorisation or access to the safeguards required by Article 5(4). There is therefore a very real possibility that the UK is in breach of its human rights obligations on a massive scale, both its international obligations under the ECHR, and its domestic legal duties under the Human Rights Act.

26. Those who work with and in local authorities and hospitals report a widespread lack of awareness of the role of the MCA, the types and degree of restraint it covers and, in particular, a lack of understanding of the kind of situations where a DoLS order is required.[10] There is a perception that a DoLS order is only required for 'serious' cases, where a person is deprived of their liberty in the classic sense (such as being locked up), when in fact a huge range of care options and treatment could potentially require DoLS authorisation to be lawful. For example, restrictions on visits from friends and family, or severe restriction of trips outside the accommodation may, even if the individual is not locked in the accommodation, amount to a deprivation of liberty.

27. This lack of awareness is said to be particularly acute in care homes, and in hospitals, where doctors and psychiatrists, used to working with the Mental Health Act, fail to consider the option of detention or restraint under the MCA. This lack of awareness is exacerbated by the fact that a DoLS authorisation can only be made if the managing authority of the care home or hospital proactively make an application to the supervisory authority.[11] Authorities are understandably reluctant to invite scrutiny of their actions,[12] and greater provision needs to be made to protect and support whistleblowers within the NHS. If a DoLS order is not made when a deprivation of liberty is in fact occurring, there is little pressure to apply for one. The only weak safeguard is in paragraphs 68 and 69 of the DoLS schedule, where a request can be made to the supervisory body to assess whether or not a deprivation of liberty is occurring.

[10] See report by the Care Quality Commission, *The Operation of the Deprivation of Liberty Safeguards in England*, 2011/12.
[11] MCA Schedule A1 Para 22(a)
[12] There is a similar reluctance on the part of local authorities to go to the Court of Protection to seek a court order authorising detention, or action which engages an individual's article 8 rights. This perhaps stems from a view that court and legal proceedings are a negative outcome, and something to be avoided, rather than a means of obtaining legal authorisation and protection.

28. Earlier this month, the Health Select Committee published its post-legislative scrutiny report on the Mental Health Act 2007. The committee included DoLS (enacted in a Schedule to that Act) in its terms of reference, and its damning conclusions echo our concerns:

"The committee found that application of the safeguards is variable and on many occasions those responsible for ensuring patients are protected by them have failed to do so. There is considerable confusion around the scope of the safeguards and how and when to apply them in practice.

The evidence the Committee heard regarding the application of DOLS revealed a profoundly depressing and complacent approach to the matter. There is extreme variation in their use and we are concerned that some of the most vulnerable members of society may be exposed to abuse because the legislation has failed to implement controls to properly protect them."[13]

Fundamentally, it seems that in areas of practice where DoLS are used (or should be used) there has been a failure to develop a genuine human rights approach, where the rights and autonomy of individuals are placed at the heart of decision-making in care homes and hospitals. Undoubtedly, rhetoric coming from the highest levels of Government that devalues and mischaracterises human rights law will do little to help this situation. The result is that huge numbers of vulnerable individuals throughout the UK are being detained without legal authorisation and, as a result, without procedural protections to review and challenge their detention. This situation is not only a violation of the UK Government's obligations under the HRA and the ECHR, but creates a serious risk that, without robust safeguards, the kind of horrific abuse and human rights violations that occurred at Winterbourne View could easily happen again.

29. Many of these issues could be resolved by better training, including training for managers responsible for supervising and authorising the use of DoLS in care homes and hospitals. It is important that the DoLS regime is fully understood in *all* settings in which it applies, including hospitals and care homes. In particular, it seems that doctors and psychiatrists do not receive

[13] Health Committee, First Report, 2013, Post-legislative scrutiny of the Mental Health Act 2007.

sufficient training on the meaning and importance of mental capacity, nor on when the MCA applies instead of the MHA.[14]

30. **Given that a DoLS order must be applied for proactively, Liberty believes that a new statutory duty should be imposed on supervisory authorities to plan for and carry out regular reviews and inspections of the care homes and hospitals for which they are responsible, to ascertain whether unauthorised deprivations of liberty are occurring, and to ensure that DoLS orders are being sought where necessary.** This would provide a much more practical and effective safeguard than relying on third parties to request such an assessment under paragraphs 68 and 69.

Structural problems

31. However, the problem is not merely one of implementation or lack of training. The hastily-drafted DoLS regime has a number of weaknesses inherent in its structure, which create an environment in which such rights violations can occur. In general, the Schedule is widely criticised as being difficult to understand; Byzantine; bureaucratic; and requiring overly intricate assessments to determine if it applies. In particular, the interface between the DoLS schedule and ósectioningôunder the Mental Health Act 1983 is particularly difficult to understand, even for those with legal training.

32. The sections below highlight problems of the DoLS regime, and suggest discrete changes that could be made to address them. **However, there is a strong case for the complete repeal of the much-criticised Schedule A1, and its replacement with a newly-drafted legal regime governing the deprivation of liberty of those lacking mental capacity.** Many of the problems identified, such as the inadequacy of review procedures, are fundamental flaws in the design of the DoLS regime and could not easily be remedied by non-legislative action, nor by surgical amendments to either the MCA or the DoLS schedule. Similarly, the tensions created by the UKôs obligations under the UN Convention on the Rights of Persons with Disabilities (discussed further below) point towards a radical overhaul of the UKôs regime regulating the care of those with mental disabilities or illnesses, which may prove to be necessary in the not-so-distant future.

[14] Anecdotal evidence suggests that, even where such training is offered to medical staff, frequently it is not taken up.

Definitions

33. There is no statutory definition of ñdeprivation of libertyòin the MCA; subsection 64(5) simply provides that it shall have the same meaning as under Article 5(1) ECHR, tying the definition to the interpretation of that article by the British and Strasbourg courts. The constantly-changing, and sometimes conflicting, case law on the meaning of ñdeprivation of libertyòmeans that this loose, referential definition creates significant uncertainty for those who work in this area. This is clearly illustrated by the fact that the Supreme Court has recently granted permission for two DoLS cases,[15] each with a different analysis of whether article 5 has been breached, to be heard. Social workers are put in the difficult position of having to keep up with and read the most recent judgments handed down by the Court of Protection and appellate courts to determine how they can lawfully discharge their duties, and then apply the legal concepts in practice. At one training session for best interests assessors that we attended, the instructor showed slides with extracts from recent Court of Protection decisions. The social workers attending the course were then asked to apply the passages from the judgments directly to case studies that they might encounter in their work.[16]

34. This uncertainty is particularly acute in relation to the distinction between ñrestraintò(which can be lawfully employed under the general authorisation in sections 5 and 6 MCA) and a deprivation of liberty, which to be lawful requires a DoLS order. This confusion around when restraint reaches the level of a deprivation of liberty is another factor contributing to the low level of DOLS applications in some areas, as carers may not realise that the level of restraint used requires DoLS authorisation.

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[15] *P & Q v Surrey County Council* [2011] EWCA Civ 190; *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257. See the judgment of Baker J in the recent Court of Protection case *CC v KK* [2012] EWHC 2136 (COP), for an example of how the changing and sometimes inconsistent case law on this issue creates uncertainty and difficulty even for the judges who are forced to apply it, particularly pending *Cheshire West* going to the Supreme Court.

[16] It seems that case law does filter down to those who have to implement it, even if it does result in uncertainty. Following the decision in *J Council v GU* [2012] EWHC 3531 (COP) local authorities have shown an awareness that detailed policies will be required where Article 8 rights are interfered with.

35. The absence of a clear and stable definition of a deprivation of liberty obviously produces uncertainty; inconsistency in practice across local authority areas; and a risk that social workers may end up acting unlawfully because of a lack of understanding of what they are permitted to do under the MCA. This problem is compounded by the fact that the DoLS Code of Practice is badly in need of updating: since the guidance was drafted there have been at least 16 published judgments clarifying the meaning of ñdeprivation of libertyò, with the result that its guidance is no longer accurate. Even when it was published, the guidance was, if accurate, at best extremely vague:

"The question of whether the steps taken by staff or institutions in relation to a person amount to a deprivation of that person's liberty is ultimately a legal question, and only the courts can determine the law… decision-makers need to consider all the facts in a particular case. There is unlikely to be any simple definition that can be applied in every case, and it is probable that no single factor will, in itself, determine whether the overall set of steps being taken in relation to the relevant person amount to a deprivation of liberty."[17]

Restrictive judicial interpretation

36. Where courts have had to consider the proper definition of ódeprivation of libertyô judicial interpretation of the extent of the application of Article 5 in these types of cases has been restrictive, further narrowing the application of the Safeguards to a very small number of cases.

37. In *Cheshire West*, Lord Justice Munby held that if a person was subject to restrictions that a person with similar disabilities might be subject to, they were unlikely to be deprived of their liberty.[18] We respectfully disagree with this interpretation. The use of a different ñcomparatorò for disabled people is unprincipled and undermines the autonomy of the individual. It disregards the philosophy

[17] DoLS Code of Practice, at pp.16, 18.

[18] ñ*In determining whether or not there is a deprivation of liberty, it is always relevant to evaluate and assess the 'relative normality' (or otherwise) of the concrete situation…In most contexts (as, for example, control order cases) the relevant comparator is the ordinary adult…But not in the kind of cases that come before the Court of Protection…Some adults are inherently restricted by their circumstances…In such cases the contrast is not with the previous life led by X (nor with some future life that X might lead), nor with the life of the able-bodied man or woman on the Clapham omnibus. The contrast is with the kind of lives that people like X would normally expect to lead. The comparator is an adult of similar age with the same capabilities as X, affected by the same condition or suffering the same inherent mental and physical disabilities and limitations as X.*ò Munby LJ, *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257, at para 102.

underlying human rights protections: that all individuals are guaranteed the full protection of all the rights in the Convention and, while their application will obviously differ depending on individual circumstances, this does not reduce an individualôs entitlement to enjoy these rights to the fullest measure possible. The *Cheshire West* approach distorts accepted methods of human rights analysis by allowing an individualôs particular characteristics (in this case, their mental impairment or disturbance) to determine whether or not the particular right is engaged in this instance, rather than introducing these factors at the second stage of the analysis, which considers whether restriction of this right can be justified.[19] The wording of Article 5 of the Convention clearly supports the traditional approach, as subsection 5(1)(e) clearly contemplates being ñof unsound mindòas a reason potentially justifying restriction of the Article 5 right, not as determining whether that article is engaged in the first place. Article 4 of the Convention on the Rights of Persons with Disabilities also makes clear that a Stateôs duty is to ñensure and promote the *full realization of all human rights* and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disabilityò[emphasis added].

38. In practice, this highly controversial approach means that people lacking capacity may be subject to high levels of unscrutinised restriction on their liberty before the DoLS safeguards are engaged. Holding that a deprivation of liberty is not occurring in these cases would exclude whole swathes of individuals from the scope of the ECHR and its protections. Furthermore, in an era of cuts to welfare and local authority budgets, this analysis also raises the possibility that the level of ónormalityô provided for persons with, for example, learning difficulties, who reside in local authority care homes, may be dependent on ever-tightening resource constraints, with the result that ever greater restrictions on and deprivations of liberty become acceptable.

39. *Cheshire West* also saw the unwelcome resurrection of the use of the óreasonsôfor the detention to determine the preliminary question of whether or not a deprivation of liberty is occurring, influenced by domestic ókettlingôcase law.[20] Again,

[19] To use an analogy: we say that depriving someone of their liberty pursuant to a criminal sentence is justified because that deprivation is sanctioned by a court of law and for the legitimate purpose of punishing and deterring law-breaking. We do *not* say that the prisoner was for those reasons never being deprived of his liberty to begin with.

[20] *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257, at para 77. Munby LJôs reasoning on this point is based on a rather elusive distinction between óreason,ôópurpose,ô

this approach turns the accepted approach to human rights analysis on its head: the purpose of the detention may be relevant to whether or not it can be justified, or whether it falls within one of the exceptions listed in Article 5, but it should not be used to determine the initial question of whether a deprivation of liberty is actually taking place. Allowing the motive behind the restriction to influence whether or not the individualôs Article 5 rights are actually engaged in the first place risks significantly reducing the level of protection for those detained or restricted by the state for treatment or their own safety. As with the normality test, such an approach excludes whole categories of individuals from the scope and protection of the HRA and ECHR.

40. The DoLS schedule should be amended to introduce a statutory definition of "deprivation of liberty", that is broad enough to satisfy the requirements of the ECHR's jurisprudence, but which will also provide clarity and certainty for those working in this field. The definition should be free-standing, and not directly dependent on the fluctuations of Strasbourg case law.

41. It is likely ï and to be hoped - that at least some of the more controversial aspects of the *Cheshire* West decision will not survive scrutiny by the Supreme Court in the autumn.[21] However, it should be stressed that any new statutory definition should not create a separate, lower test for deprivation of liberty for disabled persons (the approach followed in *Cheshire West*) but start from the presumption that disabled persons are entitled to the same individual freedoms as anyone else. The reasons for the restrictions should be considered only when assessing whether the deprivation of liberty is justified, not in determining whether such a deprivation exists. From this starting point, which respects the universality and integrity of human rights protections, the courts will then be able to consider whether the restrictions in question are necessary and proportionate given the particular circumstances of the individual lacking capacity.

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and ómotive.ôIn Austin v Commissioner of Police of the Metropolis [2009] HL 5, the House of Lords held that a public safety/order purpose for the detention (in this case, kettling of protestors) could be relevant in deciding whether or not a deprivation of liberty existed. However, the ECtHR has cast serious doubt on this approach, see note 20,

[21] In particular, the ECtHRôs decision in *Austin v UK* casts significant doubt on relying on an ñunderlying public interest motiveòto determine the question of whether a person has been deprived of his liberty. See *Austin v UK* [2012] ECHR 459 at para 58-59 of the majority judgment. See also Baker Jôs judgment in *CC v KK* [2012] EWHC 2136 (COP), where he struggles to apply the *Cheshire West* tests in a post-*Austin* context.

42. **The DoLS Code of Practice should be urgently reviewed and updated. Updates to the guidance and Code of Practice should be issued more regularly, taking account of, and explaining, the impact of subsequent case law interpreting the statutory definitions.**

Review

43. There have been very few challenges made to DoLS authorisations under the MCA, reflecting the difficulty for these individuals in challenging their care arrangements and the low number of DoLS authorisations applied for. Given these obstacles to challenging an individualôs detention under DoLS, there are serious concerns that the DoLS regime may be in violation of article 5(4) ECHR.

44. Unlike detention under the Mental Health Act 1983, there is no periodic review of detention under DoLS ï even though a standard authorisation may have a duration of up to one year.[22] The first means of challenge is for the detainee to apply to the supervisory body for a review of any of the 6 qualifying criteria for the DOLS order, to see if they are still met. However, it is that same supervisory body that authorised the application for an order in the first place. Therefore, where the review hopes to challenge the basis of the original order, the review is neither independent nor external.

45. An individual can challenge the detention by applying to the Court of Protection under section 21A MCA, but there are significant obstacles. At present, under section 39D MCA, a person detained under DOLS has the right to request appointment of an IMCA by the supervisory body, and the body has a duty to appoint one in some, but not all cases where a person is detained under DOLS. In addition to the obvious practical problems that a person with, for example, learning disabilities, may experience in communicating their intentions and contacting a solicitor, local authorities have been accused of inappropriate delay in appointing an IMCA to represent that personôs interests, or the representative may support the detention and not consider it to be in their best interests to bring an application.

46. This was the situation in the Neary case,[23] where there was a delay of several months in appointing an IMCA, seriously restricting Steven Nearyôs ability to

[22] MCA Schedule A1, para 42.
[23] [2011] EWHC 1377 (COP)

challenge his ongoing detention. The London Borough of Hillingdon took Steven Neary, who suffers from autism and a severe learning disability, into respite care for a few days at the request of his father in December 2009. He remained there until December 2010 against his own and his father's wishes, detained under a series of DoLS authorisations obtained by the local authority. Ultimately, the judge found that the local authority had breached Steven's right to a family life under Article 8 ECHR, had deprived him of his liberty and therefore breached Article 5(1), and by failing to refer the matter to the Court of Protection sooner, failing to appoint an IMCA for Steven sooner and failing to conduct an effective review of the DoLS best interests assessments, it had deprived him of his entitlement to take proceedings for a speedy decision by a court on the lawfulness of his detention contrary to Article 5(4).

47. By contrast, where persons are detained under the Mental Health Act 1983, they have relatively easy access to the Mental Health Tribunal. The tribunal has a number of advantages over either of the avenues for challenge available to those detained under DoLS: the tribunal frequently holds hearings in the place of detention (for example, the tribunal will hold its proceedings in the mental health hospital in which the individual is detained), making it easier for those detained to take part in proceedings and express their views; the tribunal is fast-moving, and when a hearing is requested it will usually be heard within 5 working days; and, as a tribunal, it is much cheaper, more flexible and more informal than equivalent proceedings before the Court of Protection.

48. A statutory requirement for regular periodic review of any detention authorised under DoLS should be introduced, similar to that provided for detained mental health patients. This review should be at regular intervals, and at least every three months.

49. The MCA should be amended to provide that supervisory bodies have a statutory obligation to appoint an IMCA automatically and promptly in all situations where an individual is detained pursuant to a DOLS order.

50. If the DoLS regime is to comply with Article 5(4) ECHR, there must be an independent, external body to review challenges to detention under DoLS, which can be easily and speedily accessed by detained individuals and their representatives. One way of achieving this would be to extend the current

powers and jurisdiction of the Mental Health Tribunal to allow it to hear challenges to deprivation of liberty under DoLS.

Extent

51. The DoLS regime is also structurally flawed in the limitation of its application to hospitals and care homes. Many individuals, for example with dementia or learning disabilities, are cared for in residential homes, in special accommodation or ósupported livingô, or in their own homes. These individuals may equally be subject to deprivations of liberty, for example, if their ability to go out into the community is significantly restricted, or if their lives are regimented in a particularly comprehensive or invasive way. However, as the DoLS regime does not apply, these deprivations of liberty will not be in accordance with any legislative provision, nor will the individuals enjoy Article 5 protections, which is not consistent with the UKôs obligations under the HRA.

52. **Paragraph 1(2) of Schedule A1 to the MCA should be amended, to cover any place where a person is receiving care.**

53. The combination of a restrictive interpretation under Article 5 as offered by the courts, its limited application to hospitals and care homes, and the lack of applications for a DoLS authorisation suggest that there are potentially thousands of individuals without capacity in the UK who are being deprived of their liberty within the meaning of Article 5 ECHR, but who are not being afforded the protection demanded by the Article 5 safeguards. This is not compatible with the Governmentôs obligations under the ECHR or HRA.

Access to Justice

The Court of Protection

54. One of the innovations of the MCA 2005 was to create a new Court of Protection, which would have jurisdiction over not just the financial decisions made on behalf of those lacking mental capacity, but also more general care and welfare decisions.[24] While the creation of a specific jurisdiction, which allows the

[24] S.45, MCA 2005.

accumulation of expertise by judges and lawyers is welcome, there are aspects of the Courtôs structure that could be amended, to improve access to justice for those subject to the MCA.

55. Applying to the Court is a costly and lengthy process, with decisions regarding DoLS orders taking up to a year. The Court of Protection often sits in London or other regional centres, which may be far from the individual concerned (although under subsection 45(3) MCA, it may sit ñat any place in England and Walesò, which would allow hearings to be conducted in the care homes or hospitals where the individual is, as is common for Mental Health Review Tribunals). In addition, as DoLS cases will usually be heard by a member of the senior judiciary, the instruction of counsel will often be required, further increasing costs. The result is that cases before the Court of Protection are frequently many times more expensive than appearances before an equivalent tribunal, and this can impose a significant obstacle to an individualôs exercise of their right of access to justice.

56. These problems would be made significantly worse, should the Government decide to proceed with its much-criticised proposals in the Ministry of Justiceôs consultation paper *Transforming Legal Aid*. In particular, any restriction on client choice would be particularly acutely felt in the area of mental health law, a highly-specialised area of law, which requires lawyers with expertise in this area. Given the severely limited avenues of challenge for persons subject to the MCA, particularly those detained under DoLS, any restriction of access to legal aid will directly impact the adequacy of their access to justice and their human rights under the HRA and ECHR. In particular, any cuts in this area will increase the already-high likelihood that the DoLS regime is in violation of the review requirements in Article 5(4).

Litigation capacity

57. Several European Court of Human Rights rulings on Article 6 have found that deprivation of legal capacity must have similar procedural safeguards to Article 5.[25] Strasbourg case law has also suggested it is unacceptable for a person to be deprived of their capacity to litigate where the judge has had no contact with the

[25] *Winterwerp v The Netherlands* (App no 6301/73) [1979] ECHR 4 [33]; *Shtukaturov v Russia* (App No 44009/05) [2008] ECHR 223 [66], [71], [90]. See generally, L. Series, *Legal Capacity and Participation in Litigation: Recent Developments in the European Court of Human Rights*, forthcoming in the European Yearbook of Disability Law.

person and is merely acting on the evidence of those who allege incapacity. The Court has also emphasised the importance of the quality of the medical evidence, and of the judge giving reasons for a determination that a person lacks capacity.[26]

58. Litigation friends make a range of decisions about how litigation should be conducted on behalf of P, including whether it should be conducted at all. Although a settlement or compromise cannot be reached on behalf of P without the consent of the court, it seems possible under the Criminal Procedure Rules that a litigation friend could decide to discontinue proceedings brought by P. This effectively means that Pôs access to justice, to obtain a remedy for interferences with their rights, is at the discretion of his litigation friend who, in certain cases, may be a public official such as the Official Solicitor. If a litigation friend were to use this discretion to discontinue proceedings challenging Pôs detention under DoLS, Pôs article 5(4) rights could be subject to discretionary restrictions which may be incompatible with the ECHR.

59. The discretion of litigation friends is just one example of how persons lacking capacity may be unable to have their case advanced in the Court of Protection. Litigation friends, such as the Official Solicitor, may bring proceedings, but not advance the case desired by P. For example, if P believes she has capacity, but her litigation friend does not and refuses to advance this argument, the issue of her capacity (or lack thereof) will not be tested fully and adversarially in court.

60. For example, in *Re E (Medical treatment: anorexia) (Rev 1)*,[27] where a local authority sought a declaration that it was in Eôs best interests for her to be forcibly fed for up to a year to prevent her death from anorexia nervosa. E was represented by the Official Solicitor, although her counsel stated that ñin the absence of contrary medical opinion he would have felt able to take instructions from E.ôThe Official Solicitor argued that it was in Eôs best interests to have the treatment, notwithstanding her objections. However, nobody in the court was making Eôs case, either that she did in fact have capacity or that force-feeding would not be in her best interests. Eôs parents agreed with her, but were unable to afford independent legal representation. No counsel was making the best possible case for what E wanted to the court. All the experts were instructed by the local authority.

[26] *X and Y v Croatia* (App no 5193/09) [2011] ECHR 1835.
[27] *Re E (Medical treatment: anorexia)* [2012] EWHC 1639

61. Similarly, in the case of *D v R (Deputy of S)*,[28] S had given money as a gift to D. Sôs deputy, R, asserted that S lacked capacity, despite Sôs protestations to the contrary. Therefore, it was left to D, the alleged donee of the gift, to make the argument that S had capacity in Court. It is unclear how a person, deemed to lack capacity, can proceed where their litigation friend refuses to challenge that finding of incapacity. This situation is clearly unsatisfactory and represents a depressing return to paternalism via the back door, which contrasts with the emphasis on autonomy in the MCA itself.

62. One way to address this problem would be to introduce provision to the MCA to impose a duty on the Court of Protection to consider, of its own motion, whether they should examine and/or hear argument on the question of whether P does in fact lack capacity.

United Nations Convention on the Rights of Persons with Disabilities

63. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) came into force on 3 May 2008 and currently has 114 States Parties. The UK ratified on 8 June 2009 and is therefore bound by its international obligations under the Convention. The CRPD has been widely hailed as a óparadigm-shiftôin thinking about the rights of persons with disabilities. The Convention places weighty positive obligations on States Parties to ensure that persons with disabilities are able to fully realise the rights they are guaranteed by the general human rights treaties, such as the ICCPR and ECHR, which were drafted in the immediate post-war period. As a result, there is a real possibility, not only that the UKôs mental health law does not comply with the requirements of the CRPD, but also that the UKôs obligations under the CRPD and its obligations under the ECHR are in conflict.[29] The interaction of these international treaties is extremely complex. However, there are some potential points of conflict between English mental capacity law and the CRPD, which should be highlighted, and may need to be addressed in future.

64. Article 12 CRPD guarantees equal recognition before the law for persons with disabilities. British mental capacity law may be in conflict with this provision for two

[28] [2010] EWHC 2405
[29] See, for example, Fennell and Khaliq, *Conflicting or Complementary Obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law*, [2011] EHRLR 6, p662.

main reasons. First, article 12(4) sets out a number of safeguards to prevent abuse where persons with disabilities are exercising their legal capacity. The objections to the UK system here are the same as those outlined above in relation of deprivation of litigation capacity and access to justice. However, secondly, and more fundamentally, the ñparadigm shiftòeffected by the CRPD is clearly evident in article 12, which not only imposes a duty on States Parties to ñrecognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life,ò (12(2)) but also imposes a positive duty to ñprovide access by persons with disabilities to the support they may require in exercising their legal capacityò (12(3)) and ensure that persons with disabilities enjoy an equal right to, for example, inherit property and control their own financial affairs (12(5)).

65. There are a number of aspects of UK mental capacity law which immediately seem to be in potential conflict with these requirements. For example, the system whereby persons with disabilities or who lack mental capacity are simply deprived of their ability to litigate would not seem to fulfil the duty to provide support for decision-making in 12(3). Indeed, the text of article 12(2) would seem to prohibit any denial of legal capacity simply on the grounds of disability. There are also concerns that substituted decision-making, such as the system under the MCA whereby carers can make a ôbest interestsô decision on behalf of the person lacking capacity, may be contrary to the requirement for supported decision making in article 12(3). Under section 4(6) MCA carers must consider the past and present wishes, feelings, beliefs and values of the individual, but on some interpretations of Article 12(3) it is not clear that this would go far enough to satisfy the requirements of the CRPD.

66. In addition, it seems likely that the serious flaws identified in the DoLS regime above would put the UK in breach of its obligations under articles 13 (Access to justice) and 14 (Liberty and security of the person) CRPD, as well as the ECHR.

67. The precise requirements of the duties laid down in the CRPD, and their interaction with other sources of human rights law, are still unclear. However, the UK is bound by the treaty, and it is worth bearing in mind that, should the Convention be interpreted in future in a way that would put UK mental capacity law in conflict with its provisions, a radical overhaul of both the Mental Capacity Act 2005, and the Mental Health Act 1983, may be required to ensure the UK complies with its obligations under international law.

68. The Mental Capacity Act 2005 was a well-intentioned and progressive piece of legislation, with many positive features. However, evidence since its enactment, including the horrific revelations of abuse at care homes and hospitals in recent months, show that the regime is not functioning properly in practice, with tragic consequences. The scale of the problem, and the vulnerability of the individuals placed at risk, mean that the seriousness of this issue cannot be underestimated. We have recommended a number of structural or legislative changes above, but much could be achieved relatively quickly and simply, through better training and the revision of guidance and codes of practice. We urge the Committee to take advantage of the opportunity their inquiry represents, to further raise awareness of these issues, and ï more importantly - to use the weight which will be accorded to their report and recommendations to effect real change.

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