



MENTAL CAPACITY (AMENDMENT) BILL 2017-19

February 2019

EXECUTIVE SUMMARY

- Commons Amendment 1, which defines ‘deprivation of liberty’ is too complicated, is incompatible with Article 5 rights and will lead to costly litigation.
- Embedding supported decision-making in a new definition of deprivation of liberty would help to address the perceived problems with deprivation of liberty in the community.

Introduction

The Mental Capacity (Amendment) Bill is the primary means to protect the rights to freedom of over 2 million of the most vulnerable people in society: it is imperative that it works as well as possible. If it does not, then it will not solve the problems of the existing Deprivation of Liberty Safeguards (DoLS) framework, which include rising costs, significant delays, and the backlog of applications. Getting this Bill wrong could also lead to costly litigation and additional human rights breaches.

Many amendments have substantially improved the Liberty Protection Safeguards (LPS). For example, amendments to reduce the potential for conflicts of interest in care homes, and that ensure that Approved Mental Capacity Professionals (AMCP) undertake the pre-authorisation review of all deprivations of liberty in independent hospitals are to be welcomed. Similarly, Commons amendments that prevent independent hospitals from acting as the responsible body are imperative for protecting our most vulnerable citizens.

Other amendments are less positive. The new definition of deprivation of liberty is too complicated, unclear, out of step with international human rights obligations and will likely lead to early challenges in the courts.

Consideration of Amendments on 26 February 2019 is the final opportunity for members of the House of Lords to improve the Bill. The focus of this briefing is on how and why the Lords should seek to improve the definition of deprivation of liberty in Commons Amendment 1 “Meaning of Deprivation of Liberty”.

The current definition of deprivation of liberty

The meaning of “Deprivation of Liberty” for the purposes of the Mental Capacity Act 2005 is dependent on the interpretation of Article 5(1) of the European Convention on Human Rights (ECHR) by the European Court of Human Rights (ECtHR) and the UK Supreme Court. Because the current definition relies on court interpretation, it can change in unpredictable ways following case law.

There is a temptation to blame the Supreme Court’s interpretation of Article 5 ECHR in [Cheshire West](#) for the problems with the current DoLS framework. Yet the court’s ‘acid test’ is closely aligned with ECtHR case law. The number of DoLS applications increased after the case because the existing DoLS were being under-used, and intellectually disabled people were being deprived of their liberty without safeguards, not because the court extended the definition beyond the reach of the ECtHR Article 5. The [ECtHR have recently confirmed](#) that the current DoLS framework is compliant with Article 5.

The difficulty of creating a statutory definition of liberty

Many stakeholders would like to see a statutory definition of deprivation of liberty on the face of the Bill. The benefits would be to provide clarity to everyone working with the LPS, but there are prob-

lems with trying to create a statutory definition for a changing legal concept. The [Law Commission did not recommend a statutory definition](#) in the report that formed the basis of this Bill, seeing it as counterproductive.

The Joint Committee on Human Rights (JCHR) proposed [a definition of deprivation of liberty that would narrow the scope of LPS](#) so that it would not apply people living in the community, but who are subject to care and treatment that otherwise falls under the definition in the ‘acid test’. The danger with doing this is that it would likely be incompatible with Article 5, and it would therefore lead to costly litigation similar to *Cheshire West*.

The JCHR also suggested an amended approach to valid consent for the purposes of a deprivation of liberty, in an attempt to reduce the numbers of people subject to the LPS process. This idea has more potential, both in terms of bringing the MCA closer to [the United Kingdom’s international obligations under the UN Convention on the Rights of Persons with Disability](#), and as a means of ensuring that the least restrictive option for care and treatment is always used. Fully implementing this approach would, however, require more than a change to the meaning of deprivation of liberty, it would [require more substantial amendments to the MCA](#) to facilitate supported decision-making and the prioritisation of the person’s wishes and feelings in best interests decisions.

Problems with Commons Amendment 1 “Meaning of Deprivation of Liberty”

Commons Amendment 1 introduces a definition of deprivation of liberty. There are three main problems with the definition in Commons Amendment 1:

1. The language of the new definition is very complicated, which will make it inaccessible to those who it is designed to protect. It is much more complex than the ‘acid test’ set out in *Cheshire West*.
2. There are aspects of the definition (especially clause 4ZA(3), 4ZX(4) and 4ZA(5)) that are in conflict with the ECtHR interpretation of Article

5. The technical detail of these conflicts were clearly set out in written evidence submitted to the Public Bill Committee by [Professor Harding](#) (MCAB47), [Doughty Street Chambers](#) (MCAB68), and [CoPPA](#) (MCAB51).
3. The complicated language of the definition, in combination with the points of tension with Article 5 case law, will inevitably lead to early, and costly, litigation.

As a consequence, the House of Lords should reject Commons Amendment 1.

Alternative options for defining deprivation of liberty

There are three alternative approaches for defining deprivation of liberty in the MC(A)B.

1. Leave the current definition, found in s. 64(5) of the Mental Capacity Act 2005, in place. This would leave the ‘acid test’ from *Cheshire West* as the authoritative statement of the meaning of deprivation of liberty in the law of England and Wales.
2. Provide an alternative definition that would place the ‘acid test’ on a statutory footing, whilst also recognising the limited exception in *Ferreira* relating to treatment in intensive care. [Baroness Tyler’s proposed amendment](#) could achieve this outcome.
3. Provide an alternative definition that maximizes the potential for intellectually disabled people to consent to arrangements for care and treatment in the community, whilst also fully protecting those who are unable to consent, similar to [the second part of the JCHR proposed amendments](#).

All three of these approaches have merit. The first approach would be legally most straightforward. The second would place the current common law interpretation on a statutory footing. There are dangers inherent in this approach, especially if ECtHR interpretation moves closer into alignment with the UN CRPD. The third approach would bring the law closer into compliance with the UN CRPD, but would also require much more engagement with supported decision-making in health

and social care practice. Authority for supported decision-making is embedded in principle 2 of the MCA, but the [Everyday Decisions research project](#) found that it is not well embedded in care practice for more complex life choices and legal, financial or medical decisions. Without a wider review of and greater regulatory underpinning for supported decision-making, there is a danger that changing understandings of valid consent could be misconstrued. In a worst case scenario, it could be implemented to mean that if people do not object to their care and treatment, they have given consent. This could then take us back to the position before *HL v United Kingdom* where intellectually disabled people are deprived of their liberty without review, and without access to safeguards, which would be an untenable result.

Find out more

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