LPS is coming, and what can we do whilst we wait?

February 2020

Alex Ruck Keene

Barrister, 39 Essex Chambers

Wellcome Research Fellow and Visiting Lecturer King's College London

Visiting Senior Lecturer, Institute of Psychiatry, Psychology and Neuroscience, King's College London

Research Affiliate, Essex Autonomy Project, University of Essex

alex.ruckkeene@39essex.com

@capacitylaw

Tying LPS to the MCA

- The MCA comes first
- How well do you know the MCA?
- How well do your staff know the MCA?
- How well do your partners know the MCA (the Mrs Jones test)?
- What can you do to improve their knowledge?

What makes a good capacity determination?

"The fundamental principles of self-determination, freedom from non-consensual medical treatment and personal inviolability, and the equally fundamental principles behind the right to health, are most respected by capacity assessments that are criteria-focussed, evidence-based, person-centred and non-judgmental. Such assessments engage with the demand (or plea) of the person to be understood for who they are, free of pre-judgment and stereotype, in the context of a decision about their own body and private life."

PBU & NJE v Mental Health Tribunal [2018] VSC 564

What is a deprivation of liberty?

- Article 5 ECHR:
  - Objective element: confinement to restricted space for non-negligible period of time: ‘the acid test’
  - Subjective element: either cannot or will not give valid consent
  - Imputable to the state: the state knows or ought to know of the confinement

Consequences

- Can only be authorised by a procedure prescribed by law – a check on arbitrariness
- Right to challenge before a court
- Damages for the person if unlawfully deprived of liberty or not given effective right of challenge

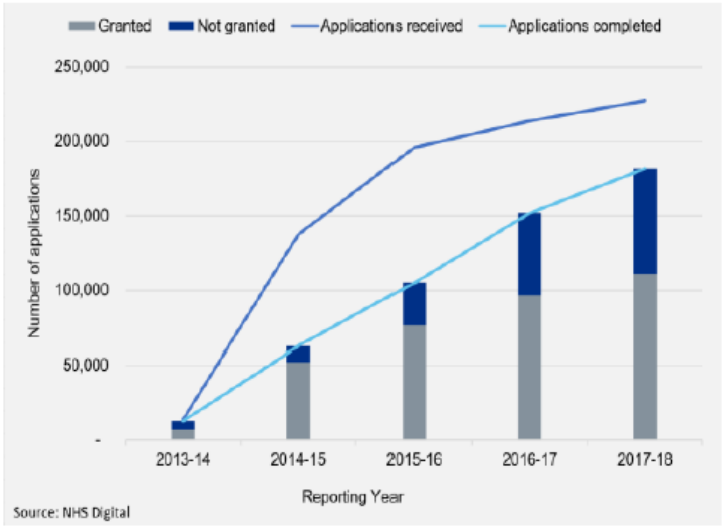
Authorisation: the present

- Deprivation of Liberty Safeguards:
  - 18 +, hospitals and care homes
  - Urgent authorisation: 7 days, renewable once
  - Standard authorisation: granted by local authority supervisory body
  - No definition of deprivation of liberty

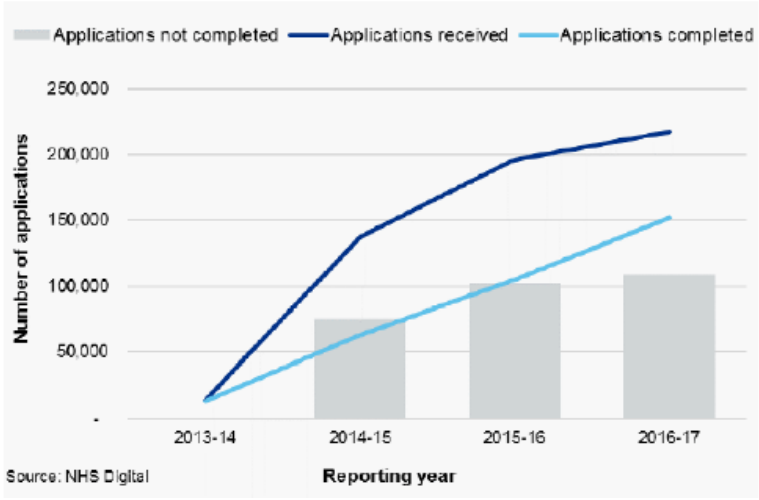
The problems at present (1)

- Post *Cheshire West* backlogs in relation to care homes and hospitals

DoLS applications in England, 2013-18



Backlog numbers 2013-2017



The problems at present (2)

- DoLS doesn't apply outside care homes and hospitals: e.g. supported living, own home, and doesn't apply to those under 18
  - So need to go to the Court of Protection for a 'community DoL' order
- Criticisms of complexity of DoLS by House of Lords
- Combination of all of these led to Law Commission report in 2017 and legislation in 2018-9

The Mental Capacity (Amendment) Act 2019 in one slide

- Body of the Act:
  - Revised s.4B – court approval, replacement for urgent DOLS and emergency
  - Provisions relating to Court of Protection

- Schedule AA1: The Liberty Protection Safeguards
  - Setting neutral and more than one setting, from age 16
  - Authorisation by responsible body – NHS for CCG/hospitals, LA for all other cases (including self-funders and independent hospitals). Potential for delegation of some tasks to care home managers in some cases
  - Conditions: capacity, mental disorder and necessity and proportionality (of risk to self alone)
  - Additional scrutiny by AMCP in 'RTB' cases (and independent hospitals)
  - (Broadly) opt-in representation and support by appropriate person/advocate (latter on 'all reasonable steps' basis)
  - Provisions for variation, review and renewal (1 year, 1 year then up to 3 years)
  - (Broadly) the same interface between the MCA and MHA as under DOLS

LPS: what's the point?

- Deprivation of liberty is everyone's business
- Moving consideration to the frontline
- It's not about the backlog

Deprivation of liberty

- Government proposed 'exclusionary' definition – i.e. if X then not deprived of liberty
- Lords advanced alternative definition codifying acid test
- Government compromise – no statutory definition but guidance in Code of Practice (to be reviewed regularly)
- No provision for advance consent (as Law Comm had proposed) but Government thinks works in palliative care setting as matter (?) of interpretation of concept of subjective element of consent
- Attorney/deputy cannot consent (as at present) to prevent confinement being deprivation of liberty
- And nb, parent cannot seek to authorise confinement for 16/17 year old who cannot consent to confinement: *Re D* [2019] UKSC 42

When will LPS be relevant for the NHS?

- In hospital when circumstances amount to deprivation of liberty
  - Advance consent to planned operations and post-operative delirium
  - Advance consent to palliative care
  - The exception for 'ordinary' life-saving medical treatment: how wide does the 'carve-out' go: http://www.39essex.com/mental-capacity-guidance-note-deprivation-liberty-hospital-setting

- Outside hospital, CHC funded care amounting to deprivation of liberty in any setting, including the person's own home

- Note the position of hospices: most will count as independent hospitals, so responsibility will lie with local authorities (either arranging the care for the person or where the hospice is present)

Deprivation of liberty: emergency and interim authority

- Section 4B to be amended so as to give authority to deprive of liberty:
  - Pending resolution by court of question of authorisation (as at present)
  - Pending authorisation under LPS
  - In emergency

- In all cases, contingent on
  - Reasonable belief in lack of capacity to consent (new)
  - Necessary to deliver life-sustaining treatment/carry out vital act

- No time limit - no more 'urgent' authorisation – (if follow Law Commission approach) intended safeguard advocacy/appropriate person

The centrality of ‘arrangements’ (para 1)

- “Arrangements” – the LPS keyed to arrangements for enabling care and treatment of 16+ giving rise to a deprivation of liberty
  - Can be in any setting, or multiple settings
  - Can include arrangements for transport
  - Can include arrangements to ensure return of individual to particular placement(s)

Main arrangements which cannot be authorised

- "Mental health arrangements" for in-patient treatment for mental disorder to which person objects (as with DoLS) (para 54) (but subject to LD exception)
  - Note that could have LPS alongside MH detention for additional deprivation of liberty to which patient subject for physical health treatment – e.g. *Dr A* case.

- Arrangements which conflict with MH requirements (e.g. s17 leave, guardianship, CTO, conditional discharge)

- (According to Government, but not on face of Act) arrangements conflicting with decision of attorney/deputy as to where the person is to live

- Nb ADRT 'no refusal' provision not carried forward

Responsible body (paras 6-13)

- If carried out mainly in an NHS hospital: the hospital manager (in most cases the trust that manages the hospital in England or the local health board in Wales)
- If carried out mainly through the provision of NHS continuing health care: the relevant clinical commissioning group in England or local health board in Wales
- Otherwise: the responsible local authority, identified (in most cases) on basis of OR, but physical location in the case of independent hospital
- NB, the RB identity can change (e.g. if person becomes eligible for CHC care) without necessarily ending authorisation – but limits to what new RB can do to vary authorisation

Process (para 17)

- Responsible body takes necessary steps to secure determination of conditions, consultation, advocacy/appropriate person support and pre-authorisation review (by AMCP where relevant)

- RB can outsource steps, except for pre-authorisation review, to care home managers where arrangements (for 18 plus) are in care homes

Conditions for authorisation (paras 18; 21-22)

- Determination on capacity assessment: lack of capacity to consent to arrangements (no express provision for fluctuating capacity)
- Medical assessment: person has a mental disorder (not limited on face to s.12 psychiatrists)
- Necessary and proportionate assessment: likelihood of harm to self alone (not to others), and express requirement to have regard to cared-for person's wishes and feelings
- Can make use of existing assessments for capacity/medical assessment, not for N&P

Care homes (paras 19-20)

- If RB delegates, care home manager can:
  - Coordinate process and produce statement
  - Make determinations as to capacity/mental disorder based upon assessments by others
  - Undertake consultation
  - Produce draft authorisation record

- Care home manager cannot:
  - Carry out assessments themselves
  - Rely upon assessments conducted by those with "prescribed connection" to care homes (waiting to see regulations)
  - Determine that the deprivation of liberty is necessary and proportionate

- NB: for Code
  - Criteria for delegation
  - Can care home manager refuse delegation?

Consultation (para 22)

- By care home manager if RB has delegated to them, otherwise by RB
- With statutory list, including cared-for person
- Main purpose to try to ascertain the cared-for person's wishes or feelings in relation to the arrangements

Pre-authorisation review

- Reviewer not involved in day to day care and treatment of person, providing treatment to cared-for person or with prescribed connection to care home in case of care home arrangements

- Task to review information (not interview cared-for person) and decide whether reasonable for RB to conclude authorisation conditions are met

Authorisation

- Where conditions met (including pre-authorisation review by AMCP if required and preparation of draft authorisation record) RB may authorise (para 17)
- Government intention that will be authorisation in advance of arrangements (up to 28 days) (para 28(2))
- Then creation of authorisation record (para 27) – including programme for review
- Effect of authorisation – defence to liability to acts done pursuant to authorisation (not acts of care and treatment themselves) (new Section 4C)

AMCP pre-authorisation review (paras 24-25)

- Review:
  - In 'RTB' cases – i.e. Reasonable To Believe that the person does not wish to reside at / receive care and treatment at the place
  - In independent hospital cases
  - Where RB referred to AMCP and AMCP accepted

- AMCP to be approved by LA (para 39)

- Cannot be involved in day to day care/treatment of individual

- Task to review information to determine whether conditions are met

- Must meet individual if appears practicable or appropriate, and may consult and take any other steps necessary

Duration, termination, and variation

- Can be renewed, on first occasion for up to 12 months, and on second and subsequent occasions for up to 3 years (para 32); can delegate requirements to care home manager in care home case

- Can be terminated by RB, and will cease to have effect if automatic cessation where RB determines it should or where believes or ought reasonably to suspect that authorisations conditions no longer met (para 29)
  - Protection for those acting on basis of authorisation if no reason to believe that has come to an end (para 31)

- Can be varied after consultation and where reasonable (but Government view cannot vary to cater for entirely new arrangements e.g. after emergency admission to hospital) (para 37)

Safeguards

- Reviews – RB unless delegated by RB to care home
  - Planned programme of reviews in authorisation record (para 27)
  - Also where variation of conditions (para 38)
- Representation and support by appropriate person, on an opt-in basis where have capacity and where would be in BI where lack capacity (para 41)
- Where no appropriate person, "all reasonable steps" to provide advocate on opt-in basis with capacity, and unless provision not in BI where lack capacity (para 41)
- Appropriate person eligible for advocacy support as well on "all reasonable steps" opt-in basis (para 42)
- LA for area under statutory duty to make such arrangements as it considers reasonable to enable IMCAs to be available to support people under LPS
- Right of access to court
  - S.21A replaced with s.21ZA – and non-means-tested legal aid
  - Section 16A abolished (eligibility fetter on Court of Protection)

Implementation for local authorities (1)

- Responsibilities as local authority (not RB)
- To publish information about
  - Effect of authorisation, process of authorisation, assessments/determinations/consultation/pre-authorisation review/IMCAs/AP role/AMCP/right to make application to court/review/right to request a review/referral to AMCP
  - Accessible to and appropriate to the needs of cared-for persons and appropriate persons
- To make arrangements to enable IMCAs to be available to represent and support
- To make arrangements for approval of AMCPs and ensure that enough are available for their area

Implementation for local authorities (2)

- Who will LA have RB responsibilities for?
  - Independent hospitals
  - Self-funders
  - Anyone else who is not either in NHS hospital or mainly under CHC-funded arrangements

- Preparing for care home delegation

Implementation for local authorities (3)

- Who will do relevant tasks?
  - Consideration of age
  - Consideration of whether arrangements are mental health arrangements
  - Capacity assessment
  - Medical assessment
  - N&P assessment
  - Pre-authorisation review
- How much can be integrated into care planning
- Who will be your AMCPs?

Implementation for NHS hospitals (1)

- Responsibility on "hospital manager" of each NHS hospital to publish information about
  - Effect of authorisation, process of authorisation, assessments/determinations/consultation/pre-authorisation review/IMCAs/AP role/AMCP/right to make application to court/review/right to request a review/referral to AMCP
  - Accessible to and appropriate to the needs of cared-for persons and appropriate persons
  - ? Standard forms – but even so, do they need modifying for specific patient groups?

Implementation for NHS hospitals (2)

- Identification of likely patients to be subject to LPS, i.e. in circumstances amounting to deprivation of liberty

- Specific considerations:
  - Advance consent to planned operations and post-operative delirium
  - Advance consent to palliative care
  - The exception for 'ordinary' life-saving medical treatment: how wide does the 'carve-out' go: http://www.39essex.com/mental-capacity-guidance-note-deprivation-liberty-hospital-setting
  - Matters for Code of Practice, but can start thinking now

- At what stages from admission to discharge will deprivation of liberty need to be considered?

Implementation for NHS hospitals (3)

- Who will do relevant tasks?
  - Consideration of age
  - Consideration of whether arrangements are mental health arrangements / clash with mental health requirements
  - Capacity assessment
  - Medical assessment
  - N&P assessment
  - Pre-authorisation review

- How much can be integrated into care planning, and at what stages from admission to discharge?

- Who will be your AMCPs?

Implementation for CCGs (1)

- Responsibility on CCGs to publish information about
  - Effect of authorisation, process of authorisation, assessments/determinations/consultation/pre-authorisation review/IMCAs/AP role/AMCP/right to make application to court/review/right to request a review/referral to AMCP
  - Accessible to and appropriate to the needs of cared-for persons and appropriate persons
  - ? Standard forms – but even so, do they need modifying for specific groups

Implementation for CCGs (2)

- Identification of likely people to be subject to LPS, i.e. in circumstances amounting to deprivation under "arrangements carried out mainly through the provision of NHS continuing healthcare under arrangements made by a clinical commissioning group"

- Specific considerations
  - Respite placements?
  - Planned admissions into hospital?

Implementation for CCGs (3)

- Who will do relevant tasks?
  - Consideration of age
  - Consideration of whether arrangements are mental health arrangements / clash with mental health requirements
  - Capacity assessment
  - Medical assessment
  - N&P assessment
  - Pre-authorisation review
- How much can be integrated into care planning?
- Who will be your AMCPs?

Implementation for care homes

- Identification of those likely to be subject to LPS, i.e. in circumstances amounting to deprivation of liberty
- Who will be your Responsible Body
  - LA: if so, which one?
  - CCC
- If you're a care home manager, what do you need to do to be able make these statements:
  - that the cared-for person is aged 18 or over,
  - that the arrangements give rise to a deprivation of the cared-for person's liberty,
  - that the arrangements are not mental health arrangements/clashing with mental health requirements.
  - that capacity, medical and N&P determinations have been made (by the right people doing the assessments without 'prescribed connections')
  - that you have carried out consultation, and
  - about whether it is reasonable to believe that the person does / does not wish to live in the care home / receive care and treatment in the care home, or do not know
- And to be able to prepare a draft authorisation record

Implementation for independent hospitals (1)

- Identification of likely patients to be subject to LPS, i.e. in circumstances amounting to deprivation of liberty
- Not just psychiatric hospitals – physical health hospitals as well
- The position of hospices
- Specific considerations:
  - Advance consent to planned operations and post-operative delirium
  - Advance consent to palliative care
  - The exception for 'ordinary' life-saving medical treatment: how wide does the 'carve-out' go: http://www.39essex.com/mental-capacity-guidance-note-deprivation-liberty-hospital-setting
  - Matters for Code of Practice, but can start thinking now
- At what stages from admission to discharge will deprivation of liberty need to be considered?

Implementation for independent hospitals (2)

- Identification of likely patients to be subject to LPS, i.e. in circumstances amounting to deprivation of liberty
- Not just psychiatric hospitals – physical health hospitals and hospices as well
- Which LA will be your RB?
- How much work can you do (including re the draft authorisation record) before you send to AMCP?

Where next?

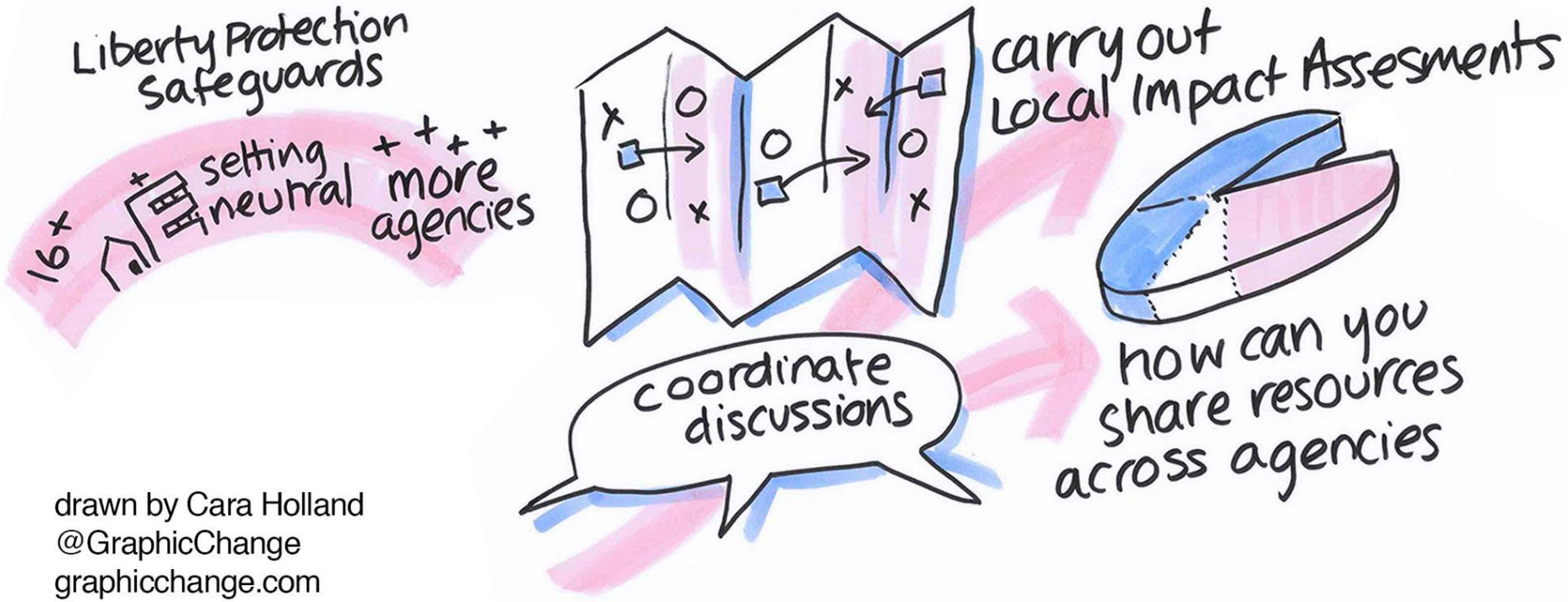
- Implementation day
- Regulations required – e.g. as to knowledge and experience required for assessors
- Code of Practice – in parallel or as part of new single Code (main Code also under review)
- Transition arrangements – including backlog

Things to keep an eye on

- Case-law
- DHSC fact sheets
- Implementation plans – national and sector-specific
- Code of Practice – MCA and LPS
- Regulations
- http://www.mentalcapacitylawandpolicy.org.uk/resources-2/liberty-protection-safeguards-resources/

Things to do whilst we wait

- Local impact assessments
- Sharing expertise
- Planning to share personnel
- Identifying sources of advocacy



drawn by Cara Holland
@GraphicChange
graphicchange.com

Keeping yourself up-to-date

- http://www.39essex.com/resources-and-training/mental-capacity-law/
- www.mentalhealthlaw.co.uk
- http://www.scie.org.uk/mca-directory/
- http://www.mentalcapacitylawandpolicy.org.uk/resources-2/liberty-protection-safeguards-resources/
- www.courtofprotectionhandbook.com

@capacitylaw