

Case study: a practical analysis of a mental capacity assessment

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Introduction

This practice analysis reflects on a particular piece of work analysing issues of mental capacity, choice, best interests and deprivation of liberty. It is written by Daniel Baker, lead officer – Mental Capacity Act and Dols, safeguarding vulnerable adults team, at Central Bedfordshire Council. For the purpose of demonstrating depth and breadth of knowledge, at points during this case study he has hypothetically explored what actions may have been required if the circumstances were different.

The analysis of how the case was handled is provided by Steven Richards, director of Edge Training & Consultancy, who provides training on the Mental Capacity Act and deprivation of liberty safeguards. The legal analysis at the end of the case study is provided by Jess Flanagan, associate solicitor at Clarke Willmott, who specialises in welfare proceedings in the Court of Protection.

The case

Mrs Smith (not her real name) was 87-years-old. She had a diagnosis of dementia and presented with periods of short-term memory loss. Mrs Smith lived alone with a care package consisting of four double-up care calls per day. A hoist was required for all transfers. In addition to the care workers, Mrs Smith's ex-husband visited daily to assist. Despite the care package there were reports of frequent falls requiring paramedics to attend because Mrs Smith asked her ex-husband to assist with transfers between the allotted care calls. Mrs Smith disclosed to her social worker that her ex-husband "gets frustrated" and has hit her. A bruise was noted on her face at the time of this disclosure. Mrs Smith agreed for a period of respite care which was arranged by her social worker while further assessments and enquiries took place regarding the safeguarding disclosures.

My involvement started after Mrs Smith had moved into respite care. I was asked to support the allocated social worker with Mrs Smith's mental capacity assessment in relation to accommodation. This piece of work formed part of a much wider intervention by the allocated social worker, including enquiries and risk assessments completed in line with Central Bedfordshire Council's multi-agency adult safeguarding policy.

Analysis

The fact that Mrs Smith was already in respite care raises the question of whether her capacity to consent to this specific decision was assessed before the admission. In this case, Mrs Smith was assessed as having capacity to agree to going into respite. The [Supreme Court ruling in the Cheshire West case](#) means that if a person is moved to a 24-hour staffed residential care placement and they lack capacity to consent to admission, then the potential for deprivation of liberty becomes a real possibility. The court judgment in [AJ v A local authority \[2015\] EWCOP 5](#) noted that in the vast majority of cases it should be possible for a standard authorisation under the Deprivation of Liberty Safeguards to be put in place before a person has moved into a placement, where it is likely that the placement will lead to a deprivation of liberty.

In fact, this is expected by the Dols code of practice, chapter 3. Given the practical lowering of the threshold for deprivation of liberty, as a result of the Cheshire West decision – in that a person is deprived of their liberty if under continuous supervision and control, not free to leave and their confinement is the responsibility of the state – many people who lack capacity to agree to residential care are potentially likely to meet the threshold.

The Mental Capacity Act 2005 provided the legal framework for my intervention. The act must be followed and, by section 42 of the act, I was required to have regard to the guidance in the accompanying code of practice (Department for Constitutional Affairs, 2007). The code provides guidance on how best to support people to make decisions and how to assess functional ability, and also includes a checklist that decision makers should follow in determining best interests. The act describes what is meant by lack of mental capacity in section 2(1) and provides five principles that must underpin practice (section 1(2)-(6)). Brown et al (2013) provide a helpful practitioner's guide to these principles in their book *The Mental Capacity Act 2005: A Guide for Practice*.

Analysis

The relationship between safeguarding adults and the Mental Capacity Act is a very close one. Many people involved in safeguarding cases have problems with capacity to make decisions and this places them at risk of abuse. What the courts have consistently found, however, is that social care staff mistakenly believe they have express 'powers' under the law to take coercive action to protect vulnerable adults. (Examples of two such cases are examined in this analysis on Community Care Inform Adults). This is not the case even with the advent of the Care Act 2014, which introduces a duty to investigate safeguarding concerns but no direct powers to take action (although in Wales section 127 of the new Social Services and Well-being Act 2014, when in force, will provide for Welsh local authorities to apply to a justice of the peace for an 'adult protection and support order'. The writer of the article correctly identifies that it is the Mental Capacity Act that can be deployed in order to achieve protection, and the key issue under that act is whether the person involved has capacity to decide where to live.

The Mental Capacity Act code of practice lists examples of when a professional might be required to assess a person's mental capacity. One of these is when "somebody has been accused of abusing a vulnerable adult who may lack capacity to make decisions that protect them" [DCA, 2007, chapter 4, p60]. This was my remit for questioning the presumption of capacity.

Analysis

It is important to note that the first principle of the act, which, along with the other four principles, applies to actions taken or decisions made under the act (DCA, 2007, p20, 2.2), is that a person should be presumed to have capacity to make decisions unless proven otherwise. Therefore, although Mrs Smith has dementia, her capacity to make a decision should not be questioned unless there is a reason to do so. A social worker or other practitioner should ask themselves: "Why am I assessing capacity?". The code of practice (as statutory guidance to the legislation) highlights practical examples for staff on putting the first principle into practice.

I applied the two-stage test for mental capacity as outlined in sections 2-3 of the act, and further explained in chapter 4 of the code of practice.



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I first established that Mrs Smith had a formal diagnosis of dementia and noted that her presenting behaviours corresponded with the diagnosis. I deemed that there was sufficient evidence to show that Mrs Smith was suffering from an impairment of, or disturbance in the functioning of, her mind or brain, satisfying the first stage of the capacity assessment, the “diagnostic test” (section 2 of the act).

Analysis

Although Mrs Smith has a diagnosis of dementia, a formal diagnosis is not required when using the act. Staff need a reasonable belief that the person has an “impairment or disturbance in the functioning of the mind or brain”, and section 2(2) makes clear that it does not matter whether the impairment is temporary or permanent. This allows the act to be used where a person presents with evidence of an impairment or disturbance of mind or brain (for example, because of a urinary tract infection which can cause sudden confusion, also known as delirium, in older people and people with dementia; concussion; confusion from drugs) but they do not have a formal diagnosis (DCA, 2007, p44). This is particularly relevant for staff working with people with dementia or learning disabilities where there may not be a formal diagnosis in place. The more serious the decision being made, the stronger the required evidence of lack of capacity, which may include the need for a formal diagnosis.

Functional test

Before I started the second element of the mental capacity assessment, known as the 'functional test', I confirmed that Mrs Smith was provided with all the necessary information and support required to make the decision. In particular, I ensured that the allocated social worker had completed her social care needs assessment under section 47 of the NHS and Community Care Act 1990, the legislation in place at the time, including identified risks of each option for Mrs Smith's future accommodation, so that the views and opinions of professionals could be fully shared with Mrs Smith. I also arranged for the occupational therapist to visit Mrs Smith in the care home and demonstrate the importance of the hoist.

The level of support that could be offered in each environment was also explicitly explained. These were all communicated in verbal and written form and a summary sheet with bullet points was provided in light of Mrs Smith's increasingly poor short-term memory. We repeatedly referred back to this summary sheet during the discussion, which Mrs Smith appeared to find useful. It is also noteworthy that Mrs Smith was receiving respite in a care home which obviously gave her first-hand experience of this type of care provision.

There was no evidence of any additional loss of capacity due to short-term medical needs, such as a urinary tract infection, which if present could potentially be addressed to improve capacity. The discussions also took place in a quiet room of Mrs Smith's choice. This approach reflects the second principle in the act (section 1(3)), that a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success. This is also closely linked to the core social work value of empowerment; where service users are given "meaningful choice" and "valuable options" (Clark, 1999) in order to "maximise the power of clients and to give them as much control as possible over their circumstances" (Thompson, 2001, p85).

Analysis

The second principle of the act is that those assessing capacity must take 'practicable steps' to help the person with the assessment.

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The writer highlights the many good practical steps he has taken. As with the other 'principles' of the act this applies to any relevant action taken or decision made under the act, so that failure to take such 'practicable steps' for an individual could invalidate the entire capacity assessment. A recent court case, concerning a man with learning disabilities who was supported during a capacity assessment with the use of pictures, highlighted the importance of taking these steps.

Two elements of this principle strike me in this case. First, the word is 'practicable' steps, which means staff have discretion to take steps that are practicable depending on the situation presented. Very simply, in A&E, with limited time before treatment is required, there may be very few, if any, practicable steps available for staff. In this case, with a decision that is very important and for which there is no immediate rush, then multiple practicable steps can be taken. Second, a person may not need any practicable steps and be assessed as having capacity. Therefore, a

social worker or other practitioner may consider assessing capacity without taking practicable steps, but if the person does then have problems or difficulties with any part of the assessment the practitioner would then take 'practicable' steps to support them in the assessment.

Understanding information

We had considerable discussions around accommodation options and associated matters, such as Mrs Smith's care needs and ongoing support from her ex-husband. The specific decision was to decide where to reside, but this decision involved other elements such as her care needs and relationships. I framed our discussions around the format described in section 3 of the act, which sets out four types of inability, the presence of any of which would mean that the person was unable to make the decision in question. These are that the person is unable:-

- to understand the information relevant to the decision (section 3(1)(a));
- to retain that information (section 3(1)(b));
- to use or weigh that information as part of the process of making the decision (section 3(1)(c)); or
- to communicate the decision, whether by talking, using sign language or any other means (section 3(1)(d)).

It soon became apparent that Mrs Smith had a good understanding of the information relevant to the decision (section 3(1)(a)). She was able to discuss in detail the pros and cons of her situation at home; provide insight into her experience of being in respite; the care she received at home from care workers and her ex-husband; what she liked about living at home; what she missed about being at home; the difficulties experienced regarding the frequent falls and necessity to call paramedics; and the concerns expressed by the professionals involved.

After sensitive prompting, Mrs Smith also recalled the disclosure made regarding her ex-husband. I determined that after being provided with all relevant assessments, and information on the options available, Mrs Smith was able to sufficiently understand the information relevant to the decision.

Analysis

In relation to understanding information, the code of practice (DCA, 2007, p46, 4.16) notes that a person should be able to understand:

- the nature of the decision;
- the reason why the decision is needed; and
- the likely effects of deciding one way or another, or making no decision at all.

An important development in case law has been guidance from the courts on what a person should understand in relation to moving to a residential care placement. In one case the judge considered that a person whose capacity to move into a community mental health rehabilitation unit was being assessed would need to understand the following points:

1. She will live with other people (and not with her parents).
2. She will be supported by staff.
3. The location of the placement (near or far from family).
4. The age and gender of other residents.
5. She will need to abide by house rules.
6. Whether it is a long- or short-term placement (living/visiting).

7. In general terms, that one of the residential options has a therapeutic component.

(Derbyshire CC v AC, EC & LC [2014] EWCOP 38)

There are other cases that have considered what a person would need to understand in relation to returning home from a care home, admission to a mental health ward and moving into a supported living placement.

Weighing information

In reference to assessing Mrs Smith's ability to retain the relevant information (section 3(1)(b)), it was evident that she had moments of forgetfulness. I considered section 3(3), which states that the fact that the person is able to retain the information relevant to a decision for a short period only does not prevent him or her from being regarded as able to make the decision. I then deemed that since I could evidence Mrs Smith was holding the pertinent information in her mind for long enough, considering each element at the same time, she was sufficiently able to retain the relevant information. Mrs Smith consistently expressed the same view and rationale each time she was given the information, but crucially would often require support, such as the memory aids previously stated, each time, in line with the need to take all 'practicable steps' (section 1(3)).

Having concluded that Mrs Smith was able to retain the information relevant to the decision, I turned my attention to her ability to use this information (section 3(1)(c)). On reflection, this is one of the more challenging aspects of assessing a person's capacity. Through the discussion Mrs Smith described her process of weighing up what she perceived as the benefits of returning home against the other options; one being remaining in a residential care home. With prompting, Mrs Smith was able to explain how she compared and contrasted between different aspects of her situation, which helped me understand the differing weight of importance she attributed to each element of the decision.

Mrs Smith expressed, perhaps not unsurprisingly, very high importance on her home environment, pet cat, seeing her ex-husband daily and her personal belongings at home.



Photo: ramonespelt/Fotolia

Interestingly, Mrs Smith identified that at home she is possibly more 'lonely' compared to being in respite, but disparagingly added that she would rather see fewer people in her own home than see more people in a care home.

We also talked about day care options. Mrs Smith talked very fondly of her ex-husband and explained how they were married for more than 30 years and had a son with learning disabilities who sadly passed away. Mrs Smith explained how despite her husband deciding they should separate and divorce, they had been through a "lifetime together". Mrs Smith consistently reiterated a strong desire to return home and continue daily contact with her ex-husband.

Analysis

The assessment of whether a person is able to use or weigh information is, as the writer notes, probably the most challenging part of the capacity assessment. There are a series of court rulings on its meaning relating to people with delusional beliefs, phobias, lack of insight into their condition and compulsive disorders. What is important to remember is that the act separated the ability to understand from that of being able to use or weigh. This is because, as case law has shown, many people may well be able to understand the information required but are then unable to use or weigh it in the balance. Being able to assess this can be challenging because on the surface the person may show a high degree of understanding.

In social care settings one case (NCC v WMA & MA [2013] EWHC 2580) involved a man with learning disabilities being neglected and abused by his mother, with whom he lived. Although he was able to understand his situation and that he could move into a supported living placement provided by the council, he refused to do so. Social workers and the court recognised, however, that he was not able to use or weigh the information, his personal wishes being dominated by his mother.

Communicating a decision

Mrs Smith was fully able to communicate her decision, which meant that the communication requirement of the functional test (section 3(1)(d)) was also met. If, for whatever reason, Mrs Smith had difficulty communicating verbally I would have considered other means for example, specialist services, such as speech and language therapists, or appropriate communication aids (MCA code of practice, p22).

Although Mrs Smith had an impairment of, or disturbance in the functioning of, her mind or brain (section 2) she was crucially able to understand (section 3(1)(a)), retain (section 3(1)(b)) and use (section 3(1)(c)) the information relevant to the decision, as well as communicate her view (section 3(1)(d)). She was therefore assessed to have mental capacity about this particular decision at the time in question. As a result, a 'best interests decision' was neither required nor appropriate.

With regards to the first principle cited in the act, I started from the presumption that Mrs Smith had mental capacity to make her own decisions around her accommodation (section 1(2)). My initial questions were open and broad; I did not want to start with questions that assumed a certain level of incapacity. Trevithick explains that open-ended questions are "designed to give freedom of choice, enabling service users to express their thoughts and feelings in their own words and in their own time; to choose or to ignore certain questions" (2005).

I also considered that my assessment should not be based on 'age, appearance, assumptions about their conditions or any aspect of their behaviour' (section 2(3)), which reflects anti-discriminatory practice, a core social work principle, and a registration requirement to treat clients with respect and dignity (HCPC, 2012).

From previous experience there was the potential for tension between professional disciplines in that the occupational therapist could have taken a 'risk averse' position, and been against the decision for Mrs Smith to return home. However, in this particular case the occupational therapist had a good understanding of the Mental Capacity Act and agreed that Mrs Smith understood the risks and consequences. Furthermore, we identified strategies that could help improve the situation at home.

Hypothetically, if there had been any professional disagreement I would have started from the position of explaining the Mental Capacity Act in detail, particularly the right of a person with capacity to do so make unwise decisions (section 1(4) and code of practice, p50, 4.30). In my experience many professional disagreements about the MCA originate from misguided intentions to maintain a person's safety at all costs. The House of Lords Select Committee on the Mental Capacity Act recognised this in the summary of its 2014 report, which states: "The prevailing cultures of paternalism (in health) and risk aversion (in social care) have prevented the act from becoming widely known or embedded." Protecting the right of people to refuse care or treatment is also reflected in the HCPC registration standards (HCPC, 2012, p12).

On reflection I believe that this is an area of my practice which has improved over the years. In the past I was predisposed to seeing the safest option as the most appropriate, protection over empowerment, and risk taking evidencing incapacity. However, through my development and understanding of the Mental Capacity Act, this has changed and I now consider that all people have a right to take informed risks.



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My discussions with Mrs Smith benefited from being mindful of non-verbal communication. I found that on a number of occasions she used non-verbal gestures to control the conversation. Knapp (1978) terms this as 'regulation', and as a result I was able to respond to these cues. I believe that this gave Mrs Smith a sense of power and security in the conversation.

In completing my mental capacity assessment I made sure not to conflate two very different issues: the perceived potential risks and the assessment of Mrs Smith's functional ability. The concern is that assessors may be more inclined to determine a lack of capacity in circumstances where the individual's expressed wishes, if allowed, involve high risk. Baroness Hale, quoting the Law Commission in its 1995 report on mental incapacity [paragraph 3.4], said in *R v C* [2009] UKHL 42 [paragraph 13] that such an 'outcome' approach, which focuses on the final content of the person's decision, "penalises individuality and demands conformity at the expense of personal autonomy".

Hale's perspective protects the third principle of the Mental Capacity Act (section 1(4)), that a person is not to be treated as unable to make a decision merely because he or she makes an unwise one. It can be seen in the judgements of *PC & Anor v City of York Council* [2013] EWCA Civ 478 [paragraph 53] and *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam) [paragraph 100].

The case of *PC & Anor v City of York Council* [2013] EWCA Civ 478 [paragraph 58] was also helpful in reminding me that it is vital for assessors to determine that the inability to make a particular decision arises from the impairment of, or a disturbance in the functioning of, the brain or mind. In doing so I gave due regard to other factors that might influence the decision, such as the emotional and relational context.

The fact that Mrs Smith might have an overwhelming reluctance to accept, for emotional reasons, that her ex-husband may pose future risks does not, in itself, support a finding that any inability arises because of her impairment. On the contrary, Mrs Smith was able to recall and refer to the concerns identified but rejected the seriousness of them throughout the conversation, preferring to focus on the positive aspects of his contact.

Analysis

In the case of *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342, which concerned whether a woman with mental health problems had capacity to make a decision about the amputation of her leg, the judge noted at paragraph 39: "Her tendency at times to be uncommunicative or avoidant and to minimise the risks of inaction are understandable human ways of dealing with her predicament and do not amount to incapacity." In the case of Mrs Smith, minimising the risk posed by her ex-husband could be seen as an understandable human reaction. What would be problematic, in relation to the 'use or weigh information' part of the assessment of capacity, would have been if she completely denied the risks of returning home to be supported by her ex-husband.

Influencing factors

In this regard I consider that mental capacity is a complex area. People do not make decisions in a functional ability vacuum; they make them within their own, often complex circumstances. It is important for an assessor to be aware of and understand the factors that influence a person's decision-making ability, in addition to any particular impairment, so that they can be distinguished from each other.

With regards to Mrs Smith, two examples of such influences might be loneliness and emotional/relational ties with her ex-husband. I would suggest that a sociological perspective can assist in understanding the wider influences on a person and their decisions. Wright Mills states in his book *The Sociological Imagination*:

“The individual can understand his own experience and gauge his own fate only by locating himself within his period, that he can know his own chances in life only by becoming aware of those of all individuals in his circumstances.” (p5)

Wright Mills makes distinctions between ‘personal troubles’ and ‘public issues’, explaining that we are required often to look beyond what might be considered as our own ‘personal troubles’ and consider what ‘public issues’ lay beneath (p9). This is because he considered that ‘public issues’ cannot be addressed by the individual and require structural changes in society.

On reflection Mrs Smith might consider ‘loneliness’ and being a divorcee as a personal trouble. However, when examined from a historical and societal perspective, there are indications that these matters are ‘public issues’ and so require structural changes in society to address them fully. For example, in a report from the Office of National Statistics (ONS), 46% of those aged 80+ reported being lonely often or some of the time. Furthermore, there is a strong association between reported feelings of loneliness and reported limitations in performing daily activities (ONS, 2013a). Another ONS study revealed that a 73% increase in divorce rates for men aged over 60 from 1991 to 2011 was in contrast to a drop in divorce rates for people under 60 (ONS, 2013b).

Since Mrs Smith was assessed as having mental capacity to make decisions about her accommodation, the social worker supported her in returning home and arranged for appropriate care, support and monitoring. For the purpose of demonstrating ‘understanding’ I would, however, like to examine hypothetically what actions I might have taken if the circumstances had been different.

If Mrs Smith had failed one or all of the functional elements of the mental capacity assessment, it would have been necessary for a best interests evaluation to have been carried out before making a final decision on how to proceed. In such circumstances I would have been required to ensure, or reasonably believe, that any decision made was in her best interests (section 1(5)) and was the least restrictive option (section 1(6)). I would have also referred to the best interests checklist (section 4) examined in chapter 5 of the MCA code of practice.

Although Mrs Smith was not ‘unbefriended’, there were safeguarding concerns, so it may have been appropriate for an independent mental capacity advocate (IMCA) to be involved before any best interests decision was made (DCA, 2007, chapter 10). Local authorities or NHS bodies have the power to appoint an IMCA for a person in safeguarding cases when certain conditions are met, as set out in regulation 4 of the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 for England and regulation 9 of the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) Regulations 2007. The power applies when the authority proposes to take, or has taken, protective measures in relation to a person who lacks capacity to consent to any one of the measures, following allegations of abuse or neglect against or by the person and in accordance with safeguarding procedures. It applies even where the person is ‘befriended’ – that is to say where they have a person available to support or represent them, such as a family member (DCA, 2007, p198).

Analysis

The government has voiced concern about independent mental capacity advocates' (IMCA) referral rates generally and specifically for safeguarding cases. "There continue to be wide disparities in the rate of IMCA instructions across different local areas which cannot wholly be explained by population differences. It is likely that in some areas the duties under the MCA are still not well embedded."

And: "...fewer than 1% of people who were referred to local authorities for safeguarding assistance received the help of an IMCA. This proportion is decreasing as safeguarding numbers increase and IMCA supported safeguarding decreases".

(Department of Health, *The Sixth Year of the Independent Mental Capacity Advocacy (IMCA) Service, 2013/2013*)

Restriction versus deprivation

By following the MCA, as outlined above, I would have received protection from liability under section 5 of the act (chapter 6, code of practice). Section 5 states that a person ("D") is protected from liability in relation to any act done in relation to another person's ("P") care or treatment if:

- Before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter; and
- When doing the act, D reasonably believes that D lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done.

If, however, the best interest decision resulted in Mrs Smith's restraint, the restrictions would have been additionally required to be a) necessary to prevent harm, and b) a proportionate response to the likelihood and seriousness of that harm (section 6(1)-(4)) for the decision maker to be protected from liability.

Section 4A contains a general prohibition on using the act to deprive a person of their liberty. That is disapplied in certain cases, one of which is where the deprivation is authorised under the Dols provisions. Section 4A was added by the Mental Health Act 2007 as part of the Dols legislative project. At the same time, section 6(5) of the act was repealed (that provision having stated that the act's provisions authorising restraint did not permit deprivation of liberty).



Until recently it had proved difficult to define what constituted the difference between restriction and deprivation of liberty. Nevertheless, it was accepted that they are both on the same continuum and the difference is about "degree or intensity and not one of nature or substance"

(HL v the United Kingdom [paragraph 58], and Dols code of practice, chapter 2). Furthermore, the 'type, duration, effects and manner of implementation of the measure in question' was also considered relevant. There was no simple definition, only a growing number of case law judgements that identified *factors* that might be relevant.

Justice Munby in *JE v DE and Surrey County Council* (2006) EWHC 3459 (Fam) considered previous case law, including *Storck v Germany* (2005), and put forward that a deprivation of liberty consists of three elements:

(a) An objective element of a person's confinement in a particular restricted space for a not negligible length of time (*Storck v Germany* (2005) at paragraph 74).

(b) A subjective element, namely that the person has not validly consented to the confinement in question (*Storck v Germany* (2005) at paragraph 74).

(c) The deprivation of liberty must be imputable to the state (*Storck v Germany* (2005) at paragraph 89).

Analysis

I would note that the European court established these three elements and Munby was just reiterating them within a British judgment.

On 19 March 2014 the Supreme Court handed down a landmark judgment on *P v Cheshire West and Chester Council* and *P and Q v Surrey County Council*. This judgment overturned previous rulings and concluded that all three individuals concerned were indeed deprived of their liberty under article 5 of the European Convention on Human Rights.

With this judgment Lady Hale affirmed that the relevant person's compliance or lack of objection, the relative normality of the placement and the purpose behind it are all irrelevant to what constitutes a deprivation of liberty [paragraphs 50, 87].

The judgement provided an objective 'acid test' for determining if a person's circumstances amounted to deprivation of liberty:

"The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements." [paragraph 49].

In her judgment Lady Hale explained that the starting point "should be the same as that for everyone else...What it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities..." [paragraph 46]

In order to apply the deprivation of liberty safeguards to this practice analysis please consider, once again, the hypothetical scenario where Mrs Smith was assessed as lacking mental capacity to decide on her accommodation. Let us also imagine that a best interests decision was made complying with the best interest checklist (section 4 of the act) to accommodate her in a residential care home: what would be the Deprivation of Liberty Safeguards process and would the arrangements require authorisation?

Analysis

The ruling by the Supreme Court effectively means that if a person is assessed as lacking capacity to be placed into a 24-hour staffed care setting then there is a real possibility they could be deprived of their liberty. This is because if a person does lack capacity to be resident for care or treatment, the care provider will often need certain restrictions in place to keep them safe, such as ensuring a person is escorted when outside. Whether the person has ever tried to go out alone or shown any indication they want to go out alone is not relevant. The Supreme Court ruling means that potentially only a few restrictions are needed to breach the threshold of being deprived of liberty in a care setting.

Authorisations

Chapter 3 of the Dols code of practice (Ministry of Justice, 2009, p28-38) describes how and when a deprivation of liberty authorisation should be applied. The care home's registered person or organisation (managing authority) is responsible for applying for a standard authorisation and granting itself an 'urgent' authorisation if required. Following application for a standard authorisation, or the granting of an urgent authorisation, the local authority (supervisory body for care homes) would need to consider the request, arrange the required six assessments and, if all requirements are met, grant an authorisation. The supervisory body would also set appropriate conditions and timeframe for the authorisation to a maximum of 12 months (but a longer period than that recommended by the best interests assessor cannot be set: schedule A1.51.2, Mental Capacity Act 2005).

Analysis

The positive duty under the Human Rights Act 1998 to protect people from unlawful deprivation of liberty means that local authority staff need to be proactive when placing people who lack capacity to consent into 24-hour staffed care settings. If a local authority is placing a person then the social care practitioner involved does not need to postpone planning for a possible deprivation of liberty until the managing authority of the care home has submitted a Dols request form. In the recent case of *AJ v A local authority* [2015] EWCOP 5, the judge stated that in the majority of cases a standard Dols authorisation should be in place even before a person moves into a residential care setting where a local authority had reason to believe a deprivation of liberty would arise.

The court did not in express terms rule that a local authority (as supervisory body) could act on a social care practitioner's request for a Dols authorisation and begin the formal process of a statutory Dols assessment without a managing authority's request having been made.

In fact, schedule A1.22 to the MCA expressly prohibits a supervisory body from giving a standard authorisation unless the managing authority of a care home makes a request for one (with one limited exception which would not have applied in the present scenario). But the court did criticise the local authority for not 'initiating the authorisation process' which makes the decision not altogether clear on this point.

Unfortunately, it seems that schedule A1.22 was not drawn to the court's attention. But what is clear is that a local authority, as placing authority, must ensure that a care home seeks a Dols authorisation where there is a real possibility of the adult being deprived of liberty at the home. This needs to be built into placement planning.

The Local Government Ombudsman has also expressed the view that a positive duty arises by virtue of section 25(7) of the Local Government Act 1974, where a council exercises functions by means of an arrangement with a third party including an independent care home. This would be the case where the council has arranged for a person to receive care in the home. The wording of the 1974 act means that in such cases any action taken by a care home is considered to be taken on behalf of the council. Therefore, as in this case of an investigation into a complaint against Cambridgeshire County Council, it was not reasonable for the council to blame the care home for not completing a Dols request form. The council placed the person in a care home in a situation where it was reasonable to know there would be a deprivation of liberty, so the council should have informed the supervisory body that they thought an authorisation was required.

In this hypothetical scenario Mrs Smith would have been assessed as meeting the mental capacity assessment element of Dols (Dols code of practice, paragraphs 4.29-4.32). I suggest that she would also meet the following assessments:

- Age assessment: since her age is well in excess of 18 (Dols code of practice, paragraphs 4.23 and 4.24).
- No refusals assessment: since there was no advanced decision, lasting power of attorney or court-appointed deputy (Dols code of practice, paragraphs 4.25 to 4.28).
- Mental health assessment: since she had an established diagnosis of dementia (Dols code of practice, paragraphs 4.33 to 4.39).
- Eligibility assessment: since her necessity to be accommodated was not within the scope of the Mental Health Act 1983 (Dols code of practice, paragraphs 4.40 to 4.57).

However, after reflection, the best interests assessment might have proved more challenging. Establishing that the care arrangements amounted to a deprivation of liberty, using the case law previously referred to, would be relatively easy. And yet it might have proved much more difficult to justify placing Mrs Smith in a care home using the general welfare assessment and balance sheet approach as advocated for in case law such as *Re A (medical treatment: male sterilisation)* [2000] 1 FCR 193.

The best interests assessor would have to be satisfied, on the balance of probabilities, that a move to a care home was necessary, proportionate to the risks and in her best interests. In this regard, the best interests determination should include emotional and other welfare matters (*Re A [medical treatment: male sterilisation]* [2000] 1 FCR 193), the importance of relationships and belonging (*FP v GM and A Health Board* [2011] EWHC 2778 [paragraph 21]) and Mrs Smith's 'happiness' (*Re MM (an adult)* [2007] EWHC 2003 (Fam)).

I would suggest that this broad welfare assessment of 'best interests' would inevitably take account of Mrs Smith's high levels of opposition and objection, which might indicate the potential for significant distress and unhappiness, and therefore could potentially sway a best interests decision away from the residential care home option. The 'strength and consistency of the views being expressed' would be a significant factor in the best interests decision (*Re M; ITW v Z* (2009) EWHC 2525 (Fam) [paragraph 35]).

It is also noteworthy that if the best interests assessor had no independent person 'appropriate to consult', the supervisory body would be required to arrange an independent mental capacity advocate (section 39a of the MCA). A part of their role would be to ascertain Mrs Smith's wishes and feelings and the beliefs and values that would likely influence her if she had mental capacity (section 36(2)(c)).

The broad general welfare assessment approach to best interests decisions, as well as the use of advocacy, is of extreme importance to my practice. I strongly support the individual being

central to any best interests decision-making process. Personal safety is only one facet of living; a life without achievable autonomy, happiness or familial relationships is arguably no life at all.

The legal analysis

by Jess Flanagan, associate, Clarke Willmott

My day-to-day work is occupied with applications to the Court of Protection made on behalf of people deprived of their liberty pursuant to section 21a of the Mental Capacity Act 2005, in order to challenge one or more of the qualifying requirements of the standard authorisation, or the purpose for which it is given. I frequently represent individuals, either by being provided with instructions from the Official Solicitor, independent mental capacity advocates (IMCAs) or paid representatives as litigation friends.

In considering the case study of Mrs Smith, I naturally consider how the case would be treated should it reach court. I am writing at a time when applications to challenge authorisations are increasing, following the sheer weight of individuals who are now subject to the framework (post *Cheshire West*) and the case of *AJ v A Local Authority* [2015] EWCOP 5 (which reminded us that if someone is objecting to being deprived of their liberty in word or by behaviour, then a timely application should be made to the court, and if no one else will, the local authority must). So I am going to use this opportunity to comment on best practice, and how good assessments from the outset will ensure that the right decision is made, and the need for court time in many cases can be reduced significantly.

Capacity: complying with the law

The level of detail in the information provided to Mrs Smith, the time taken with her and the work done to ensure her capacity was assessed in an environment that she was comfortable in, leads me to suggest that this is a very good example of precisely how capacity should be assessed. In this case, it is apparent that the professionals involved had a very good understanding of the Mental Capacity Act and how to apply it correctly. Sadly, this is not always the case.

It is not likely to be a coincidence that Mrs Smith was assessed as having capacity to make a decision about where she should live and receive care following such a detailed and sympathetic assessment. I see so many capacity assessments which justify a deprivation of liberty, but which on detailed reassessment – usually carried out following a challenge to the court – finds that the individual does after all have capacity to make relevant decisions. A lot of time, frustration, worry and distress (on behalf of the individual and their families), money and energy could be saved if the assessments were carried out correctly to begin with.



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When considering assessments, I am always looking to see whether the guidance of Mr Justice Baker, in the case of *CC v KK and STCC* [2012] EWCOP 2136, is followed, and it appears to me that this assessment has done just that:

“The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed.” (paragraph 68)

It is encouraging to see that before Mrs Smith’s capacity was assessed, a care needs assessment had been carried out, options for meeting those needs had been considered and risk assessed, and the professional opinion shared with Mrs Smith, with demonstrations where necessary. This meant that Mrs Smith had all the relevant information required to make a decision about how she would like her assessed needs to be met. I would hope she would have also had the opportunity at some point to comment on whether she agreed with that assessment.

It is also important not to conflate best interests with assessment of capacity. We frequently see assessments that use the outcome approach, focusing on the final content of an individual’s decision to assess capacity, to protect someone from making what some perceive to be an unwise decision. This often leads to the wrong conclusion being drawn in respect of capacity, only to be reversed on detailed reassessment. Mr Justice Baker’s guidance in *CC v KK and STCC* [2012] EWCOP 2136 at paragraph 65 is pertinent (and something that I know was at the forefront of this assessor’s mind):

“There is, I perceive, a danger that professionals, including judges, may objectively conflate a capacity assessment with a best interests analysis and conclude that the person under review should attach greater weight to the physical security and comfort of a residential home and less importance to the emotional security and comfort that the person derives from being in their own home. I remind myself again of the danger of the ‘protection imperative’ identified by Mr Justice Ryder in *Oldham MBC v GW and PW* (supra). These considerations underpin the cardinal rule, enshrined in statute, that a person is not to be treated as unable to make a decision merely because she makes what is perceived as being an unwise one.”

It is encouraging to see such a thorough and detailed assessment of capacity. This should be the norm but sadly it isn’t. It highlights that time must be taken in assessing capacity for such fundamental decisions, and time is not something that busy professionals will always have, especially when the vulnerable adult is at risk of harm and a balance needs to be struck against working out someone’s capacity and keeping them safe.

I would be interested to know whether Mrs Smith was just lucky that an experienced MCA lead was asked to assist in this assessment, and whether this standard of 'service' is afforded to everyone assessed pursuant to schedule A1 of the Mental Capacity Act in Central Bedfordshire, or just those who fall within the parameters of a safeguarding investigation. I have had to acknowledge recently that one way of ensuring a good quality capacity assessment is to get the matter before the court. This is not only because we then have access to independent experts, but because the responsible authority would be in a position to give the particular case more time and resources, so as not to fall foul of judicial directions.

However, I have also begun to see far more detail in the capacity assessments from Dols assessors and, in fact, the best assessments are those carried out by assessors who have a social work background. Where the assessments are good, unless the matter is hugely complex, there is infrequently the need to obtain further evidence in respect of capacity.

When the scheme was first introduced, the quality of assessments were often considered to be woefully inadequate. This is, in some cases, still true. When an assessment is woefully inadequate the first thing that is required when we get to court is to ask for a more detailed assessment of capacity to be filed. I far prefer being able to rely on the professionals who know an individual to assess, or reassess, but sometimes there is a need for an independent assessor to be instructed. This can be costly and cause further delay. At a time when the Court of Protection is overrun with applications and the costs of cases are under scrutiny, not to mention that individuals are often unhappily placed while all the legal wrangling is going on, I would like to avoid this additional work.

My advice is for assessors to spend more time on the initial assessments, to go through the options with the person concerned, to help them to really understand what the proposals for care are, and what this would look like, such as demonstrating how equipment would be used. If Dols assessors carrying out the initial assessments can be guided by and apply the act, principles and guidance from case law as the experts who provide reports do within court proceedings, we may start to see less contentious, lengthy and costly applications before the Court of Protection – especially when dealing with section 21a MCA applications.

Best interests

In the hypothetical analysis of what steps would be taken to consider whether Mrs Smith, if she lacked capacity, should remain in the respite placement (or alternative institution) or return home, in accordance with her wishes, the assessor suggests he would approach the assessment in a very balanced and person-centred way. I agree that an IMCA should be appointed and, in fact, I would prefer that an IMCA is always appointed, even when there are family members to support the person in expressing their wishes; the added benefit of the IMCA understanding the system can so often make the difference in the experience and outcome for the supported individual. However, the MCA only permits the appointment of a formal IMCA, with the statutory rights conferred by the MCA, in defined circumstances.

Again, this is not always the case and the decision maker will frequently hold risk of harm ahead of someone's wishes and feelings and use this to justify the restrictions as being necessary and proportionate, and not always take the opportunity to consider what his or her analysis of risk may have been prior to losing capacity, or how miserable they might be if their wishes aren't followed.

This is where a balance sheet approach is really useful, as is considering the various options and working out the benefits and disadvantages of each scenario, ensuring care is taken the person's wishes and feelings are given the correct weight.

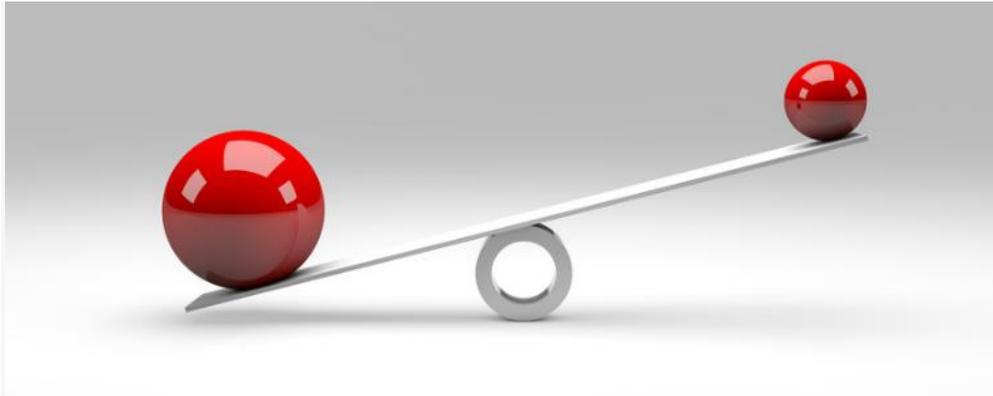


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What weight to be given is often difficult to ascertain, but I am pleased to see that the potential for distress and unhappiness and a respect for autonomy may be viewed as what we would call a 'magnetic factor of importance' and sway the decision away from a residential care placement.

If this assessment is not correctly carried out, or the individual or a family member disagrees with the approach taken to best interests, then the court may be asked to consider the same. This might include instruction of an independent social work expert, or by the court following consideration of initial written evidence. Both courses of action take time, money and cause unhelpful delay. Court of Protection practice direction 15A deals with expert evidence. When we can, we would ask the local authority to conduct this exercise, but this direction could be avoided if the work was done properly from the outset.

The Court of Appeal has now handed down its decision in the matter of MN (Adult) [2015] EWCA Civ 411 and, while clarifying that the Court of Protection is not to be a forum to determine disputes as to the availability of options for the individual on a public law basis, the president of the Family Court and Court of Protection, Sir James Munby, also made it very clear that protracted proceedings in the Court of Protection would no longer be tolerated. If professionals can get the assessments right in the first place and identify the available options, there will be less opportunity for unnecessary paperwork and delays and more time for agreement, or judicial consideration.

Conclusion

As we wait for the Law Commission's final proposals, due next year, to overhaul Dols and applications to authorise community-based deprivations of liberty, and in particular for there to be a simplification of the assessment and appeal processes for everyone involved, we must work together to make the current system as efficient as possible. My plea would be for all capacity assessments to be carried out as this one has, in line with guidance from Mr Justice Baker in CC v KK and STCC [2012] EWCOP 2136, and for up-to-date assessments of need (now under section 9 of the Care Act 2014 in England) to be prepared and referred to whenever an individual is assessed pursuant to Dols, together with detailed care plans and risk assessments for each available option, and some indication as to whether it is capable of being funded.

Such steps will potentially remove the need for as much court time and decrease the amount of evidence required by a judge to make a decision, as this is the information we will always want to see from the outset of a case. The work has to be done anyway, so why not do it upfront without having to pay for lawyers to ask you to do it, and avoid unhelpful delays for the person at the centre of it all?

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