Consultation on the Scottish Law Commission Report on Adults with Incapacity

RESPONDENT INFORMATION FORM
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1. Name/Organisation
Organisation Name

Mental Welfare Commission for Scotland

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QUESTIONS RELATING TO THE DRAFT BILL PROVISIONS ON HOSPITAL SETTINGS

1. Is a process (beyond the process of applying for guardianship or an intervention order from the court) required to authorise the use of measures to keep an adult with incapacity safe whilst in a hospital?

Yes	✓	**No**	

Please provide an explanation for your answer

We accept that, particularly following *Cheshire West*, some provision is required. Hospitals often struggle to find a legal process to detain a patient so that they can provide physical health treatment to an adult with incapacity.

The use of section 47 of the Adults with Incapacity (Scotland) Act 2000 (hereafter 'the AWI Act'), guardianship or an intervention order would not as they stand authorise measures to detain an adult with incapacity in a hospital.

The treatment of mental disorder is covered by the Mental Health Act, but this route may not be appropriate when the principal aim of the treatment is physical health.

2. Section 1 of the Commission's draft Adults with Incapacity Bill provides for new sections 50A to 50C within the 2000 Act, creating measures to prevent an adult patient from going out of hospital.
Is the proposed approach comprehensive?

Yes		**No**	✓

Please provide an explanation for your answer

New sections 50A to 50C provide a process to detain an adult who is in hospital and who lacks capacity to consent to remaining for medical treatment or assessment.

However, it is not clear to us **on what basis the person with incapacity is admitted to hospital in the first place**. This contrasts with the 2003 Act, which provides a procedure to authorise the process of detention, including removal

to hospital. We believe it is important to address this, both conceptually and in practical terms. Once admitted, the likelihood of the person being able to leave may be small, in which case the new safeguards may be of limited value.

We note the SLC view (paras 4.9-4.11) that the admission to hospital would be covered by s47, provided the certificate is granted prior to admission. That may be so, but we have some doubt, particularly as s47 explicitly does not authorise 'detention'. Our *Investigation into the care and treatment of Ms AB* states (p15) 'We have already agreed with the Scottish Government that a Section 47 certificate does not authorise transfer from home to hospital for a person who refuses'
http://www.mwcscot.org.uk/media/125447/ms_ab_web_version.pdf

Furthermore, we suspect that many s47 certificates are not granted until after admission.

3. Please comment on how you consider the draft provisions would work alongside the existing provisions of the 2000 Act, in particular section 47(authority of persons responsible for medical treatment).

In general, we believe the existing **s47 process and the new procedure should be aligned** as far as possible, including consideration of having a single certificate to cover both treatment and detention in appropriate cases. The current compliance with Part 5 of the AWI Act in general hospitals is variable, and it is important to avoid too many complex and overlapping processes.

We are concerned by s50A(5), which creates a new authority to administer medication specifically to confine the patient to the hospital. We struggle to see when it would be justified to administer medication in order to confine a person to hospital (as opposed to tranquillising medication to deal with stressed and distressed behaviour).

The reference cited by the SLC to the use of medication in this way is our *Investigation into the care and treatment of Ms AB* (cited above). In that report, we were critical of this practice and argued that the appropriate procedure to authorise such treatment, if it could be justified, would be emergency or short-term detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (hereafter 'the Mental Health Act').

We do not favour creating a third power to authorise medication added to the existing provisions of Part 5 of the AWI Act and the Mental Health Act.

We also have concerns about the **interaction of the provisions about consultation and consent** from guardians and attorneys.

The s47 Form asks the doctor to identify if there is a guardian/welfare attorney or person appointed by an intervention order, (or indeed, a nearest relative or a carer). The flowchart accompanying the s47 Form (and the principles of the AWI Act) put a duty on the doctor to consult with a guardian or welfare attorney about proposed treatment where reasonable and practicable. Section 50 further provides that consent should be sought where reasonable and practicable.

Paragraph 30 of the consultation paper notes "The Commission did not recommend involving attorneys and guardians in the process of authorising 'detention' in general hospitals because they were concerned that such involvement might undermine the delivery of treatment. In so doing consideration was given to the delay that would occur if such a person had to be notified or if their consent was a requirement before a certain measure could be used to keep the patient safe".

However the delivery of that treatment requires to be authorised by s47, which provides for consultation with a guardian or attorney.

We recommend there should be a duty to consult a guardian/ attorney where it would be reasonable for the doctor to know one had been appointed, preferably before completing a s50A certificate, which failing, within a reasonable timescale after doing so.

It is also notable that Part 5 (and the SLC proposals for deprivation of liberty in the community) provide for guardians and attorneys not just to be consulted, but to consent to treatment/deprivation of liberty.

Arguably, it would be more consistent for sections 50A-50C also to allow for consent by proxies, perhaps with a system of second opinions similar to s50 if consent was refused. It would be necessary to provide for temporary detention pending the second opinion being received. We would retain the right of appeal to the sheriff court, but a second opinion might provide a more practical and simpler initial safeguard in cases where proxies are unhappy

about detention in hospital.

Finally, we are unclear about the interaction of this new provision with s47(7)(c), which seeks to ensure that **AWI cannot be used for treatment of mental disorder against the will of a patient**. This provision is not replicated at s50A(3).

In such situations, the Mental Health Act should still be used. It should not be simpler for a doctor in a general hospital to detain a patient for the treatment of mental disorder than it is for a psychiatrist in a psychiatric hospital.

That said, there is a complicated interaction where treatment relates to a mental disorder but is intended to improve the person's physical condition, for example naso-gastric feeding for a patient with an eating disorder, or treatment for delirium or a toxic confusional state. This is one of the issues which could be addressed in the longer term by unifying legislation, but meantime the safeguards of mental health law should not be reduced.

Are there any changes you would suggest to the process?

Yes	✓	**No**	

Please provide an explanation for your answer

See answer above, in addition to comments below.

In s50B a medical practitioner who issues a certificate in respect of a patient detained in hospital shall, "**from time to time**", consider whether the patient remains incapable in relation to their detention in hospital. We feel this **is not sufficiently clearly defined** and gives the doctor too much flexibility.

We recommend that as detention in hospital is such a significant restriction on the liberty of the adult with incapacity, the certificate issued should be reviewed at least every month during the period of the adult's detention in hospital and that any guardian or attorney should be consulted at each renewal.

In s50C the sheriff may only grant the application to revoke the certificate if the patient no longer requires the medical treatment for which they have been

admitted to hospital, or does not require continuing assessment there, **and** if at s50C(3)(b):

"(i) it is appropriate and practicable for the patient to return home, or
(ii) accommodation, where appropriate long term care can be provided, is available for the patient elsewhere than at the hospital".

We would like further consideration to be given as to why the sheriff needs to consider s50C(3)(b)(i) and (ii). **If the adult no longer requires medical treatment or assessment in a hospital then on what basis should the doctor be able to continue to detain the adult in hospital?**

Under the Mental Health Act, if an adult no longer meets the criteria for detention they cannot continue to be detained.

We note also that at s52J where an adult in the community applies for release from unauthorised detention, the sheriff does not have to consider whether alternative long-term care arrangements are in place before ordering the resident be released.

In human rights terms, we do not see that this situation is materially different.

At the very least, we suggest some process akin to the 'recorded matters' procedure in the Mental Health Act whereby the tribunal can specify treatment or services that it believes will benefit an individual, and can require services to report to it on whether these have been delivered.

However, a better model may be where a patient appeals against being detained in excessive security under the Mental Health Act, as amended by the Mental Health (Scotland) Act 2015. In that situation, the tribunal (ultimately the Court of Session) can require that the detention cease within a set period. We accept that the sheriff need not be obliged to discharge the patient if accommodation is said to be available, but they should have the discretion to do so. We note the concerns expressed by the SLC about the complexity of the excessive security appeal process (see para 4.37), but would point out that the procedure has now been simplified by the Mental Health (Scotland) Act 2015.

Finally, we believe **access to advocacy** should be a requirement of the process, and the certification should make clear what advocacy support has been provided.

QUESTIONS RELATING TO THE DRAFT BILL PROVISIONS ON COMMUNITY SETTINGS

1. Is a process required to authorise the restriction of an individual's liberty in a community setting (beyond a guardianship or intervention order), if such restriction is required for the individual's safety and wellbeing?

Yes	✓	**No**	

Please provide an explanation for your answer

We agree that a process is required. If services are satisfied that a person who cannot consent will be deprived of their liberty, it is clearly necessary for lawful authority to justify that detention. We do not believe that use of the current welfare guardianship, power of attorney and intervention order procedures for this purpose is sustainable in the long term.

However, we do not believe that the best way forward is to require judicial authorisation of every situation where a person judged incapable of consenting and without a proxy is being looked after in a way which meets the *Cheshire West* test of deprivation of liberty. Indeed we doubt whether this was the result intended by the Supreme Court.

We accept that there is a legal argument that, to comply both with *Cheshire West* and some of the case-law from Strasbourg, some judicial authorisation is required in every case of deprivation of liberty affecting an incapable person, both at the start and regularly thereafter. This is set out in more detail in Professor Stavert's MWC guidance on deprivation of liberty: http://www.mwcscot.org.uk/media/234442/deprivation_of_liberty_final_1.pdf

However, particularly in the light of the UN Convention on the Rights of Persons with Disabilities, we believe the starting point should not be to try to protect services from any possible legal challenge. It should be to devise a system which empowers people in care settings, and protects them where necessary. It should focus not simply on capacity as a legal concept, but powerlessness as a lived experience.

While we do not accept the argument that there should be no such thing as

incapacity or substituted decision-making, we believe law reform should give greater weight to the will and preference of the adult, whether or not they are deemed legally capable.

We also suggest that focusing solely on potential breaches of Article 5 is misconceived. Other ECHR provisions, including Articles 3 and 8, are likely to become increasingly important, and the system of safeguards needs to reflect the full range of issues covered by the human rights framework.

If we develop a proportionate and effective system using this approach, we believe it stands a better chance of surviving future developments in human rights, and of actually benefiting people with mental health issues and learning disabilities.

This approach is discussed further in an article by Professor Peter Bartlett entitled 'Reforming the Deprivation of Liberty Safeguards (DOLS): What Is It Exactly that We Want?' (2014) 20(3) Web JCLI:
http://webjcli.org/article/view/355/465 .

We set out below how we believe this might be applied in the Scottish context.

In policy terms, what was good practice before *Cheshire West* in large part remains good practice. The principles in s1 of the AWI Act and the guidance issued in support of s13ZA of the Social Work (Scotland) Act are a reasonable basis for protecting the rights of most people moving into care settings. However, we agree that this needs further statutory underpinning, since s13ZA is essentially a declaratory statement rather than a statutory process.

2. The proposed legal authorisation process will not be required for a person who is living in a care home where the front door is ordinarily locked, who might require seclusion or restraint from time to time.

Do you agree that the authorisation process suggested by the Commission should not apply here?

Yes		**No**	✓

Please provide an explanation for your answer

"From time to time" or "on a regular basis" (s52A(1)) are not further defined and allow for a great deal of interpretation. The question assumes that they are distinct concepts, the second of which crosses the threshold in s52(A)(1)(c), while the first does not. In practice, the distinction may not be easy to apply, and nor may it be the most significant issue.

The views of the person and their family should be sought when considering whether legal authorisation should be sought in line with the principles of the Adults with Incapacity (Scotland) Act 2000.

All of the following situations should require consideration as significant restrictions of liberty in their own right, whether or not a front door is locked

- The use or anticipated use of seclusion
- Restraint, depending on its purpose and frequency
- The use or anticipated use of medication to sedate a person, where used as a form of restraint

Where the front door is ordinarily locked and the person regularly tries to leave but is not allowed to, this may be significant enough in its own right to trigger consideration of legal authority.

However, if the views of the person and their family have been sought along with the professionals concerned; it has been decided that the front door will be locked to avoid a person wandering out inadvertently; and another restriction is applied, for instance the locking of an internal door, or the person becoming confined to bed, a process such as that proposed by the SLC may not be necessary to protect the person.

3. In proposing a new process for measures that may restrict an adult's liberty, the Commission has recommended the use of 'significant restriction ' rather than deprivation of liberty and has set out a list of criteria that would constitute a significant restriction on an adult's liberty.

Please give your views on this approach and the categories of significant restriction.

Having a list of significant restrictions and a threshold of meeting two of the restrictions is not, we feel, the best approach. The list does not capture some significant restrictions of liberty, but also risks capturing too many situations

where there is not a significant restriction of liberty warranting a judicial process.

Requiring two criteria to be satisfied appears to be an ingenious attempt to reflect the use of 'and' in the 'acid test' in *Cheshire West* ('under continuous supervision and control and not free to leave'). In practice it is not the best way to decide whether the level of restriction crosses a threshold of severity.

Our experience is that nearly all care homes lock the external door as a "house rule", and that most residents are not allowed to leave unaccompanied. We also find that nearly all care homes of any size have interior barriers sectioning off different client groups or areas of the care home.

We find that the level of understanding of the AWI Act in care homes is highly variable. Expecting care homes to be the gateway to a new process and apply complex legal tests is, in our view, problematic. If they are aware of the processes, they are likely to be risk averse, resulting in even larger numbers of people certified as being subject to significant restrictions. Not only will this put pressure on the system, it risks reducing the freedoms of people who might not otherwise have been so restricted.

For example, if more able residents are allowed out unaccompanied, then the exclusion from the process intended by s52A(2) would not apply. A care home manager might want to make exceptions, but be concerned that if the house rule doesn't apply to "all residents" they would have to initiate the SLC's proposed process for all the other residents. This risks a perverse outcome, that homes will become less accommodating of the individual needs of their residents.

In our experience we do not find that residents confined to bed, or a wheelchair due to ill-health, suffer a greater restriction or infringement of their rights than ambulant residents, unless they are expressing unhappiness with their stay in the care home. The SLC list makes special note of this situation. However, confinement to a bed or a wheelchair only becomes significant in this proposal if in addition the front door (or an internal door) is locked. This does not seem to make sense, as the bed-bound resident could not get to a door whether locked or not.

However, there are some people who may subjectively feel they experience a significant restriction of liberty who would not trigger the process proposed by

the SLC. Some residents may have relatives unhappy with the restrictions imposed, but they also do not trigger the Commission's proposed process.

Also, there are a host of other reasons why the regime in a home may objectively restrict a person's liberty, but which are not caught by the test. Several of these are set out in the list proposed by the English Law Commission at pages 5 and 6 of their summary consultation paper: http://www.lawcom.gov.uk/wp-content/uploads/2015/07/cp222_mental_capacity_summary.pdf.

Others might include controlling sexual relationships, over-use of CCTV, and control of access to social media.

We are not suggesting that all these restrictions warrant a judicial process. However the legal framework should address the range of ways in which people's freedom may be compromised.

4. The authorisation process provides for guardians and welfare attorneys to authorise significant restrictions of liberty. Do you have a view on whether this would provide sufficiently strong safeguards to meet the requirements of article 5 of the ECHR?

Yes		**No**	✓

Please provide an explanation for your answer

There must be some doubt about whether such an approach is compatible with ECHR cases such as *MH* (MH v UK 11577/06 (2013) ECHR 1008, (2013))and S*tanev (Stanev v Bulgaria 36760/06 (2012) ECHR 46, (2012))* which seem to require regular judicial review, and state that the adult should not be reliant on the person who authorised a deprivation of liberty to challenge its lawfulness. This is particularly an issue with welfare attorneys, who are not subject to any process of regular review.

In terms of what provides a sufficiently strong safeguard in policy terms, it would be important that significant restrictions of liberty are explicitly addressed in the powers contained in the power of attorney, or granted by the court. At the moment, many statements of powers are extremely general, and potentially encompass severe restrictions. We believe this is not appropriate.

The MWC has previously taken the view that welfare attorneys should not

authorise *de facto* detention. If legislation is introduced along the lines proposed by the SLC, we accept that it will be necessary to allow welfare attorneys to consent to some situations classed as significant restrictions of liberty. But we do not believe they should be able to consent to more severe intrusions on liberty, for example, the kind of forced compliance authorised by s70 of the AWI Act.

Finally, this is another area where we believe express provision should be made for access to advocacy for the adult.

5. The Bill is currently silent on whether it should be open to a relevant person to seek a statement of significant restriction in relation to a person subject to an order under the 1995 or 2003 Acts which currently do not expressly authorise measures which amount to deprivation of liberty.

Please give your views on whether these persons should be expressly included or not within the provisions, and reasons for this.

In relation to community-based compulsory treatment orders, the authorised measures will have been imposed by a judicial body (the mental health tribunal) and will be subject to regular review. We presume the issue is that the conditions operating in the place where the individual is required to reside may amount to a significant restriction or deprivation of liberty, and those conditions will not have been explicitly authorised under s66 of the Mental Health Act.

Our general view is that it would be undesirable to create a process under incapacity law which operates alongside a compulsory treatment order under the Mental Health Act or the criminal equivalent. If further provision is needed, it should be by amending mental health law to ensure that any deprivation of liberty is contemplated and authorised by the tribunal, (or the sheriff in imposing a criminal disposal).

That said, we do have a concern that some services are currently using the suspension of detention procedure to place a person in a care home because it is quicker than guardianship proceedings. We understand why they do so in some cases, but it is not what the Mental Health Act is for, and we agree that this needs to be addressed in any new legislation.

6. The process to obtain a statement of significant restriction would, as the bill is currently drafted, sit alongside existing provisions safeguarding the welfare of incapable adults, and require the input of professionals already engaged in many aspects of work under the 2000 Act, such as mental health officers and medical practitioners.

Please give your views on the impact this process would have on the way the Act currently operates.

There is a need to focus on the proportionality and the practicability of the procedures. As we said in a submission to the SLC, which they quote at para 1.21 of their report:

> "An over-reliance on judicial procedures whereby a universalist approach is taken to seeking welfare guardianship whenever individuals lack capacity to make any decisions about their care and treatment will result in an unsustainable demand on the statutory services involved. The net result will be a process of professional assessment, application and judicial decision-making which is cursory, routine and overly bureaucratic. It will provide only the semblance of the rights of the individual being protected."

Although we understand why the SLC make their recommendations, we respectfully suggest that this risk has not been avoided in their proposals.

At the census point (March 2014) there were 36,751 residents in care homes in Scotland (Information source is ISD). Most of these will have some degree of mental disorder, and a very large number are likely to be incapable of consenting to their care and treatment, either at admission or subsequently. As far as we know, most will not have welfare powers of attorney.

There will also be several thousand people living in more domestic settings, supported by a local authority care package, whose situation might also meet the *Cheshire West* test.

There are very clear workload pressures on staff at present, with 2455 guardianship applications in 2014-15. The new procedures are likely to require mental health officer reports and court disposals in thousands more cases than

currently come before the courts. The small saving in only requiring one medical report to authorise a statement of significant restriction is likely to be greatly outweighed by the volume of new business. These proposals will therefore increase workload on a small number of professionals who are already stretched.

We also suspect that, in many cases, the making of a statement of significant restriction may prompt an application for guardianship by relatives, rather than forestall it.

To date, although guardianship applications have risen substantially in recent years, it is not evident that local authorities are insisting on guardianship applications in all cases potentially covered by the *Cheshire West* test. We accept that, if they feel obliged to do so in future, the impact on public bodies and professionals of introducing an alternative process such as that proposed by the SLC would be less.

As we set out in our suggested alternative approach below, we believe that restrictions of liberty should be fully considered as part of the care planning process.

If you do not agree with the approach taken by the Commission, please outline any alternative approaches you consider appropriate.

Rather than create a parallel process to cope specifically with the problem created by the *Cheshire West* judgement, we believe there is an opportunity to develop a proportionate and tiered approach, rooted in the AWI principles, and which reflects the increasing significance of supported decision making.

We propose a system of <u>graded welfare guardianship</u>, the general features of which we outline below. The Public Guardian has previously proposed a similar graded approach to financial guardianship, and we believe these approaches can be combined.

<u>Level 1: Registered supporter</u>

This would be a mechanism to recognise formally a person who supports the adult in decision-making. It would give effect to the concept of supported decision making, as called for by the UN Convention on the Rights of Disabled Persons. It also reflects the fact that many carers and family members still feel excluded and disempowered in dealings with services. Health and care services

and other bodies such as banks may refuse to share information with or seek input from those who, in practice, support the adult in day to day living. The lack of formal status raises problems in relation to obligations of confidentiality.

In our experience, it is this fear of lack of involvement which drives many families to seek guardianship, rather than a wish to control every decision of the adult. A less formal process which is explicitly designed as a model of supported decision making could, apart from its intrinsic value, reduce the pressures of guardianship applications.

There are various ways in which the appointment could be regularised – including approval by the local authority or registration with a public body (such as the Public Guardian or the Mental Welfare Commission) or the court. There would require to be evidence that, so far as can be ascertained, it is the will and preference of the adult that the appointed person be their supporter. No-one could be a supporter against the clearly expressed wishes of the adult. There could also be a light touch process of certification that the person is suitable to take on the role (perhaps by a "passport signatory" system).

Any person with an interest (including the adult) could challenge the appointment in the sheriff court, or seek appointment at one of the higher tiers.

We do not see this role as only being available for people who completely lack capacity – it should also be possible for individuals who have capacity to authorise a person to support them in the exercise of this capacity.

These are tentative suggestions, and there are a number of supported decision making systems in other jurisdictions which could serve as models.

In general the powers and duties would reflect the supporter role – health and social care providers and potentially other public and private bodies would have a duty to consult the supporter before making an intervention concerning the welfare or treatment of the adult.

Depending on the level of impairment of the adult, the supporter should be authorised to assist the person to make a decision, or should be able to express their view of what would be the will and preference of the person. Services would be obliged to have regard to this and would not be able to proceed with a decision which significantly conflicts with the supporter's assessment of the person's will and preference unless another level of

guardianship, or authority from other legislation was used.

Level 2a: '13ZA plus'

We suggest that s13ZA of the Social Work (Scotland) Act 1968 should be reformed to formalise best practice in care planning for incapable adults. Key to our approach is that these procedures should be able to be used in cases which may meet the *Cheshire West* acid test, but where the level of interference with the person's freedoms does not justify a requirement of prior court authorisation.

The legal framework could build on existing guidance:
http://www.sehd.scot.nhs.uk/publications/CC2007_05.pdf

It would require that

- There is proper, documented care planning and assessment of need, which identifies what restrictions of liberty may be involved in the delivery of care and the extent to which the adult is able to consent to those, and how far the adult accepts them
- The ability of the adult to participate in the process has been maximised, including by supports for decision making and access to advocacy
- There is clear evidence of the involvement of the person and their family in the process, and of how their views have been taken into account
- There are arrangements for regular review.

The restrictions of liberty to be recorded could be on the lines of the English Law Commission checklist, rather than be based on the *Cheshire West* criteria or the narrower Scottish Law Commission test.

The procedure could not be used where the restrictions reach a threshold which requires 'level 3' approval, or where the will and preference of the adult is being overridden. Any interested party who is unhappy could escalate the case to level 3.

There may be a need from some degree of formal oversight. We are hesitant about suggesting a process analogous to the DOLS procedure in England and Wales, which is perceived as highly bureaucratic and of limited value. In general, we think it more important that the people making the actual decisions about care have the right skills and procedures, rather than allocate large amounts of money and skilled professionals into a process of checking what others seek to do. On that basis, our provisional suggestion is that the

documentation be signed off by a mental health officer of the local authority.

However, an additional safeguard could be that the record of significant restriction is lodged with an independent body (the Mental Welfare Commission, the Public Guardian or even the sheriff court). That body could do some level of checking that the documentation is, on its face, appropriate. Subject to resourcing, the MWC could undertake risk-based visiting to some of those covered by this procedure, and could also monitor the overall use of the powers by different authorities. It should also be possible for the MWC to refer any case which it believed required more detailed scrutiny or judicial authorisation to a Level 3 hearing.

Level 2b: Non-court guardian

This process would create a means to regulate situations where families and others close to an adult are making day to day decisions on behalf of that adult, without requiring prior judicial authorisation.

In some ways, it seeks to provide for families what section 13ZA was intended to provide for local authorities – the authority to make arrangements to promote the welfare of the adult. This would include authorising the adult's place of residence, and agreeing to care packages.

It could not be used against the will of the adult, if the adult resists, or if there is dispute amongst the interested parties. It would not authorise severe restrictions on liberty.

There would require to be an application which would set out the powers sought. It would include a medical certificate of incapacity and a report from a health or social care practitioner with qualifications/experience/training and knowledge of the adult and applicant, as to the suitability of the applicant and the appropriateness of the powers sought. To reduce duplication of effort, this certification and reporting could be combined with assessments required for other decisions – e.g. an assessment of incapacity for medical treatment, or the development of a care plan.

There are various options for the appointing authority. The most practical may be the Chief Social Work Officer. The CSWO would have a supervisory role, including receiving regular reports from a supervising officer, and a duty to

investigate any complaint about the actions of the guardian. The CSWO would also have a duty to initiate a level 3 guardianship application in any situation where this is necessary to authorise particular interventions, or desirable to protect the interests of the adult.

There is an issue of conflict of interest, given that the local authority may also be heavily involved in the provision of care. If that is felt to be a fatal objection, it might be possible for an application to be authorised by an independent body (the Public Guardian or the Mental Welfare Commission), or for it to be formally approved by the sheriff court in an administrative procedure. Whether or not there is authorisation by a national body, we would support a process of national recording of such decisions for monitoring purposes.

The appointing authority could cancel the appointment on cause shown. Challenges by any other interested party to the appointment or seeking removal of authority could be made to the Sheriff and could be combined with an application for level 3 welfare guardianship. Again, the MWC would have a power of reference to the sheriff.

The Sheriff would also have power in any level 2 hearing to make an order for level 3 guardianship at his/her own discretion. Alternatively, the sheriff court could be given similar authority as it currently has in relation to welfare proxies under s 3 and 20 of the AWI Act.

<u>Level 3: full guardianship</u>

This would be used where it is believed that the powers sought would entail a serious restriction of liberty of the adult or where there is a dispute as to the action needed in relation to welfare or treatment matters. It would be the only level of guardianship that requires court authorisation, under a process similar to the present guardianship application.

Applications would continue to require two medical reports and a report by an MHO on the necessity of level 3 powers and the suitability of the proposed guardian. There would remain a requirement on local authorities to take forward applications where necessary and no one else is doing so. It would still be possible to appoint the Chief Social Work Officer as welfare guardian. Supervision of the guardian and the visiting of the adult would remain local authority statutory duties as set out in Regulations.

The main changes from the current system would be

- A much greater participation of the adult than is currently the norm, with an explicit duty to seek to ascertain their will and preference
- It might be acceptable to have one medical report, rather than two
- There should not be indefinite orders, and some level of periodic review should be built in. We understand that European caselaw may suggest a need for annual review, but this may not need to involve a new court hearing at every stage. The Mental Health Act provides that some periods of detention can be extended by the responsible medical officer without a further tribunal hearing, provided a process of review is carried out and certified. Something similar could be done annually in these cases, with a judicial review perhaps at least once every five years.

We refer to the sheriff court above for consistency with the current AWI Act. However, we support consideration of whether the Mental Health Tribunal (or another tribunal in the planned Mental Health chamber of the new unified tribunal service) could replace the sheriff in AWI cases.

Principles and Safeguards

The Principles of the Act would still apply at all levels. The existing protections that exist in the legislation such as sections 3, 9, 10, 14, and 20 would all be retained. Sections 57(2), 59(1) (b), 70 and 71 would only be retained in respect of level 3 guardianship.

At every level, it should be straightforward for any interested party, including the individual, family members, the local authority, independent advocates and the MWC to refer any concerns to the court.

We feel such a model would have the following benefits:

- Gives recognition to supported decision making
- Focuses attention on the real concerns about interference with the liberty and dignity of adults
- Promotes the rights of family and carers
- Reduction in court time, legal aid costs and workload for MHOs and doctors

- Simpler mechanisms for basic consultation and authorising decisions.

We acknowledge this scheme needs further work. More discussion is needed on what powers may be exercised at what level, who should register or authorise the first two tiers, and how reports for family members could be paid for in non-court cases (where civil legal aid would not be available). The MWC would be happy to participate in such further discussion, if this proposal is felt to have merit.

Our proposal would not provide automatic judicial review of all cases that may cross the *Cheshire West* threshold. That said, nor do the Scottish Law Commission proposals, nor those from the English Law Commission. We believe the safeguards we propose are not just more proportionate; they would prove more effective in protecting the rights of the adult.

Ultimately, we feel it is reasonable to hope that domestic or European judges would be supportive of a carefully developed process which provides genuine protection against deprivation of liberty, focusing most attention on the most intrusive interventions.

POWER TO MAKE ORDER FOR CESSATION OF UNLAWFUL DETENTION

1. Is a process required to allow adults to appeal to the Sheriff against unlawful detention in a care home or adult care placement?

Yes	✓	**No**	

Please provide an explanation for your answer

We support the arguments in the Law Commission report. In our visits, we do encounter people whom we regard as *de facto* detained: i.e. they have not consented to be where they are, and nor do they wish to be there, or subject to the constraints of the particular regime. This is clearly incompatible with Article 5, and requires an effective remedy. While a new legal framework may increase awareness of the need for lawful authority for deprivation of liberty, we do not believe it will remove all poor practice.

Currently the Mental Welfare Commission's advice is that s13ZA can only authorise care and placement if all relevant parties and the adult, in as much as they are able to express their views, are content with the care arrangements. It is possible that a local authority may ignore this advice and continue to use s13ZA as a justification for a care placement in the face of opposition by a relevant person or the adult, and this provision would help bridge that gap.

2. Is the proposed approach comprehensive?

Yes		**No**	✓

Please provide an explanation for your answer

There does not appear to be any process of notification, no clarity on the reports to be produced, no timescales, and no limit on the frequency of such applications being made.

3. Are there any changes you would suggest?

The notes to Section 52J suggest it only applies to adults who lack capacity. We believe it should be open to people who may always have had, or have regained, capacity to make an application.

If the adult has been assessed as having capacity, then the sheriff should be able to order their release under s52J. This might apply for instance where an adult with alcohol related brain damage recovers capacity and no longer accepts the need for residential care.

We would suggest that in any case where the adult, lacks, or may lack capacity, and resists the care provided in a residential setting or feels that placement in that setting to be excessive for their need, that this should trigger consideration by the local authority of a guardianship application. On receiving a s52J application the court could order a guardianship application be lodged within a timescale and warn that if there were a failure to lodge an application order the adult may be released.

We note here that, unlike s50C for patients wanting to apply for discharge from a general hospital, the sheriff is not required to consider at s52J the additional criterion of no "appropriate long-term care" alternative being available.

In the notes to s52J it suggests the sheriff could bridge this gap by using directions at section 3(1) of the 2000 Act. We would want clarity about how they could do this, and why, if this is possible, they could not bridge this gap at s50C.

Finally, we believe the process should be at least as quick and simple to trigger as the comparable process in the Mental Health (Care and Treatment) Act, which can be initiated by a simple form downloadable from the tribunal website, and where a hearing will be held within 5 days.

NEXT STEPS/WIDER REVIEW

Over and above the question of deprivation of liberty considered by the Commission do you believe the 2000 Act is working effectively to meet its purpose of safeguarding the welfare and financial affairs of people in the least restrictive manner?

Yes		**No**	✓

Please provide an explanation for your answer
If you have answered no, can you please suggest two or three key areas which any future wider review of the provisions of the 2000 Act might consider

We believe the entire legislative framework for non-consensual care and treatment (Adults with Incapacity Act, Mental Health (Care and Treatment) Act and Adult Support and Protection Act) requires a comprehensive review for the following reasons

- The **development of international human rights norms** (particularly the UNDCRPD but also ECHR cases such as *X v Finland 2012 MHLR 318*) has called into question several of the underlying assumptions of the legislation, including the potentially discriminatory use of mental disorder as a gateway to compulsion, the balance between substituted and supported decision making, and the sharp distinction between capacitous and non-capacitous decision making
- The sharply increasing use of guardianship (even without *Cheshire West*) is placing **unsustainable pressures** on courts and particularly mental health officers, and on the legal aid budget. This increasingly means that the safeguards in the legislation do not operate effectively
- Although there has been a welcome reduction in the use of indefinite orders, there is still a tendency to **wide general powers** being granted, sometimes with little apparent evidence of need, and generally with very little involvement of the adult in the process. This is not consistent with the intentions of, and principles in, the AWI Act
- There are many areas where **the three Acts overlap in complex and confusing ways** – and the SLC proposals would add to these. In the light of the new Northern Irish unified legislation, we believe it is time to explore a unified legal framework which applies a coherent set of principles and a single judicial body to oversee statutory measures

- At the moment, there are different reviews underway or planned, including this consultation, and a separate promised review of the inclusion of learning disability and autism in the Mental Health Act, which is also intended to review the use of psychotropic medication and the role of psychologists. We do not believe the position of learning disability in the 2003 Act can be reviewed without linking it to the provisions the AWI Act, or indeed considering the implications for other groups such as people with dementia. **A disconnected series of piecemeal reviews is highly undesirable**.

Focusing specifically on AWI, the following are areas we believe should be reviewed (in addition to the proposals on graded guardianship which we cover in our earlier comments)

- Ensuring **compliance with the UNCRPD**, in the light of the forthcoming report by the Essex Autonomy Project, including a more positive requirement to assist and support the adult in decision making
- Whether the **judicial forum** should be a tribunal in the new mental health chamber, rather than the sheriff court
- The possible need for an **emergency or urgent order**, in situations where the time taken for even an interim order will be too long
- The **powers which guardians may or may not have** – there is still uncertainty over the extent to which guardians can authorise certain types of restraint, or return people who leave the place the guardian has determined they should stay
- The procedures intended to provide a **simple alternative to guardianship** in common situations – Parts 3 and 4 of the Act are under-used, and there should be a simpler process to manage direct payment arrangements for social care
- The interaction of Part 5 of the Act and the **common law authority** to provide or withhold medical treatment – there is uncertainty over the status of **advance decisions to refuse treatment** (which have statutory force in England and Wales) and over the legal authority for a treatment decision in emergency situations. There is also a specific issue over the interaction of the AWI Act and the Human Tissue (Scotland) Act 2006, which has called into question the basis on which an incapable adult can give a bone marrow transplant
- **Consolidating the process of appointment of a welfare attorney with other procedures**, such as appointing a named person or making an advance statement under the Mental Health Act, to make it easier for people to plan for any future incapacity/illness

- **Jurisdictional issues**, particularly cross-border recognition of guardianship and powers of attorney, clarifying the complex interaction of residence requirements (where AWI applies a different test from the rules on which local authority should fund care), and making it possible to apply for guardianship in advance of a move to Scotland
- **The duties of the Mental Welfare Commission** under AWI – in particular we feel it would be helpful if we had a similar responsibility as under the 2003 Act to monitor the operation of the Act and to promote its principles.