Submission to JCHR inquiry into reform of DOLS

Introduction

1. This submission is made by Alex Ruck Keene, a barrister specialising in mental capacity law (for full details of my practice, see here). I emphasise that I make it in a personal capacity, having been on secondment to the Law Commission as consultant to their Mental Capacity and Deprivation of Liberty ('MCD') project, and currently acting as legal adviser to the independent review of the Mental Health Act 1983 ('MHA 1983').

The balance struck by the LPS

2. I do not address here, but emphasise that I endorse, the approach set out in the MCD report to (1) balancing protections and bureaucracy; and (2) ensuring that issues relating to deprivation of liberty are not seen as a 'bolt-on' to care planning decisions, but are thought about from the outset of the process.

Implementation of reform

3. The publication of the NHS Digital DOLS statistics for England in November 2017[1] reinforces the need for urgent implementation of reforms in this area. It is hard to see how a system where the average length of time to complete the assessment process is 120 days[2] is affording actual protection to a significant majority of those concerned. Further, the 'triaging' process undertaken by local authorities and other relevant public bodies to identify priority cases[3] is necessary but intensely depressing because those concerned are having to identify how best to break the law. More perniciously, embedding this approach into social and health care practice over almost 4 years has made it increasingly difficult to argue that the right to liberty is, in fact an important right which requires safeguarding, as opposed to posing a bureaucratic headache which, if managed, appears to carry no particular consequences where a person low down in the triaging order is unlawfully deprived of their liberty for many months (if not even years).

4. Two cases decided since the MCD report was published, *R (Liverpool City Council & Ors) v Secretary of State for Health*[4] [2017] EWHC 986 (Admin) and *Re KT & Ors* [2018] EWCOP 1, illustrate respectively (1) the financial burden on local authorities caused by DOLS; and (2) the inadequacy of the current provisions relating to deprivation of liberty outside the scope of DOLS.

Whether a definition of deprivation of liberty for care and treatment should be debated by Parliament and set out in statute

5. As the Committee is aware, the Law Commission took the view that it could not seek to define deprivation of liberty. Respecting this approach as the conservative one, I would suggest there are three reasons why serious consideration should be given to defining deprivation of liberty in this context:

[1] NHS Digital: Mental Capacity Act (2005) Deprivation of Liberty Safeguards, (England) 2016/17, Official Statistics, November 2017: http://digital.nhs.uk/catalogue/PUB30131.
[2] In 2016/17, up from 83 days in 2015/6; the relevant regulations requiring completion in 21 days.
[3] Both for DOLS and those outside the scope of DOLS for purposes of making applications for judicial authorisation.
[4] In this submission, hyperlinks relating to cases are to summaries on the 39 Essex Chambers Mental Capacity Report database.

a. The effect of leaving the definition to the courts[5] is to give them a key role in deciding why and how public monies should be allocated as between the delivery of health/social care and the implementation of procedural safeguards to regulate that care. Lady Hale expressly recognised that she was making policy in *Cheshire West* (see paragraph 57 of her judgment), and the Committee is entitled to ask whether such is appropriate;

b. The shifting terrain makes it difficult to institute policies and practices. For instance, by refusing permission to appeal, Lady Hale has implicitly endorsed the approach of the Court of Appeal in *Ferreira* to carving out of the scope of Article 5 ECHR the delivery of urgent/acute life-saving treatment in hospital. However, and as discussed in a recent guidance note to which I contributed, the effect of the decision has been to cause further confusion as to when and where the boundaries are drawn in this context;

c. Above all, perhaps, the approach taken by the Supreme Court means, ironically, that an important tool has been removed from the human rights toolkit. If an individual such as MIG, subject to no apparent coercion and manifesting her contentment living with her 'mummy,' is to be considered to be deprived of their liberty, then we have lost the ability to use arguments based upon Article 5 to seek to bring about a reduction in the level of restrictions imposed upon individuals with complex care needs.[6] An unintended result of the judgment could therefore be seen as negating a long-standing and important policy goal: the DH anticipating in 2008 that the use of DOLS would decline over time as all concerned learned how to avoid the 'extreme' circumstances giving rise to deprivation of liberty.[7] The LPS seeks to insert calibration, and some degree of leverage, by way of additional scrutiny in 'objection' cases,[8] but can only go so far whilst accepting the current definition of deprivation of liberty.

6. As discussed in detail elsewhere,[9] and drawing upon the principles contained in the Convention on the Rights of Persons with Disabilities, I suggest it is possible to define deprivation of liberty as confinement imputable to the state to which the individual does not give their valid consent. Critically, however, that 'valid consent' should be construed more broadly than by application of the binary capacity test contained in the MCA 2005. This approach preserves the non-discriminatory ideal sought by Lady Hale I *Cheshire West* because it asks the question as to whether the person is confined applying exactly the same 'acid test' for person with disabilities as for persons without disabilities; in answering that question, however, it allows for the fact that it is possible to manifest assent to a situation in a broad range of ways.

7. Any statutory definition run the risk that the courts will conclude that it is too narrow, such that all those who fall outside the definition but within the scope of Article 5 ECHR will fall into a continuing gap. However, especially if it maintains the 'acid test,' I suggest that there are sufficient grounds to consider that a statutory definition would be upheld that it should be explored. I note in this regard that Scottish Government are consulting on proposals to amend the Adults with

[5] Which is highly unusual in English law, only the Modern Slavery Act 2015 (to my knowledge) also directly tying to a 'travelling' definition of a such a key concept in the European Convention on Human Rights (see s.1(2) of that Act).
[6] Article 5 is not concerned with conditions of detention save in extreme circumstances: *NYCC & Anor v MAG & Anor* [2016] EWCOP 5.
[7] http://webarchive.nationalarchives.gov.uk/20130105042638/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_084982, paras 21-33 in particular.
[8] In legal terms, opening the door to greater focus on interferences with Article 8 ECHR rights.
[9] http://www.39essex.com/content/wp-content/uploads/2017/12/Valid-Consent-Discussion-Paper-December-2017.docx.pdf.

Incapacity (Scotland) Act 2000 along precisely these lines.[10] Finally, it seems to me that the courts would also likely be reassured if the JCHR has, in essence, conducted pre-legislative scrutiny of the idea from the standpoint, specifically, of both the ECHR and the CRPD.

Mental health context

8. Finally, and related to both the second and third aspects of the JCHR's inquiry, it is important to highlight the particular difficulties caused by the interface between the MCA and the MHA in a world where the majority of patients who are in hospital at least in part for purposes of assessment/treatment of mental disorder are now to be considered to be deprived of their liberty (and hence, in reality, the once-central concept of 'informality' has all but disappeared):

    a. It requires identification of whether a person is a "mental health" or a "physical health" patient, a distinction in DOLS, which would – of necessity – be carried through into LPS and which may make sense in legal terms, but which jars with clinical realities;

    b. The consequences of detention under the MHA 1983 are very different to deprivation of liberty under DOLS/LPS, both positive (for instance, of entitlement in some cases to free aftercare under s.117 MHA 1983) and negative (for instance, the stigmatising effect of detention under the MHA 1983).

9. The Law Commission sought (within the limits of its remit[11]) to rationalise the interface; the MHA Review is also looking at this matter. The JCHR will also, likely, wish to consider this issue, and I would invite the Committee to do so by asking, above all, whether issues regarding mental health care and treatment are best to be looked at solely through the prism of the regulation of confinement.[12]

Conclusion

10. I would be happy to amplify any part of this evidence should the Committee find it of assistance.

[10] https://consult.gov.scot/health-and-social-care/adults-with-incapacity-reform/user_uploads/153750_sct1217567598-1_awi-reform-consultation_p6.pdf, page 13.
[11] The JCHR will be aware that the Law Commission very strongly recommended consideration of fusing mental health and mental capacity law.
[12] See in this regard, in particular, the article by Neil Allen: https://www.researchgate.net/publication/280932965_The_not_so_Great_Confinement.