

OUTLINE OF THE PROPOSED PROTECTIVE CARE SCHEME

1. The Law Commission's consultation paper on deprivation of liberty was published on 7 July (Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (2015) CP No 222). It puts forward a comprehensive replacement scheme for the Deprivation of Liberty Safeguards. We have called this new scheme "protective care". This document provides a brief overview of how we envisage that the scheme will work.

Protective care

2. Protective care is intended to deliver improved health and care outcomes, whilst removing unnecessary bureaucracy and ensuring compliance with human rights. To achieve this, it establishes different approaches in different settings, including hospitals, care homes, supported living and shared lives accommodation, and in some cases, family and other domestic settings. It would apply to people aged 16 years and over.
3. Broadly speaking, protective care has three parts: the supportive care scheme, the restrictive care and treatment scheme, and the hospitals and palliative care scheme.

Supportive care

4. The decision to move to new accommodation can have significant consequences for a person, and will frequently engage rights to privacy, family life and the home. Supportive care would provide protection for people whose rights are at risk, but who do not require forms of care and treatment which impinge on their liberty. Supportive care would therefore apply where a person is living in, or being considered for a move into, care home, supported living or shared lives accommodation, but lacks capacity to make decisions about their living arrangements. It would put an emphasis on prevention, and seek to reduce the need for more intrusive interventions in the longer term.
5. Where a local authority considers that a person may qualify for supportive care, it would be required to arrange an assessment, or ensure that one takes place. The assessment could be undertaken by anyone that the local authority thinks is appropriate, including social workers or nurses already working with the person. In the vast majority of cases, an assessment should have already taken place (for instance under the Care Act 2014 or Mental Capacity Act 2005), and so it should be just a matter of making sure that all the relevant issues have been addressed.
6. If this assessment shows that the person is eligible for supportive care, a number of ongoing safeguards would apply. These include the appointment of an independent advocate or an "appropriate person". Amongst other matters, advocates and appropriate persons would be tasked with ensuring that the person has access to the relevant review or appeals process (for example the appeals mechanism under the Care Act, the social care complaints system in Wales, or the Court of Protection under the Mental Capacity Act). Supportive care would also require local authorities to:
 - keep the person's health and care arrangements under review, including checking whether a referral to the "restrictive care and treatment" scheme (see below) is needed; and
 - ensure that the person's care plan includes a record of capacity and best interests assessments, sets out any restrictions being placed on the person, and confirms the legal arrangements under which the accommodation is being provided.

7. In most cases, assessments and ongoing reviews will already be happening, for instance through the Care Act in England, the community care process in Wales, and the requirements of best interests decision-making under the Mental Capacity Act. In such cases it would simply be a matter of the local authority linking with existing reviews to discharge this responsibility.

Restrictive care and treatment

8. The restrictive care and treatment scheme provides the direct replacement for the DoLS. But, importantly, it is not organised around the concept of a deprivation of liberty. Instead, the scheme looks at whether care and treatment arrangements have become sufficiently restrictive or intrusive to justify enhanced formal safeguards. These circumstances would include being deprived of liberty, but also circumstances falling short of this.
9. A person would be eligible if:
 - they are moving into, or living in, care home, supported living or shared lives accommodation;
 - some form of “restrictive care or treatment” is being proposed; and
 - the person lacks capacity to consent to the provision of the “restrictive care or treatment”.
10. The meaning of restrictive care and treatment would be determined by reference to an illustrative list. The list would include care and treatment where the person is subject to continuous supervision and control or is not free to leave. It would also cover instances where the person either is not allowed, unaccompanied, to leave the premises, or is unable, by reason of physical impairment, to leave those premises unassisted. It also refers to cases where barriers are being used, the person’s actions are controlled, the person objects, or significant restrictions are being placed on diet, clothing or contact.
11. The restrictive care and treatment scheme would be based around a revised role for the Best Interests Assessor (known as the “Approved Mental Capacity Professional” (AMCP) under our proposals). The local authority would be required to refer cases to an AMCP. The AMCP would be required either to undertake an assessment themselves or to arrange for such an assessment to be undertaken by a person already involved in the person’s care (for example, their social worker or nurse). The assessment would need to determine if the above criteria are met and whether the proposed care or treatment should be authorised. AMCPs would be in the same position legally as Approved Mental Health Professionals. In other words, they would be acting as independent decision-makers on behalf of the local authority.
12. Where a person is assessed as eligible for the scheme, an AMCP would be allocated to their case. The AMCP would be required to ensure that:
 - the decision-making processes and care arrangements continue to comply with the Care Act, Mental Capacity Act and continuing health care regulations;
 - regular review meetings take place (involving the family); and
 - an advocate or appropriate person, and representative have been appointed.
13. The AMCP would also have power to discharge the person from the restrictive care and treatment as appropriate, and have responsibility for imposing conditions or making recommendations on the care and treatment authorised by the care plan.

14. People subject to the restrictive care and treatment scheme would have the right to challenge their care and treatment arrangements before the First-tier Tribunal, and to appeal either to the Court of Protection or to the Upper Tribunal.

Deprivations of liberty

15. Under the restrictive care and treatment scheme, some people may need to be deprived of liberty. In these cases, the AMCP would need to expressly authorise the deprivation of liberty, or seek alternative solutions to avoid the need for it (such as the provision of services to end the deprivation of liberty).
16. In order to authorise the deprivation of liberty, the AMCP would need to certify in the person's care plan that objective medical evidence had been provided, and that the deprivation of liberty was in the person's best interests. Under this system, the care plan would therefore become sufficient authority for the care provider named in the plan to deprive the person of liberty if necessary, in accordance with the terms of the plan. The duration of the authority would be set by a review date (with a limit of 12 months). Where a deprivation of liberty is authorised, the person would remain subject to the same safeguards as those provided under the restrictive care and treatment scheme above, including rights to review.

Hospital settings and palliative care

17. A separate scheme would apply to authorise deprivation of liberty hospitals and palliative care. This would apply where a patient requires (or there is a real risk the patient will require) care or treatment in his or her best interests that amounts to a deprivation of liberty, but the patient lacks capacity to consent to such care or treatment.
18. If the patient qualifies for this scheme, they may be deprived of liberty for up to 28 days based on the assessment of a clinician (which has been certified by a registered medical practitioner). The hospital's managers would then be required to appoint an advocate or an appropriate person for the patient, and to assign a clinician to take responsibility for their care and treatment.
19. Patients under the scheme would also have rights to challenge their detention before the First-tier Tribunal, and to appeal to the Upper Tribunal or Court of Protection.
20. A deprivation of liberty under this scheme would only be permitted to extend beyond 28 days if an AMCP also assesses the person and confirms that the above conditions are met. In such cases a deprivation of liberty could be authorised for up to 12 months.

The Mental Health Act 1983

21. There would be a new mechanism under the Mental Health Act to enable the admission to hospital of people who lack capacity and are not objecting to their care and treatment. The safeguards provided would include an independent advocate, a requirement for a second medical opinion for certain treatments and rights to appeal to the Mental Health Tribunal. The Mental Capacity Act (and our new scheme) could not be used to authorise the hospital admission of incapacitated people who require treatment for mental disorder.